Saudi Arabia Private Healthcare Sector

Structural demand tailwinds intact despite near-term margin pressures

Executive summary

Saudi Arabia's private healthcare sector is entering a multi-year capacity build-out underpinned by structural demand, regulatory reform, and insurance expansion. Near-term margins are under pressure from ramp-up costs and rising competitive intensity, with recovery expected from FY27 as new beds reach utilization thresholds. On our covered names: we rate **SULAIMAN AB** as **HOLD** with **TP of SAR 235/sh.**, reflecting margin pressure persisting through 2026, slower-than-expected revenue per patient growth, reduced Solutions segment contribution, and rising competitive supply in Riyadh; and we rate **MEH AB** as **BUY** with a target price of **SAR 48/sh.**, supported by a gradual multi-year recovery driven by subspecialty expansion and new capacity, though margins are expected to remain structurally below historical levels given intensifying competition.

Demand drivers: Saudi Arabia's population reached 35.3mn in 2024, growing at a CAGR of 3.3% since 2019, with expatriates comprising 44% of the total. Structural demand is underpinned by a high and rising NCD burden, with 73.2% of all deaths attributable to chronic disease, adult obesity at 23.1%, and the elderly cohort projected to more than double to 4.6mn by 2030. These dynamics point to a durable, multi-decade demand pipeline.

Supply gap: Private sector beds represent only 25% of total capacity against a government target of 45% by 2030, implying approximately 15.5k incremental private beds required. At 2.4 beds per 1,000 population, Saudi Arabia is materially under-bedded versus DM peers (6.2) and EM peers (4.3). The post-acute care segment is particularly undersupplied at 8 PAC beds per 100,000 versus 53 in OECD countries.

Insurance and regulatory catalyst: Insured lives reached 14.4mn in 2025, with CHI projecting 25mn beneficiaries by 2030 and health insurance contributing approximately SAR 61bn to GDP. The MoH privatization program plans to transfer hospitals and primary care centers to private operators, with primary care specifically targeted as the front line of the government's value-based care model. Six of the nine listed operators are already building medical center networks in anticipation of this shift. On DRG, with shadow billing underway; full migration will pressure weaker operators while favoring larger, well-run groups.

Sector financials: The nine TASI-listed operators generated SAR 33bn in revenues in FY25 (16% CAGR since FY20), with EBITDA margins holding in a 23 to 25% band. Gross margins declined to a five-year low of 32% as ramp-up costs weighed on the cost base. FCF turned negative at SAR 1.7bn, with capex reaching SAR 8.8bn (1.1x EBITDA), funded by debt growing from SAR 9.1bn to SAR 20.5bn. Net Debt to EBITDA stands at 2x; ROIC is stable at 12 to 13%, with recovery expected from FY27. HMG dominates at SAR 13.7bn revenue and 14% market share, though occupancy has declined to 60% from 80% in FY23 following six new hospital launches; margin recovery is expected from FY27. MOUWASAT leads on profitability with a five-year average gross margin of 46% and sector-best FCFF margin of 15%, self-funding expansion through internal cash flows. DALLAH expanded market share to 9% through Eastern Province acquisitions but carries elevated net debt to EBITDA of 4.3x post-acquisition. MEH holds 9% market share through geographic diversification but operates with the sector's highest CCC of 192 days and net debt to EBITDA of 4x, with margin recovery back-end loaded to 2H26. CARE stands out on operational efficiency with 83% bed utilization and 29% EBITDA margin, the most conservative balance sheet at 0.1x net debt to EBITDA, and is the only operator to have expanded gross margins over the five-year period. FAKEEHCA and ALMOOSA have both deleveraged materially post-IPO to 0.4x debt to equity each, with FAKEEHCA's margin drag almost entirely attributable to Madinah hospital ramp-up losses. SMCHEALTH is the standout EBITDA margin improver, rising from 16% to 27.1%, driven by the deliberate shift from LTC to higher-acuity acute services. ALHAMMADI has added no new beds since 2021, with the Olaya hospital relaunch in 2026 as the primary near-term catalyst.

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Key risks

Margin compression from capacity ramp-up

Aggregate gross margin fell to a five-year low of 32% in FY25 and EBITDA pressure is expected to persist through FY26 as newly launched hospitals operate below breakeven utilization. Recovery is deferred to FY27 at the earliest.

Competitive intensity in Riyadh

Approximately 2,700 new beds are planned across 12 hospitals in the Central region by 2030. HMG's entry into Jeddah at competitive price points signals that pricing discipline is already under pressure. Sustained oversupply relative to demand absorption could compress revenue per patient across the sector.

DRG reimbursement transition

DRG adoption caps revenue per admission and transfers length-of-stay and complication risk onto providers. Shadow billing is underway with full rollout expected by 2028. The transition favors large, efficient operators and will pressure those with weak cost controls or limited billing infrastructure.

MoH procurement shift

MoH is moving from direct case-based referrals to competitive tender-based procurement priced at insurance-equivalent rates, reducing the premium historically attached to government referrals. MEH face the most direct earnings impact given its MoH revenue concentration.

Expatriate demand cyclicality

Expatriates account for approximately two-thirds of the insured pool and rely almost entirely on private healthcare. This demand is indirectly a function of overall economic activity and hiring, which is affected by oil prices and government project spending, not a structural constant. The expat population contracted 9% in 2021, pulling insured lives down 12% within a single year. A sustained oil price downturn or slowdown in mega-project activity could compress private healthcare volume growth.

Leverage and finance cost escalation

Sector debt (listed companies) has risen from SAR 9.1bn to SAR 20.5bn over five years, with finance costs compounding at a 39% CAGR to SAR 911mn in FY25. Interest coverage has fallen from 15.5x to 6.5x. MEH and DALLAH carry net debt to EBITDA of around 4x, with limited buffer against earnings deterioration or a sustained higher rate environment.

Long-term pricing pressure

The government's objective of reducing system-wide healthcare costs creates a structural headwind for provider pricing. DRG rollout, insurance repricing cycles, and the shift to value-based contracting collectively point to a declining margin trend over the longer term. Scale and operational efficiency will determine which operators can offset price pressure through volume and market share gains.

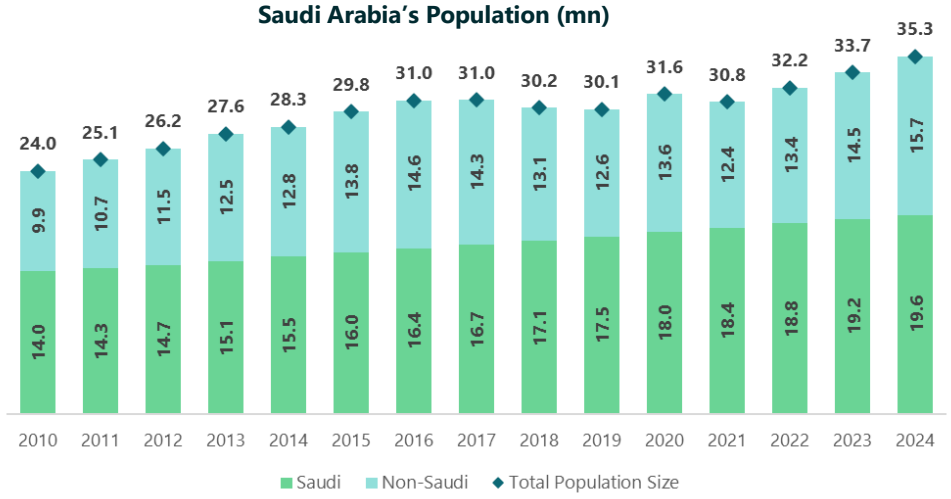
Healthcare sector favored by market and regulatory drivers

Population growth and expatriate population dynamics

Saudi Arabia has experienced strong population growth in recent years, which is supporting increased demand for healthcare services. The country's population increased from 30.1mn in 2019 to 35.3mn in 2024, representing a CAGR of 3.3% over the period. A significant portion of this growth has been driven by the expatriate population. Between 2019 and 2024, the non-Saudi population grew at a CAGR of 4.5%, compared with 2.3% growth for the Saudi population. As a result, expatriates accounted for around 44% of Saudi Arabia's total population in 2024.

The recent rise in expatriate numbers follows a sharp decline during the COVID-19 period, when economic disruptions and job losses led to a 9% Y/Y decline in the expat population to 12.4mn in 2021. Since then, expatriate inflows have recovered strongly, supported by the acceleration of mega and giga projects across the country, which are driving demand for foreign labor. As a result, the expatriate population increased at a CAGR of approximately 8% between 2021 and 2024, reaching 15.7mn in 2024. The continued expansion of the population, particularly among expatriates who typically rely on private healthcare services through employer-provided insurance, is expected to remain a key driver of healthcare demand in Saudi Arabia.

Here it is also worth highlighting that expatriate population growth in not indigenous, it remains dependent on overall economic activity in the country, which is in turn impacted by government spending, corporate spending and oil prices. This is evident from the sharp decline in expatriate population during the Covid period. As a result, there is an element of cyclicality to expatriate population growth which exposes private healthcare demand in Saudi Arabia to cyclical economic drivers such as oil prices.



Source: GASTAT

Demographic outlook: Ageing population and NCD burden

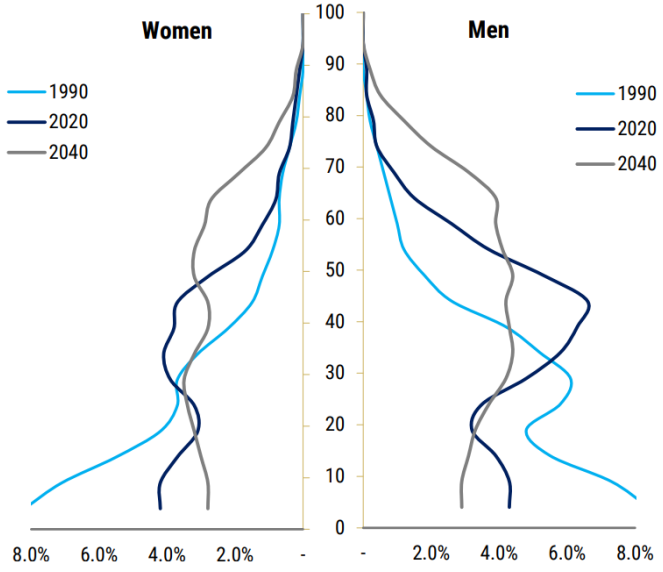
Saudi Arabia's demographic profile continues to support long-term growth in healthcare demand. The country has a relatively young population with a large and expanding working-age cohort, supported by favorable migration flows and government-led economic expansion. These factors have contributed to steady population growth and increasing demand for healthcare services.

Historically, Saudi Arabia has been characterized by high birth rates, declining mortality rates, and a relatively low old-age dependency ratio, typical of emerging high-growth economies. Improvements in healthcare access, living standards, and favorable migration trends have further supported population growth and workforce expansion.

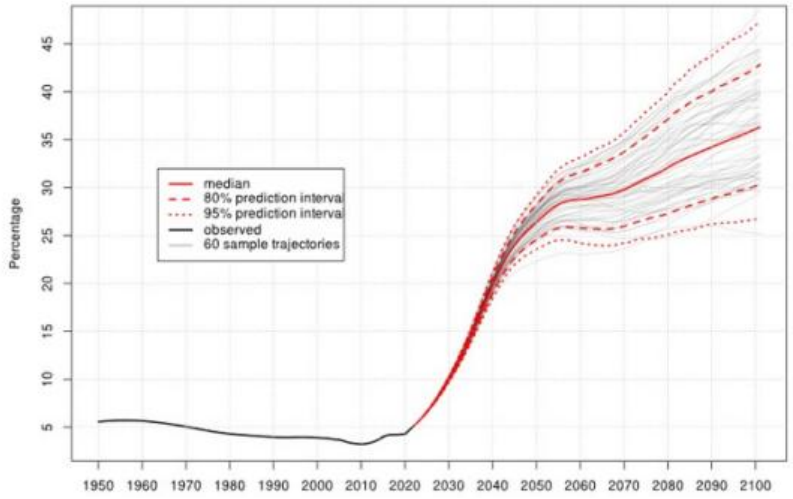
However, demographic dynamics are expected to gradually shift over the coming decades. According to a Morgan Stanley (Dec'22) report, birth rates are projected to decline over time, partly reflecting the inverse relationship between fertility rates and rising labor force participation. At the same time, population ageing is expected to accelerate.

As a result, the share of individuals aged 65 years and above is projected to increase from around 5% of the population in 2022 to approximately 10% by 2030 and nearly 30% by 2050, bringing Saudi Arabia closer to demographic patterns observed in developed economies. The expansion of the elderly population is expected to increase demand for healthcare services, particularly for chronic disease management, ambulatory care, and long-term medical support.

Saudi Arabia population pyramid 1990, 2020, 2040



>65-year-olds as a % of Population



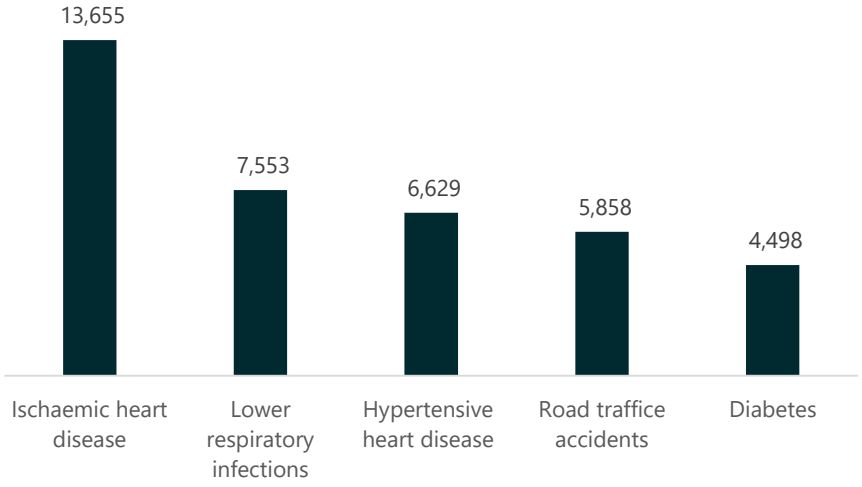
Source: UN, Morgan Stanley

Non-communicable disease burden

Saudi Arabia has a high prevalence of non-communicable diseases (NCDs) driven by tobacco use, high salt intake, poor diet and physical inactivity. According to the World Bank (2022), approximately 73.2% of all deaths in the country are attributable to NCDs, including cardiovascular diseases, diabetes, cancers and chronic respiratory diseases.

Recent mortality data further highlights the dominance of chronic diseases in the country's health profile. In 2022, ischemic heart disease was the leading cause of death with approximately 13,655 deaths, followed by lower respiratory infections (7,553 deaths), hypertensive heart disease (6,629 deaths), road traffic accidents (5,858 deaths) and diabetes (4,498 deaths). The prominence of cardiovascular-related conditions among the leading causes of death reflects the growing impact of lifestyle-related diseases.

No. of deaths by causes in Saudi Arabia, 2022



Source: World Health Organization

Lifestyle-related health risks remain a key structural driver of this disease burden. According to the General Authority for Statistics (GASTAT) 2024 Health Determinants Statistics, obesity prevalence among individuals aged 15 years and above stands at 23.1%, while 45.1% of the population is classified as overweight. Among children aged 2–14 years, 14.6% are obese and 33.3% overweight, highlighting the long-term risk of chronic conditions such as diabetes, cardiovascular diseases and hypertension in the country.

Government's regulatory push to contribute to sector growth

Government-led reforms remain a key driver of growth in Saudi Arabia's healthcare sector. Under Vision 2030, the government has launched several initiatives aimed at expanding healthcare infrastructure, improving service quality, and increasing private sector participation. A central pillar of this effort is the **Health Sector Transformation Program**, which aims to restructure and integrate the healthcare system while improving access to services. The program targets providing comprehensive healthcare coverage to around 88% of the population by 2030.

A key component of this transformation is the Privatization Program, which seeks to unlock state-owned healthcare assets for private sector investment and gradually transfer the operation of selected government hospitals and primary healthcare centers (PHCCs) to private operators. The objective is to expand the role of private healthcare providers in meeting the country's growing demand for healthcare services.

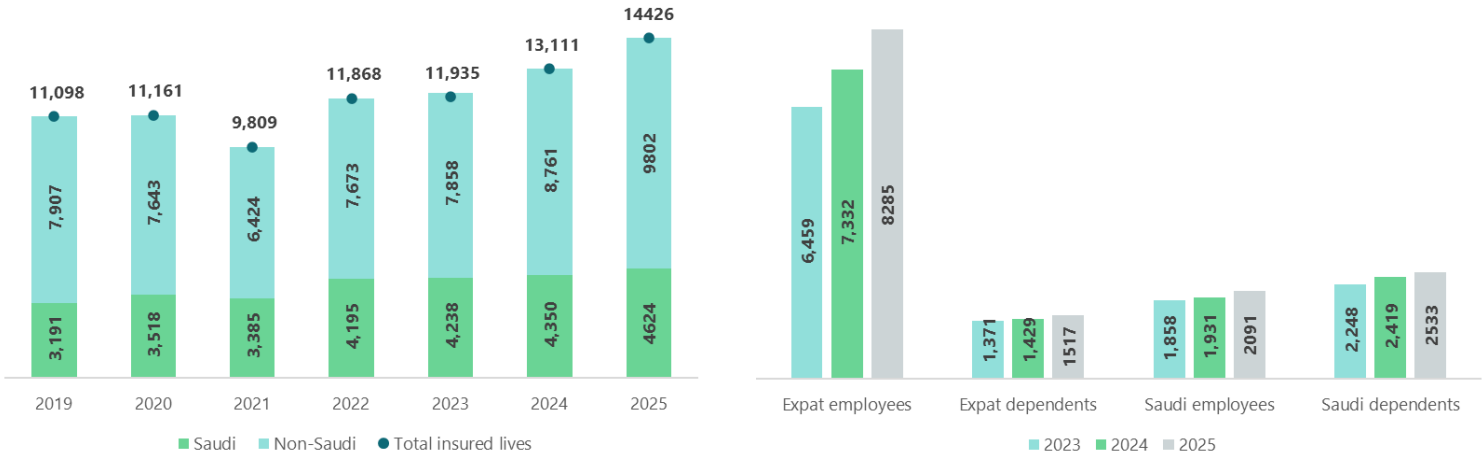
Private sector operators account for around 24% of total hospital beds, according to comments by the Minister of Investment at the Global Health Forum in Oct'23. The government aims to increase this share to 45% by 2030, reflecting a significant shift toward private sector-led healthcare delivery. In addition, the number of private sector clinics is expected to increase from around 20,000 currently to ~50,000 by 2030. According to the Minister of Investment (Oct'23), the GDP contribution from the health sector is predicted to reach SR318bn in 2030, with the private sector contributing SR145bn.

National Insurance Program to increase insured lives

Saudi Arabia's shift toward an insurance-based healthcare financing model is reshaping demand dynamics for both private providers and insurers. Over the past few years, insured lives have rebounded strongly following the earlier expatriate workforce adjustment, when about 1.05mn expats exited the market between early 2018 and 3Q21 due to the expat levy and COVID-related job losses. This disruption contributed to a drop in insured lives to 9.8mn in 2021, before a sharp recovery driven by renewed hiring, demographic growth, and stricter enforcement of mandatory health insurance for private-sector employees.

Between 2019 and 2025, the number of insured lives increased from 11.1mn to 14.4mn. The Saudi insured population increased from 3.2mn in 2019 to 4.6mn in 2025 (CAGR 6.4%), while non-Saudi insured lives recovered from the low of 6.4mn in 2021 to 9.8mn in 2025 (CAGR 11.1%), with expatriates continuing to represent roughly two-thirds of the insured pool. The structure of this pool underscores the central role of employer-based coverage: in 2025, expatriate employees accounted for over 8.3mn insured lives, with around 1.5mn expat dependents, while Saudi employees and dependents represented approximately 2.1mn (1.9mn in 2024) and 2.5mn (2.4mn in 2024) insured lives, respectively. This pattern highlights how compliance with mandatory medical insurance in the private sector remains the primary driver of coverage, with dependents, particularly Saudi family members, forming an expanding share of the insured base as enforcement improves.

Insured lives ('000) in Saudi Arabia



Source: BUPA

Health coverage patterns further illustrate the balance between public and private payors. In 2025, government coverage accounted for 56% of basic health expense coverage for adults aged 15 and above, while private health insurance represented 37% (GASTAT, 2025); the remainder relied on charity associations or out-of-pocket cash and card payments. Coverage is not uniform by gender: government schemes cover a larger share of females (around 73%) than males (48%), whereas private insurance penetration is higher among males (44% versus 23% for females), reflecting the concentration of men in expatriate labor force. This mix indicates that most adults already access care through structured risk pools, with considerable room for private insurance to deepen as labor-force participation, especially among women, continues to rise.

Council of Health Insurance (CHI) data and commentary point to a long-term structural growth runway for the sector. According to CHI, insurers are targeting a significant expansion of their coverage base, with industry expectations that the number of beneficiaries could reach approximately 25mn by 2030. In economic terms, CHI projects that health insurance will contribute around SAR 61bn to GDP by 2030, equivalent to roughly 2% of total GDP, reflecting not only sustained volume growth but also a shift toward higher-value premiums, increased case complexity, and greater formalization of healthcare financing.

Underpinning the shift towards insurance-based financing, is the gradual rollout of NPHIES, the national digital platform for claims exchange between providers and payers. Initially covering insurance claims only, the platform expanded in April 2025 to include MoH-related claims, standardizing government reimbursements through the same system. The platform levies a fee of approximately 1% of processed claims on both insurers and providers. Middle East Healthcare Co. (MEH), which carries one of the highest MoH revenue exposures in the sector, reported that NPHIES costs contributed to a contraction in operating margin in FY25, post inclusion of MoH claims in NPHIES. Specialized Medical Co. (SMC Health) similarly flagged the bilateral 1% fee in its 3Q25 earnings call. Over time, full integration should support timelier claims settlement and tighter CHI oversight of the claims cycle, though near-term costs fall disproportionately on operators with higher MoH exposure.

Health Sector Transformation Program

The Health Sector Transformation Program (HSTP) is the Vision 2030 vehicle for a comprehensive restructuring of Saudi Arabia's health system. It shifts the sector to a beneficiary centered, integrated model while separating roles: the MoH regulates and oversees quality and governance, regional health clusters under Health Holding Company deliver care, and the Center for National Health Insurance purchases services and provides free health insurance for citizens through contracts tied to outputs and outcomes. The program also embeds digital health, virtual care and AI in delivery, and mobilizes private sector participation to expand capacity and efficiency.

According to HSTP Report 2024, the program is organized around four strategic objectives:

1. facilitating access to health services,
2. improving quality and efficiency,
3. strengthening prevention against health threats, and
4. enhancing traffic safety.

These are supported by 16 indirect objectives, 55 launched initiatives and 24 indicators. Headline ambitions include raising life expectancy from about 75 to 80 years by 2030 (reached 78.8 in 2024 vs 77.6 in 2023), achieving universal coverage for citizens via the national purchaser, and building a resilient system able to withstand epidemics, disasters and other emergencies, with domestic self-sufficiency targets for priority health security supplies such as PPE, sterilizers and rapid tests.

Measured against its indicators, 2024 results show the program ahead of plan on beneficiary experience and coverage and on track in workforce densification and disease control. Beneficiary experience with primary health care centers reached 85.6% in 2024 compared with 72.1% in 2019 and against targets of 81.2% for 2024 and 81.7% for 2025. Identified infectious diseases achieving targeted reduction levels reached 87.5% in 2024 from a baseline of 55.5%, meeting the target. Coverage of population including peripheral areas by basic health services rose to 97.4% in 2024 from a baseline of 84.13 percent and against an 88% target. Nursing density climbed to 828 per 100,000 population in 2024 from 581.6 (2019) surpassing the 2024 target of 795 and tracking toward 861 in 2025. User satisfaction during hospitalization reached 88.7% in 2024 from 82.4% with targets of 85.4% for 2024 and 85.5% for 2025.

HSTP progress on performance indicators in 2024

Indicator	2019 Baseline	2024 Target	2024 Achievement	Status	2025 Target
Beneficiary experience at primary health care centers	72.1%	81.2%	85.6%	Exceeded	81.73%
Identified infectious diseases achieving targeted reduction	55.5%	87.5%	87.5%	Met	87.5%
Populated areas covered by basic health care services	84.1%	88.0%	97.4%	Exceeded	88.0%
Qualified nursing staff per 100,000 population	581.6	795	828	Exceeded	861
User satisfaction during hospitalization	82.4%	85.4%	88.7%	Exceeded	85.5%

Source: HSTP report 2024

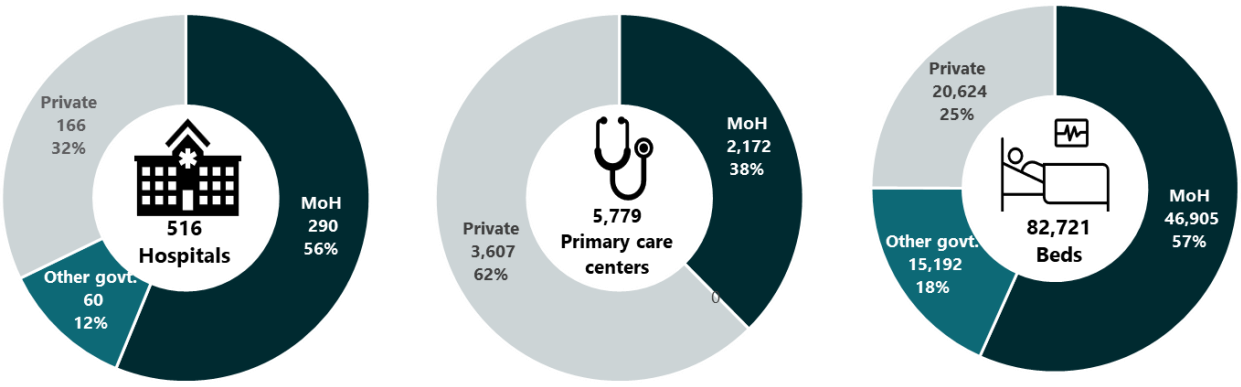
Healthcare System Structure

Saudi Arabia's healthcare sector is catered to by both public and private players, where government providers deliver majority of the care. As of 2025, basic health coverage reached 100% of Saudi citizens and 95.7% of the total population. Ministry of Health (MoH) facilities provide comprehensive services to citizens and emergency care to residents. Expatriates access services through employer-funded insurance mandated in 2005, a requirement extended in 2008 to Saudis employed in the private sector.

Before the public-health transformation completed in 2024, the MoH combined the roles of provider, regulator, and funder. After the reform, Health Holding Company (HHC), a government-owned entity established in 2022, became the national provider responsible for services to over 20mn people, while the MoH shifted to regulatory and supervisory duties and the National Health Insurance Center assumed the funding role. Under HHC, 20 health clusters were created by converting previously dispersed MoH facilities into accountable care organizations (ACOs) tasked with meeting the health needs of defined catchment populations.

As of 2024, Saudi Arabia had 516 hospitals: 290 (50% of the total) under the MoH, 60 (12%) run by other government entities (such as Security Forces and university hospitals), and 166 (32%) in the private sector. Bed capacity was segmented with 57% provided by the MoH, 18% by other government providers, and 25% by the private sector.

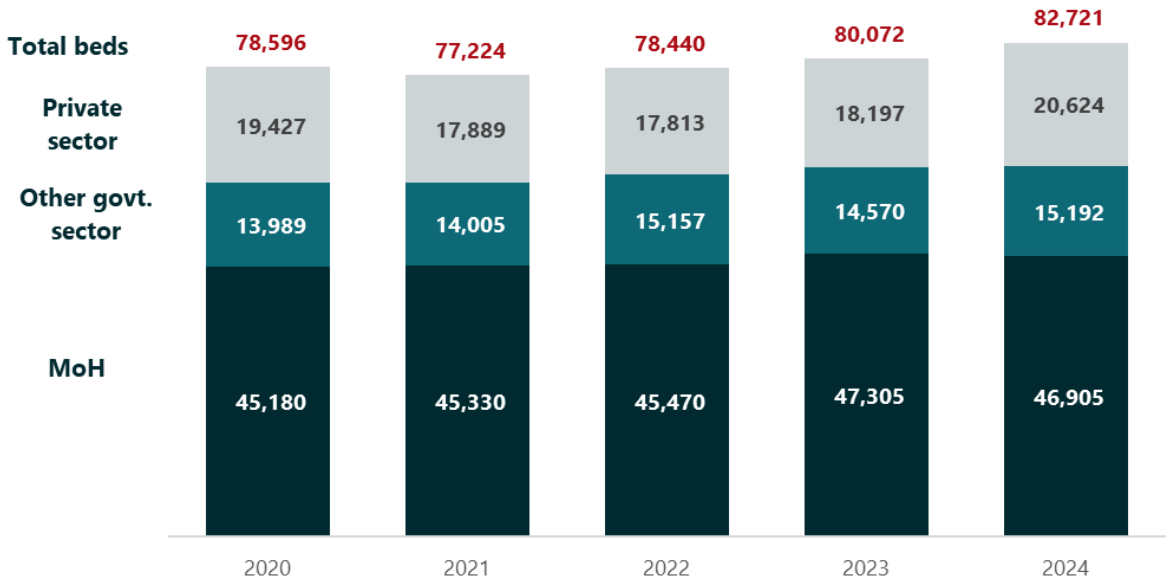
Saudi Arabia's healthcare facilities 2024; segmentation by entities



Source: MoH Statistical Yearbook (2024)

Total bed capacity in Saudi Arabia reached 82.7k (+3.3% Y/Y) growing from 78.6k in 2020. MoH bed numbers reached 46.9k beds a decline of -0.8% Y/Y, and only a slight increase from 45.2k back in 2020. Majority of the increase in bed capacity was driven by private sector. Private beds declined 8% Y/Y in 2021 to 17.9k beds due to COVID pandemic. The sector bed capacity has bounced back post covid growing at a CAGR of 5% between 2021-2024 to 20.6k beds. Other govt. sector also added 1200 beds between 2020-24 reaching 15.2k beds by 2024.

Hospital beds by entities



Source: MoH Statistical Yearbook (2024)

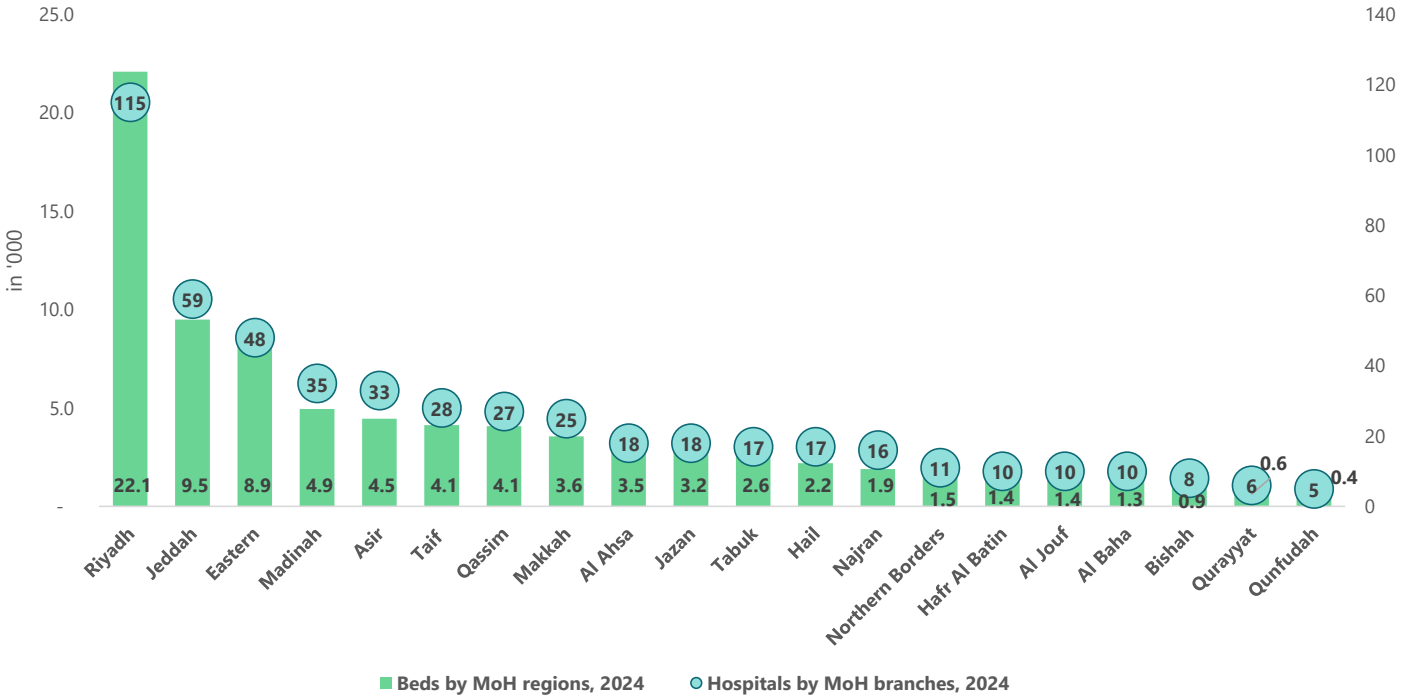
Geographical concentration of Saudi healthcare

Around 49% of the total hospital beds in 2024 are concentrated in Riyadh, Jeddah, and the Eastern regions, which together are home to about 68% of Saudi Arabia's population (Saudi Census 2022). Similarly, 71% of the country's private hospital beds are located in these three regions, establishing them as the nation's healthcare hubs. Riyadh remains the center for both general and specialized healthcare services, housing 65 public and 50 private hospitals that provide 14.6k and 7.4k beds, respectively. Supported by large-scale government programs such as the Regional Headquarters Program and extensive urban development, Riyadh's population continues to expand, generating steady demand for healthcare infrastructure, particularly in emerging northern districts such as Hittin, Arid, and Narjis.

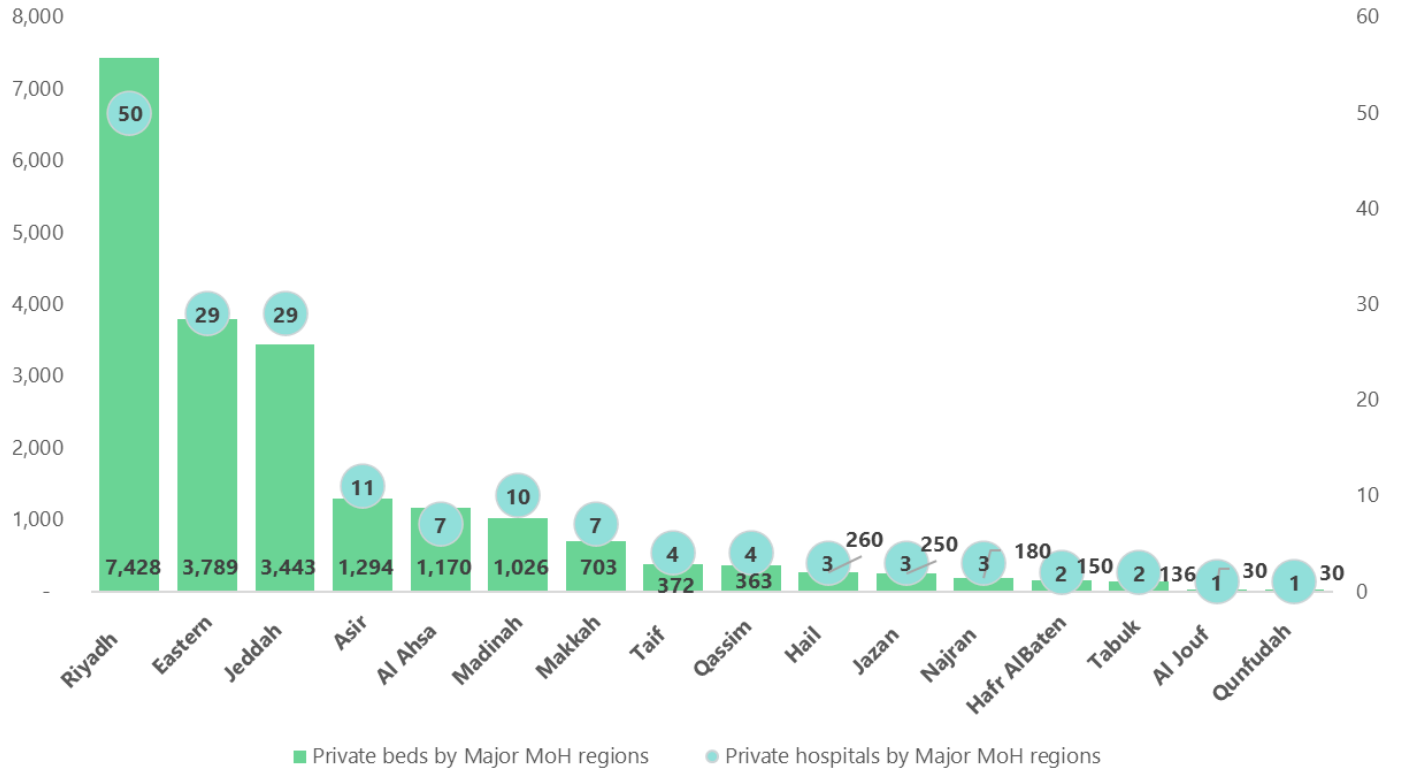
The second major healthcare region is Jeddah, which anchors the Western region's healthcare system. Although the neighboring Makkah and Madinah markets are expanding, Jeddah continues to function as the Western hub, helping absorb demand from adjacent cities. It is home to 19 public hospitals and 29 private hospitals with bed capacities of 6.1k and 3.4k, respectively. The Eastern region ranks third, supported by a balanced mix of 30 public hospitals (5.1k beds) and 29 private hospitals (3.8k beds), reflecting its growing role as a healthcare investment destination as providers expand beyond Riyadh and Jeddah. On a structural level, the average hospital size (beds per facility) is 1.5-2x times larger in the public sector than in the private sector.

Looking forward, population growth and economic expansion in Riyadh and the Eastern Province are expected to sustain demand pressures. Strategically, the current concentration of hospitals in the three metropolitan centers presents both a challenge and an opportunity. While these hubs will remain crucial for advanced and referral care, they risk capacity saturation in the medium term. Secondary regions, particularly Al Ahsa, Asir, Makkah, Tabuk etc are therefore likely to attract targeted investment as part of the government's expanding privatization and PPP initiatives designed to improve geographic equity in healthcare access.

Total hospitals (RHS) and beds ('000), by MoH defined regions/branches



Private hospitals (RHS) and beds, by MoH defined region/branches

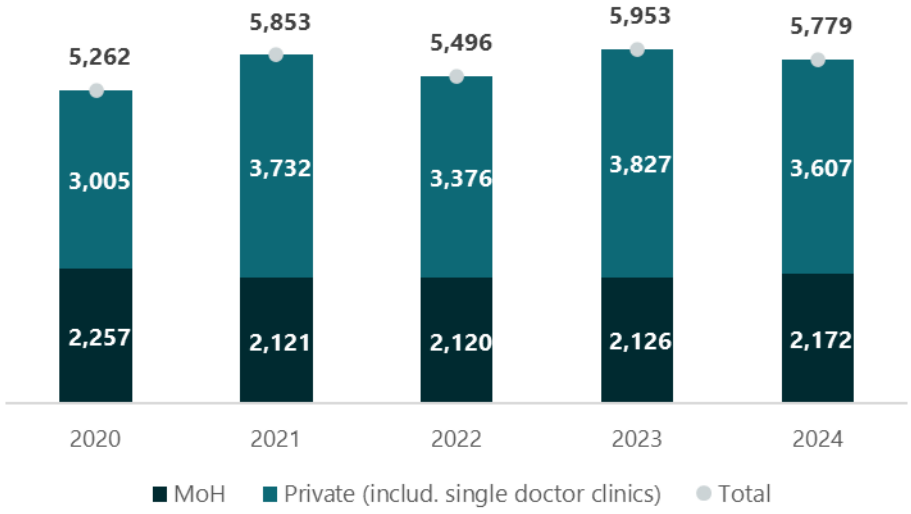


Source: MoH Statistical Yearbook (2024)

Primary care to take center stage

Both private and govt. sector primary care centers have shown mixed trends over the last four years. Primary care capacity comprised 2,172 MoH primary healthcare centers (PHCs) in 2024 as compared to 2,257 in 2020. These were alongside 3,607 private medical complexes and single-doctor clinics in 2024. The private primary facilities increased 27% in 2023 vs 2020, however in 2024, they faced a slight 5% Y/Y decline.

Primary care centers in Saudi Arabia



Source: MoH Statistical Yearbook (2024)

Saudi health transformation plan's newly adopted Model of Care program emphasizes primary care to be the first point of contact aimed at increasing efficiencies in care delivery and reducing cost at the secondary/hospital level. International precedents reinforce the strategy: Singapore holds primary care accountable for chronic-care outcomes, the UK's Primary Care Networks optimize patient flow into secondary and tertiary settings, and the US shift to value-based payments drew ~USD 16bn of primary-care investment in 2021. MoH also has laid out projects to privatize 74 PHCs followed by 150 more in a second project.

Moreover, primary healthcare centers are emerging as a key interest for private health care companies as they prepare themselves for value-based healthcare system the country is aspiring to achieve. Another major incentive of private healthcare companies towards setting up PHCs is creating hub and spoke models for their larger hospitals, aiming for higher accessibility and feeding another stream of inpatients to the larger hospitals. Six of the nine listed operators have developed medical center networks alongside their hospital facilities, comprising 30 facilities in aggregate, of which 24 are operational and six are under construction or at design stage. This interest has accelerated markedly in recent years: of the 24 operational facilities, six opened prior to 2023, 17 launched between 2023 and 2025, and one, MEH's Tawuun clinic in Riyadh, opened in 2026, with a further six facilities in the pipeline for 2026 and beyond. HMG operates the largest network with ten open medical centers across Riyadh, Qassim, KAEC, Khobar, and Dubai. FAKEEHCA has seven operational medical centers concentrated in Jeddah, with two further locations in Riyadh under construction or at design stage. ALMOOSA is developing five medical centers within the Eastern Province, two open and three at construction or design stage. DALLAH operates four clinics across Riyadh and Makkah, all open. MEH opened its first medical center at Tawuun in Riyadh in 2026, and SMCHEALTH has one facility under construction in Riyadh, targeted for 2026. MOUWASAT, CARE, and ALHAMMADI do not currently operate standalone medical centers.

Implication for the private players: More primary visits vs. specialist visits for outpatients would likely mean lower average margins for the outpatient business.

Regulatory reforms are further enabling insurance companies to enter the primary care sector. In 2024, after regulatory changes allowed insurers to engage in healthcare activities, BUPA AB launched Bupa Integrated Care subsidiary. The company is focusing efforts on a network of digital clinics that deliver remote-first primary care. The first integrated clinic opened in Riyadh in 2025, with further sites planned through 2026.

Furthermore, retail pharmacy chains like NAHDI AB are also launching clinics integrated in their pharmacies to cater to primary healthcare needs. Two new NahdiCare Clinics were opened in Riyadh and Abha during 1H25, bringing the total to 12 clinics across 9 cities in Saudi Arabia.

In 2022, MoH PHCs handled about 51mn outpatient visits compared with 13mn at MoH hospitals, underscoring their role as the front line of Saudi Arabia's public healthcare system. By 2024, this dynamic had shifted, PHC encounters fell to 41.3mn while MoH hospital outpatient visits rose to 16.8mn. As a result, PHCs represented around 71% of MoH-sponsored encounters in 2024, with an average of only 1.2 PHC visits per person per year, significantly below the Vision 2030 target of four PHC visits per person aimed at matching international benchmarks for preventive and community-based care. The gap is even starker when compared to the overall encounter rate of 4.8 per person per year across all sectors, public, private, and other governmental hospitals, indicating that much of the patient interaction continues to occur outside the govt. sponsored PHC network.

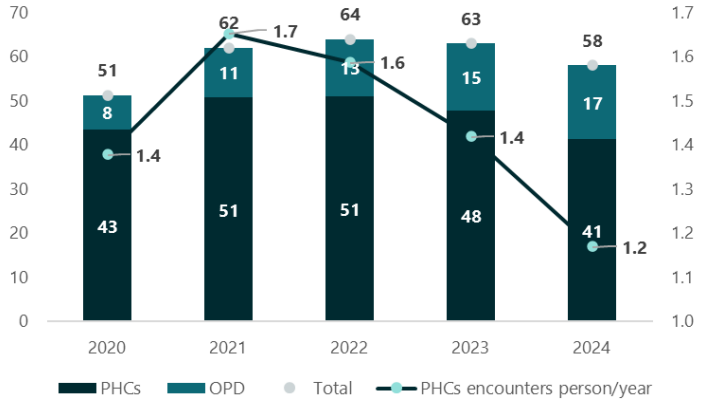
Outpatients in Saudi Arabia by healthcare sector

Total outpatient encounters across all healthcare sectors rose from 128mn in 2020 to 172mn in 2023, before easing slightly to 170mn in 2024. MoH encounters grew 30% over 2020 to 2022, but declined in subsequent years, falling 7% Y/Y to 74mn in 2024. Other Govt. Sector encounters similarly contracted 8.5% Y/Y to 25mn.

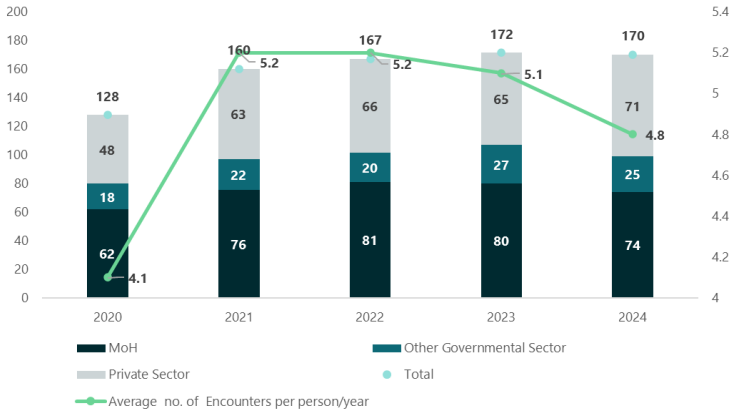
This decline in public sector encounters reflects system transformation rather than a deterioration in access. Saudi Arabia is deliberately shifting visits away from physical clinics through rapid digitization. Virtual appointments at MoH facilities nearly doubled Y/Y to 9.3mn in 2024 (MoH Statistical Yearbook). In addition to virtual appointments across MoH health clusters, MoH has also launched Seha Virtual Hospital with an annual capacity exceeding 597k patients (MoH). Further reducing in-person visits, the 937-call center and telehealth line resolved a high volume of cases without requiring physical attendance. Mass adoption of the Wasfaty e-prescription program, with 99mn prescriptions issued by mid-2024 (MoH), has also reduced visit intensity, particularly at PHCs, by streamlining chronic medication renewals and refills.

Against this backdrop, the private sector continued to gain share. Private sector encounters grew 10% Y/Y from 65mn in 2023 to 71mn in 2024, up from 48mn in 2020, representing a CAGR of 10% over the period. This was driven by expanding insurance coverage, which broadened patient access to private providers and diversified care pathways. As a result, the private sector's share of total outpatient encounters increased from 38% in 2020 to 42% in 2024.

PHCs' Encounters and Outpatients in MOH Hospitals (mn)



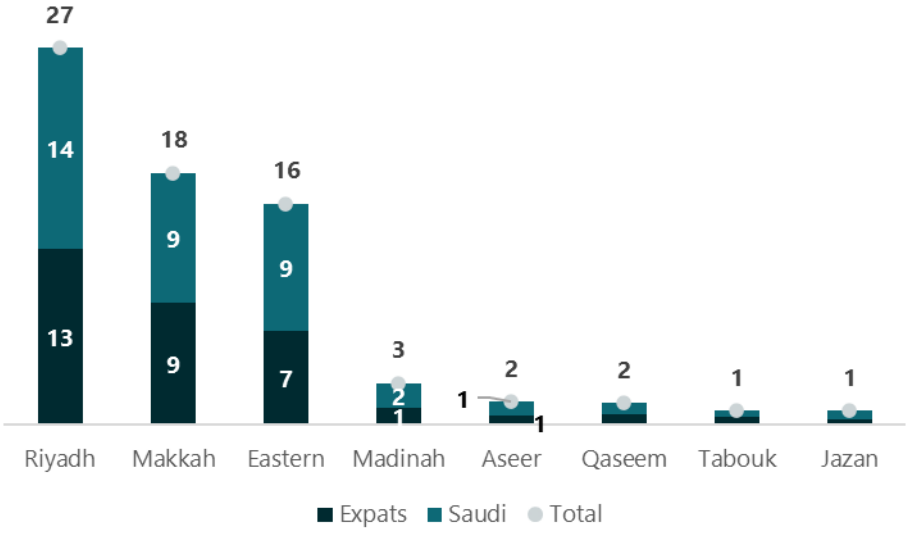
Encounters to Various Health Sectors (mn) & Average No. of Encounters Per Person



Source: MoH Statistical Yearbook (2024)

Among private sector outpatient and ER encounters in 2024, the Riyadh region (comprising Riyadh, Al Kharj, Al Majmah and Al Zulfi) recorded the highest volume at approximately 27mn, with expatriates accounting for around 47% of encounters. The Makkah region (Makkah, Jeddah, Taif and adjoining cities) ranked second, with Saudi and expatriate beneficiaries contributing in roughly equal proportions. The Eastern region (Dammam, Al Khobar, Dhahran, Qatif, Jubail, Al Ahsa and Hafr Al Batin) ranked third at 16mn encounters, with Saudi nationals comprising approximately 42% of the patient base.

Outpatients to all Private Sector Facilities by Administrative Region, 2024 (mn)



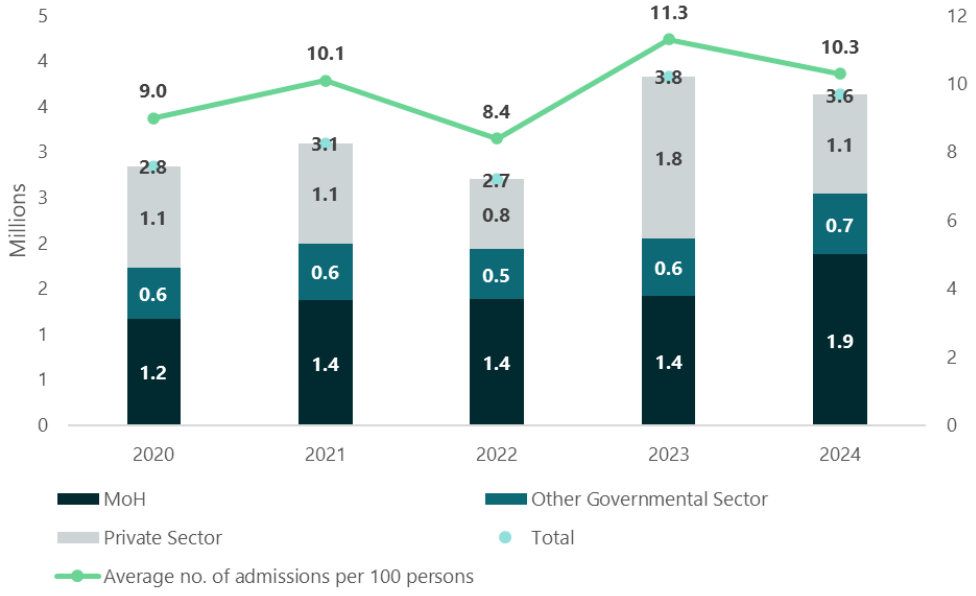
Source: MoH Statistical Yearbook (2024)

Inpatients in Saudi Arabia by health sectors

Inpatients in KSA in 2024 totaled about 3.6mn, with 52% managed by MoH, 30% treated in the private sector, and 19% in other government hospitals. This represents a modest 5% decline versus 2023, alongside a clear mix shift, as the private sector's share fell by roughly 17 ppts, while MoH and other government providers absorbed the flow. The spike in 2023 reflected post COVID catch up, particularly deferred elective and non-urgent procedures, which temporarily lifted admissions across the system. In 2024, activity normalized as more elective cases shifted to day case or observation settings, and public capacity under the health cluster model reabsorbed a larger share of medical admissions into MoH facilities. Average no. of admissions per 100 persons fell from 11.3 in 2023 to 10.3 in 2024.

While no published MoH data isolates referrals to private providers, directional evidence suggests fewer spillovers to the private sector in 2024. This aligns with data from the Saudi Medical Appointments and Referrals Center (SMARC), which recorded 755,145 e-referrals within MoH hospitals during 2023–2024, showing internal referrals increasing to 87.5% from 80.12% of total referrals while external referrals dropped to 12.5% after the unified Medical Referral Center platform launched in May'24 was scaled across MoH clusters. These shifts indicate stronger coordination and reduced need for outsourcing to private hospitals. MEH has flagged that it has experienced lower MoH referrals as MoH is transitioning from case-based referrals to tender driven procurement for procedures like join replacements, coronary catheterization etc. In contrast, CARE has reported growing GOSI/MoH referrals in FY25.

Inpatients by KSA health sectors (mn)



Source: MoH Statistical Yearbook (2024)

Post acute care: high demand and pressured existing infrastructure

Post-acute care (PAC) capacity in Saudi Arabia remains structurally undersupplied despite visible progress in recent years. According to the Statistical Yearbook 2024, MoH operates 935 long-term care (LTC) beds, including 615 beds in dedicated LTC hospitals and 320 beds embedded within general hospitals. Broader PAC capacity, including medical rehabilitation hospitals, is not reported in official MoH

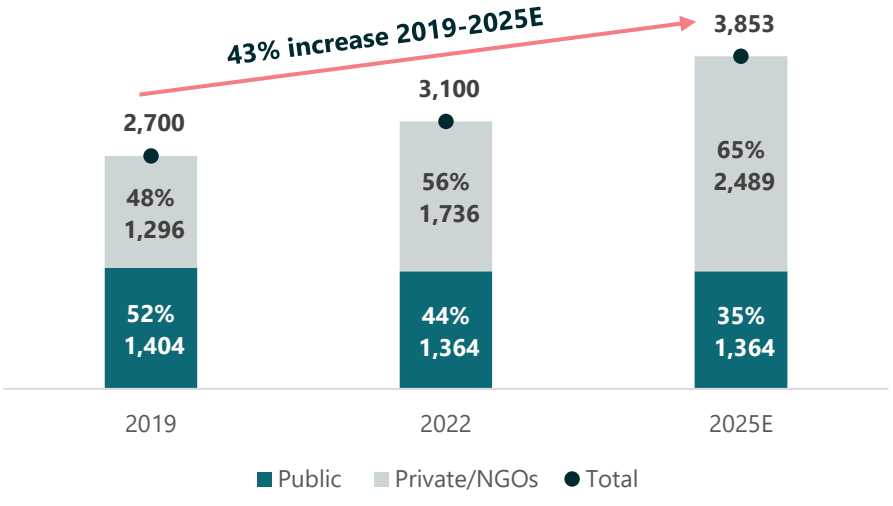
bed statistics; however, ALMOOSA Health's 2024 annual report indicates that Saudi Arabia had 22 dedicated PAC hospitals as of 2022, comprising 12 MoH facilities (55%), eight private hospitals (36%), and two under other governmental entities, with total PAC beds rising from 2.7k in 2019 to 3.1k in 2022. The private sector contributed 56% of PAC beds in 2022, highlighting its central role in the segment's development.

As of 2024, our mapping of private/NGO-sector PAC/LTC facilities, covering dedicated rehabilitation hospitals, extended-care centers, and long-term care hospitals, indicates more than ~2.5k private beds nationally. Assuming government PAC bed numbers remain broadly unchanged from 2022, and given the strategic shift toward private-sector participation, we estimate that total PAC capacity has expanded to over ~3.8k beds in 2025, with the private/NGO sector now contributing upwards of 65% of total PAC beds in the country.

Private and NGO sector PAC bed capacity 2025E

Facility	Location	Beds
Sultan Bin Abdulaziz Humanitarian City	Riyadh	511
Madeeda Hospitals	Riyadh	340
Health Oasis Hospital	Riyadh	300
Almoosa Rehabilitation Hospital	Al-Ahsa	300
National Medical Care: Chronic Care Specialized Medical Hospital	Jeddah	200
Mouwasat – LTC & Rehabilitation Hospital	Dammam	170
Sukoon International Extended Care Centre (CMRC Sukoon)	Jeddah	130
Abdul Latif Jameel Hospital for Medical Rehabilitation	Jeddah	120
Anfas Medical Care Hospital (AMC Hospital)	Riyadh	120
International Extended Care Centre	Riyadh	106
Mouwasat Hospital Madinah – LTC Portion	Madinah	100
Cambridge Medical & Rehabilitation Center	Dhahran	60
All Care Long-Term Care Hospital	Riyadh	32
Total		2,489

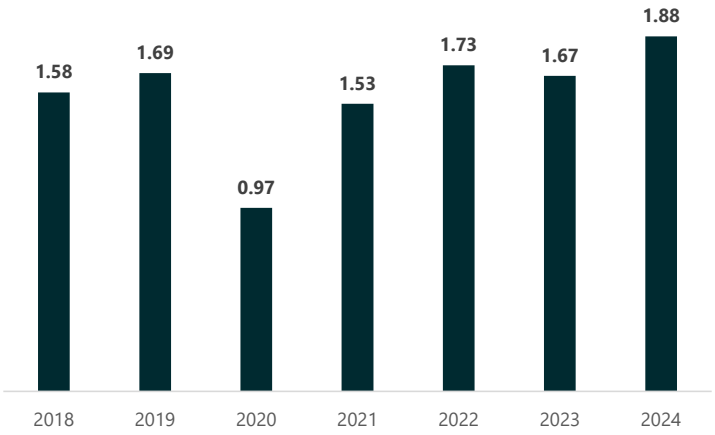
Public and private Post Acute-care (PAC) beds capacity in Saudi Arabia



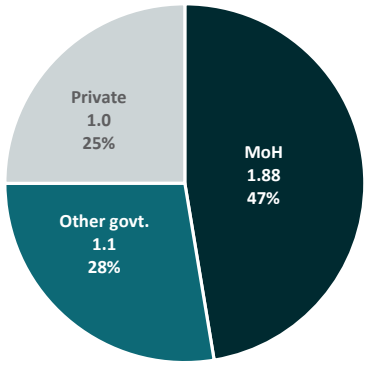
Source: Company websites, ALMOOSA 2024 report, BSFC

Utilisation indicators confirm sustained demand pressures. MoH medical rehabilitation cases increased from 1.58mn in 2018 to 1.88mn in 2024, recovering strongly after the pandemic dip in 2020. Of MoH rehabilitation activity, 79% relates to physiotherapy sessions. Total national rehabilitation visits reached 4mn in 2024, including 1.88mn under MoH, 1.1mn in other government facilities, and 1mn in the private sector. Private-sector outpatient rehabilitation activity is concentrated in physiotherapy (37%), orthotics and prosthetics (11%), while 51% is grouped under "other" by CHI, indicating significant service fragmentation.

No. of medical rehabilitation cases, MoH, mn, 2024



Rehabilitation cases across health sectors, mn, 2024



Source: MoH Statistical Yearbook (2024)

Demand pressures are reinforced by structural drivers: high prevalence of chronic diseases (diabetes, obesity, hypertension, cardiovascular diseases), increasing surgical complexity, road-traffic trauma incidence, and an ageing population. Moreover, Saudi Arabia has set a national target of 0.3 rehabilitation beds per 1,000 population, which implies a requirement for 6,500+ incremental rehabilitation/LTC beds by 2030, far above today's supply (Invest Saudi, 2022). The MoH Needs Assessment (CHI, 2020) confirms the urgency: 2,668 LTC patients were occupying acute-care beds, representing ~6% of government hospital capacity and directly crowding out acute-care throughput.

The rehabilitation segment is therefore a strategic expansion priority under the HSTP. According to Invest Saudi, rehabilitation is a core capability underpinning Saudi Arabia's Chronic and Planned Care models, supported by MoH, the Health Holding Company (HHC), and the Saudi Health Council. On the supply side, rehabilitation and LTC facilities remain relatively limited and geographically concentrated, creating market opportunity for private operators. The MoH 2020 LTC study also demonstrates the economic motivation for private-sector participation: the average LTC bed-day cost was SAR 1,875 in the private sector versus SAR 3,470 in public acute hospitals, implying ~54% savings if LTC patients are transitioned out of MoH acute beds.

Yet, when benchmarked internationally, the supply gap remains wide. Saudi Arabia has just eight PAC beds per 100,000 population, compared to 53 per 100,000 in OECD countries, and only 18 physical therapists per 100,000 versus 110 among OECD peers (PwC, 2024). This highlights both a capacity and workforce deficit that will require multi-year investment to close.

Regulatory Overview

The current healthcare regulatory landscape in Saudi Arabia consists of ten government entities, overseeing all pillars of healthcare which are the public health of the population, government and private healthcare service providers, private insurance, food, drugs, and medical devices, health practitioners, research and reports, and data and digitization. There are ongoing reforms in the Saudi Arabian health regulations, the gradual implementation of which started in 2021.

Pillars of Healthcare

- Public Health
- Provision and standards
- Private Insurance
- Food, Drugs and Medical Devices
- Health Practitioners
- Research and Reports
- Data and Digitization

Healthcare Sector Regulations

Saudi Health Council (SHC)

Coordinating between all healthcare providers to build and apply healthcare services standards

Ministry of Health (MOH)

Providing public healthcare services, promoting general health and developing laws and legislations regulating both the governmental and private health sectors

Health Holding Company

The HHC is tasked with managing the healthcare services through new operational structures called "health clusters," which are specialized entities designed to handle different aspects of healthcare provision.

Council of Cooperative Health Insurance (CCHI)

Through its implementation arm, developing and implementing policies and procedures and supervising the health insurance, including technical and medical monitoring on a continual basis for all parties of the health insurance and maintaining the rights of people insured

Saudi Commission for Health Specialties (SCFHS)

Developing educational and training programs for postgraduates, qualifying medical human cadres, and issuing professional certificates

Saudi Food and Drug Administration (SFDA)

Maintaining public health through ensuring quality, efficiency and provision of medications and that medical devices and products are in line with international standards

National Health Information Centre

Providing and organizing the infrastructure for health data exchange at the level of healthcare system.

National Center for Disease Control (CDC)

Preventing disease, prolonging life and promoting health

National Institute for Health (NIH)

"Currently part of SCH" Driving research and innovation to get effective interventions for population segments

Central Board for Accreditation of Health Inst. (CBAHI)

Setting standards, and assessing and granting accreditation to all healthcare facilities

Role of the Ministry of Health

The Ministry of Health is the main regulatory body overseeing healthcare in Saudi Arabia. It sets and enforces standards for hospitals, ensuring they comply with national healthcare regulations. This includes licensing hospitals, overseeing medical practices, and ensuring adherence to health codes and safety standards. The MoH is responsible for developing health policies that guide the operation and growth of hospital services across the country. Apart from its main function, MOH also works on the following:

- Involved in setting quality standards for healthcare services and implementing accreditation programs for hospitals.
- Working with educational institutions and healthcare facilities to ensure that medical staff are well-trained with a focus on professional development to keep pace with global standards.
- The referral of patients from public to private healthcare facilities in Saudi Arabia to optimize healthcare services manage the capacity of public hospitals and get access to specialized treatment for cases.

In addition to the MOH, The Ministry of Defence, including the National Guard, maintains its standards, but it is expected to change in future and this responsibility will fall within the purview of the MOH.

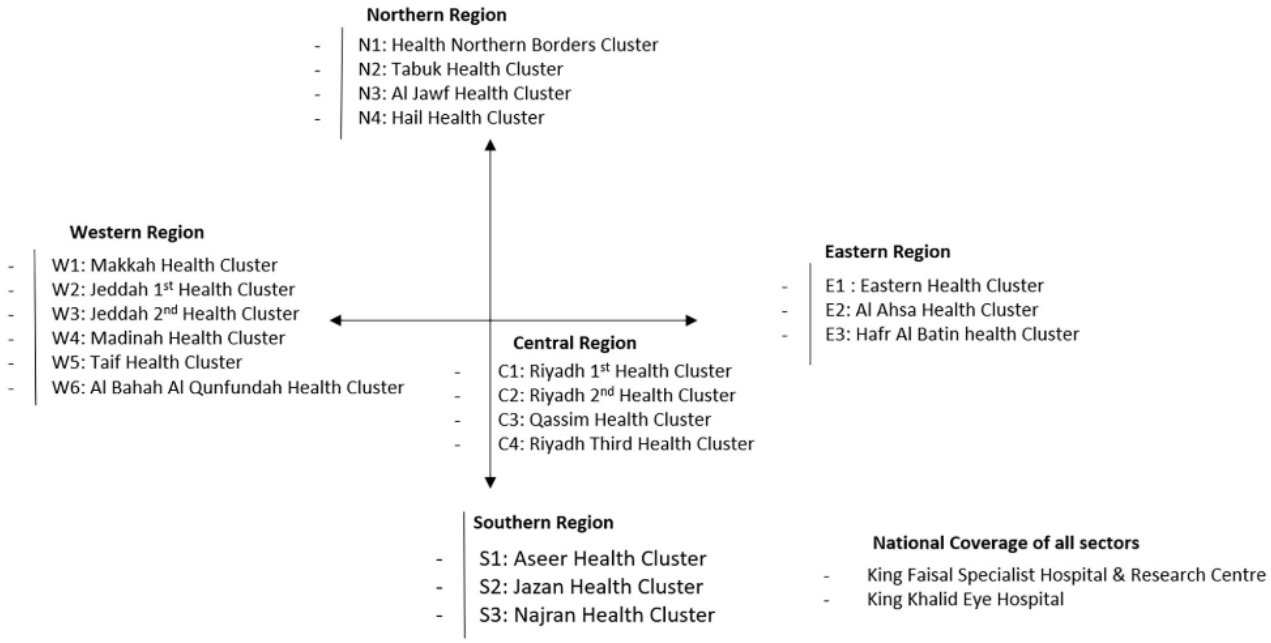
Changing structure of MOH:

Before 2024, the entire country was divided into 20 health directorates based on the 13 regions. Each directorate managed their health affairs under policy guidelines set forth by the MOH, with regions provided with lump-sum budgets, distributed to their hospitals. The budget of each region was sanctioned by MOH.

However, through the healthcare transformation model under the National Transformation Program, the MOH is undergoing drastic changes including a change in its focus and making it more streamlined. The government has separated the roles and responsibilities of regulators and service providers (Health Holding Company), whereby the latter focuses on services, and the MOH acts as a policymaker and regulator.

Under the transformation program, the government has launched health clusters in all regions of the country in Jan'24. The HHC is tasked with managing the healthcare services through health clusters which are specialized entities designed to handle different aspects of healthcare provision. Each cluster serves ~1mn persons, integrating primary care centers, public hospitals, and specialized services to provide healthcare coverage. These health clusters have more autonomy in terms of providing and managing medical and clinical services when compared to health directorates.

Health Clusters



Source: Alasiri AA, Mohammed V. Healthcare Transformation in Saudi Arabia: An Overview

Mandatory Insurance

In 2005, the Cooperative Health Insurance Act was implemented, making health insurance compulsory for all non-Saudi nationals working in the country. Subsequently, in 2008, the act was extended to include Saudi nationals employed in the private sector. By 2025, Saudi insured lives totaled 4.62mn, representing 32% of the total insured lives of 14.43mn, with dependents and employees accounting for 56% and 45% of that base, respectively. The mandatory Health insurance coverage is reinforced by the Saudi Labour Law and all business owners must have medical insurance cover for their workers from the date of their arrival, and hand them insurance cards within 10 days of their arrival in Saudi Arabia. According to the council's relatively new regulations, the insurance coverage becomes invalid only in the event of the beneficiary's death, cancellation or expiry of his or her insurance documents, or if he or she leaves Saudi Arabia on an exit-only visa. Married workers' medical insurance should cover pregnancy and childbirth.

These regulations were not fully enforced on some segments of the population such as more than 2mn domestic workers. However, in July'24, the Council of Health Insurance and the Saudi Insurance Authority started the implementation of the directive which makes insurance compulsory for domestic workers registered with an employer if their number exceeds four people.

The licensing of healthcare providers and professionals:

Medical staff, including doctors and pharmacists, must be properly licensed by the MOH and the General Directorate of Health Affairs by the Healthcare Profession Practice Regulations, including any regulations or circulars published by the Saudi Commission for Health Specialties, which is the regulatory body responsible for licensing doctors. In Saudi Arabia, only locally qualified doctors or pharmacists of Saudi Nationality can be managers for the hospital or hospital's internal pharmacy. Moreover, each hospital

must have an administrative manager of Saudi nationality, holding a university degree, to manage the hospital on a full-time basis.

Commissioning:

The MOH and the Saudi Central Board for Accreditation of Healthcare Institutions (CBAHI) are the primary parties involved in the commissioning of a new hospital. The registration process and procedural steps for obtaining a sector-specific regulatory license to set up a hospital in Saudi Arabia can be divided into three key steps: i) obtaining MOH's preliminary approval; ii) obtaining the approval of the Ministry of Commerce and Investment (MOCI); and iii) obtaining final approval from the General Directorate of Health Affairs and the CBAHI.

Saudi MoH Privatization Program under Vision 2030

Saudi Arabia's healthcare privatization program is a central pillar of Vision 2030's Health Sector Transformation Program. Since 2018, MoH has been implementing an ambitious plan to transition public assets into models that allow for private participation through public-private partnerships (PPPs), management contracts, and service outsourcing. The long-term plan, as cited by PwC and the National Center for Privatization (NCP), is to bring 290 hospitals and 2,300 primary healthcare centers into this framework by 2030. The objectives are to expand capacity, improve quality and efficiency, introduce competition and private governance disciplines, and reduce the fiscal burden on the state while modernizing infrastructure and services. NCP portal has following Live, Closed and Upcoming opportunities for PPPs.

1. Live PPP transactions

SABIC Behavioral Care Specialist Hospital – Riyadh

This 150-bed specialist behavioral health hospital in the Al-Nargis district of North Riyadh is being developed under a DBFOM (Design Build Finance Operate Maintain) model with a 15-year contract. The building and part of the equipment are provided by SABIC AB as part of its social responsibility program, while a private operator will handle both clinical and non-clinical operations, supply the remaining equipment, and deliver specialized mental health and addiction treatment services to adults and adolescents through 5 inpatient treatment rooms, 19 outpatient clinics, and 6 day-care treatment rooms.

Al-Iman Hospital Staff Accommodation – Riyadh

This project involves the development of staff accommodation for Al-Iman General Hospital in Riyadh through a 25-year DBFOM PPP. The private partner will build, operate, and maintain 564 housing units designed to accommodate approximately 808 staff members, supporting workforce stability and improving living conditions for healthcare professionals.

Rehabilitation Hospitals – Riyadh and Dammam

Under this PPP, private partners will build, finance, operate, and maintain rehabilitation hospitals in Riyadh and Dammam over a 20-year period. Each site will provide 150 inpatient beds and around 120,000 outpatient rehabilitation sessions per year, improving access to physical rehabilitation services and addressing rising demand linked to chronic disease, aging, and post-acute care needs.

Long-Term Care and Skilled Nursing Homes – Riyadh and Dammam

In Riyadh and Dammam, long-term care and skilled nursing facilities are being developed through 20-year DBFOM contracts. Each location will add 200 long-term care beds and 100 skilled nursing beds, enabling specialized care for patients with chronic illnesses and disabilities who require extended stays and support in daily activities.

Home Healthcare – Riyadh and Dammam

The home healthcare PPP focuses on delivering medical and supportive services to patients in their homes through a 10-year services contract. Qualified multidisciplinary teams will provide medical care, nursing, physical and occupational therapy, and speech therapy in Riyadh and Dammam, with the aim of serving around 10,000 patients and reducing pressure on hospital beds.

2. Closed PPP transactions

Renal Dialysis Service – Phase 1 (Nationwide)

Phase 1 of the renal dialysis PPP covered the design, financing, operation, and maintenance of dialysis services across the Kingdom under a 5-year DBFOM contract. This transaction marked one of the earliest large-scale clinical outsourcing initiatives, standardizing dialysis provision, improving quality and access, and setting a template for future PPPs in specialized services.

Radiology and Medical Imaging Services

The MoH has also concluded PPP arrangements for radiology and imaging services in selected hospitals, under which private providers are responsible for supplying and operating imaging equipment and delivering diagnostic services. These contracts have improved imaging turnaround times, enhanced technology levels, and reduced capital and operating costs for the public sector.

Al-Ansar Hospital – Medina

Al-Ansar General Hospital in Medina is widely recognized as the first full hospital PPP awarded under the national privatization program. The 244-bed facility, awarded to a consortium led by Tamasuk Holding and Alghanim International, replaces and expands the previous Al-Ansar facility by roughly 170%, and is operated under a long-term PPP that covers both clinical and non-clinical functions.

3. Upcoming PPP opportunities

Primary Healthcare Centers – 150 PHCs (Madinah, Qassim, Hail)

MoH and NCP are preparing a PPP to build, refurbish, operate (non-clinical), and maintain 150 primary healthcare centers across multiple clusters in Madinah, Qassim, and Hail. The project is designed to standardize PHC infrastructure, improve facility management, and enable the public sector to focus on clinical care.

Primary Healthcare Centers – 74 PHCs (Riyadh, Eastern, Western Regions)

A second PHC PPP covers 74 centers in Riyadh, the Eastern Region, and the Western Region under a 22.5-year DBFOM contract. The private partner will be responsible for developing and operating the physical infrastructure and non-clinical services, while MoH retains responsibility for clinical staffing and oversight.

Virtual Care and Telemedicine Network (Nationwide)

Upcoming PPPs in virtual care will provide a national telehealth platform covering tele-ICU, AI-based clinical decision support, remote patient monitoring, self-care tools, and virtual clinics. These solutions will be deployed across the Kingdom to extend access to specialist care, especially in remote areas, and to increase system efficiency.

Renal Dialysis Service – Phase 2 (Nationwide)

Phase 2 of the renal dialysis PPP will expand kidney-care services through a services contract covering approximately 150 centers and an estimated 20,000 patients. This phase builds on the experience of Phase 1 and aims to further standardize quality and ensure capacity ahead of rising demand.

Prince Mohammad bin Abdulaziz Medical City (PMMC) – Al Jawf

PMMC in Sakaka, Al Jawf, is planned as a 442-bed specialized medical city serving the northern regions. MoH and NCP have completed the necessary studies and legal work, and the project will be tendered under a PPP model under which the private sector will complete construction and participate in the provision of tertiary care services for around two million beneficiaries.

Al-Yamama Women and Children Hospital – Riyadh

Al-Yamama maternity and children's hospital in Riyadh will be developed and operated (non-clinical) through a PPP structure, with the private partner responsible for designing, building, and maintaining the facility while MoH provides clinical services.

Al-Masadiyah Women and Children Hospital – Jeddah

A similar PPP is planned for Al-Masadiyah maternity and children's hospital in the Makkah region, expanding specialized maternal and pediatric capacity in Jeddah under a long-term partnership with the private sector.

Medical Laboratories – Riyadh and Jeddah

MoH intends to tender PPPs for advanced medical laboratories in Riyadh and Jeddah, with private partners to develop, equip, and operate high-end diagnostic laboratories over an expected 15-year term. These labs will provide services such as clinical chemistry, microbiology, hematology, and molecular diagnostics, supporting both public and private providers.

Telemedicine Network and Digital Blueprint (Nationwide)
The telemedicine network PPP will support the delivery of telehealth services across the Kingdom using modern communications technology, while the Digital Blueprint PPP will implement clinical and administrative digital solutions at health-cluster level. Together, these projects aim to raise digital maturity, improve quality and safety, and support the rollout of unified patient records.

Diagnosis-Related Groups (DRG)

Diagnosis-Related Groups (DRGs) are a case-based hospital payment system that classifies inpatient episodes into groups with similar clinical characteristics and expected resource use. Instead of paying per day or per individual service, payers reimburse a fixed tariff for each DRG case, usually adjusted for complexity and severity. DRG-type systems are now a dominant form of acute-care reimbursement across many OECD health systems, primarily used to improve transparency, lower costs and improve efficiency. (OECD 2023).

In Saudi Arabia, AR-DRG (Australian Refined DRG) has been adopted by CHI as the national inpatient classification standard for the private health-insurance market. CHI positions AR-DRG as a core enabler of value-based healthcare and standardized hospital funding (CHI, 2021). Policy papers and implementation roadmaps describe a phased approach: preparatory work (coding and billing standards via the Saudi Billing System), pilot/shadow billing with selected payers and providers, and progressive migration of inpatient reimbursement to AR-DRG-based case payment for insured patients. AR-DRG has already been introduced for selected benefit lines and is integrated into both the Saudi Billing System (SBS) and the NPHIES platform, making it the reference framework for inpatient billing and claims settlement in the private insurance market (CHI, 2023-24). ***As per healthcare companies' management comments, the expected timeline for full implementation of DRG in the Saudi market is 2028.***

DRG impact on private operators

For private and listed hospital operators, DRG adoption is a structural change in the economics of inpatient care:

Revenue model and margins
Moving from itemized fee-for-service to fixed case-based tariffs caps revenue per admission and shifts financial risk for length of stay, resource use, and complications onto providers. International evidence shows DRG systems tend to reduce average length of stay and improve technical efficiency, but also compress per-case margins for inefficient hospitals (OECD, 2016). Efficient operators with strong clinical governance and utilization management can protect or even improve margins; those with long stays, high complications or weak internal controls are more likely to see margin pressure as DRG tariffs harden.

Case-mix strategy and portfolio optimization
DRG makes profitability by specialty and procedure far more transparent. Hospitals can see clearly which DRGs are structurally profitable and which are under-funded relative to cost. In other markets this has driven deliberate rebalancing toward higher-acuity and day-case procedures, and de-emphasis of low-margin DRGs (OECD, 2016).

Coding, documentation and IT investment
Accurate DRG reimbursement depends on high-quality ICD-10-AM / ACHI coding, robust clinical documentation, and tight EMR–billing integration. CHI's SBS standards explicitly align coding rules with AR-DRG to support consistent billing and analysis (CHI, 2021; CHI, 2023). Under-coding risks revenue

leakage, while over-coding creates compliance and penalty risk. Private groups therefore need to invest in coding teams, training, audit, and IT.

Negotiating dynamics with insurers
DRG gives payers and regulators a powerful benchmarking tool: they can compare cost per case, length of stay, and readmission rates across hospitals for the same DRG. Over time, this supports tariff convergence, stronger price discipline, and more selective contracting, which favours efficient, data-mature providers and increases pressure on weaker ones (OECD, 2019; CHI, 2023).

Regulatory and reputation risk
Experience from DRG systems in OECD markets shows that, without safeguards, DRG can create incentives for up-coding, premature discharge, or shifting complex cases elsewhere (OECD, 2016). CHI has indicated that AR-DRG will be used not only for payment but also for monitoring cost and quality, implying tighter audits, analytics, and potential sanctions for misuse (CHI, 2021).

Overall, DRG is likely to be neutral-to-positive for large, well-run hospital groups with strong coding, clinical governance, and throughput, and negative for smaller or less efficient providers that are slow to adapt.

Examples from other markets and outcomes for private players

Germany
Germany introduced DRG-based "Fallpauschalen" in the early 2000s. Evaluations show reduced length of stay and improved hospital productivity, but also tighter per-case margins, which contributed to consolidation and greater specialization. Private hospital groups expanded by acquiring or turning around under-performing public and non-profit hospitals (OECD, 2016; OECD, 2019).

Australia (origin market for AR-DRG)
Australia has used AR-DRG for activity-based funding of public hospitals since the 1990s. The system improved transparency on cost and complexity, enabled benchmarking across hospitals and states, and supported efficiency gains. Case-mix funding also helped clarify economics for private hospitals contracting with payers under DRG-linked arrangements (OECD, 2016; OECD, 2023).

Abu Dhabi (UAE)
Abu Dhabi's Department of Health implemented IR-DRGs as the main inpatient payment mechanism to address claims inflation and fee-for-service overuse. Evidence indicates reductions in unwarranted utilization, greater tariff transparency, and more standardized payments, but also the need for robust coding audit and monitoring to mitigate up-coding and case-selection behaviors (DOH Abu Dhabi, 2018; DOH Abu Dhabi, 2021).

The pattern across these markets is consistent: DRG improves transparency and efficiency but also compresses inefficient revenue and raises the strategic importance of scale, specialization, data, and operational discipline for private operators. This could potentially mean margin pressure for players that do not maximize efficiency of time and resources when treating patients.

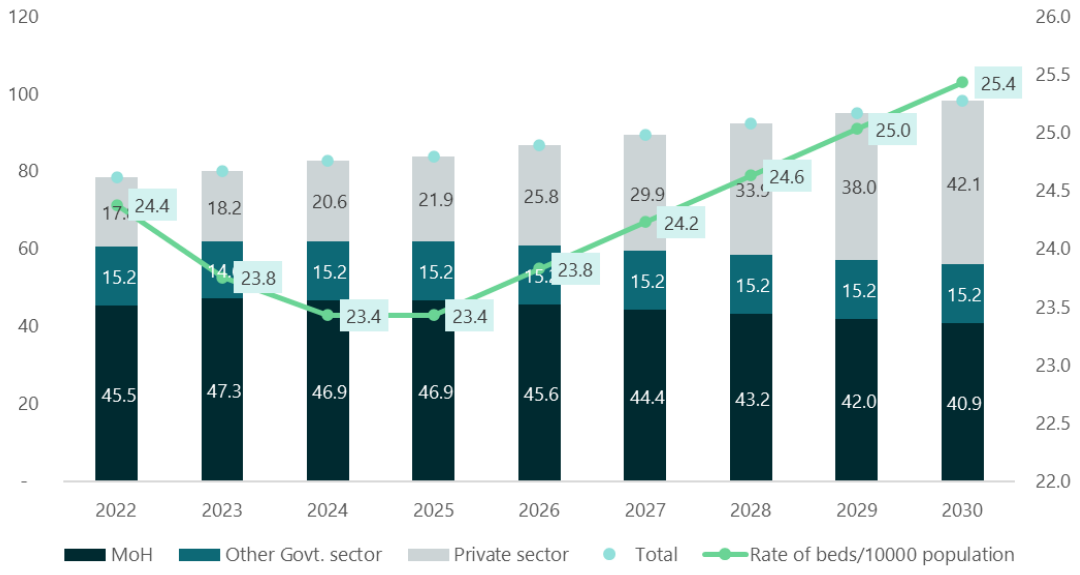
Bed capacity outlook

Knight Frank's Saudi real estate and healthcare outlooks, Colliers' multi-year healthcare capacity studies, and other reports drawing on GASTAT and Oxford Economics data consistently place the country's 2030 population at ~39-40mn. We estimate the Saudi population to reach 38.6mn by 2030 vs 35.3mn in 2024, growing at a CAGR of 1.5%.

GASTAT's statistics confirm that Saudi Arabia remains predominantly young where over 65% of population are under 35 (2022). However, the gradual ageing population trend would result in ~42% of the population expected to be over 40 by 2030. Moreover, the elderly cohort (> 60 years) in Saudi Arabia is expected to more than double to about 4.6mn by 2030, from 1.5mn in 2022 (Collier, 2023).

Saudi National Transformation Program targets a bed density of 27/10,000 population vs 23.4 in 2024. This target, if achieved, would require Saudi Arabia to add over 21k beds by 2030. This, in our view, is an ambitious target given that the speed of population growth has outpaced expansion in overall bed capacity. Bed density has declined from 25 in 2020 to 23/10,000 population. In our view, the bed density is expected to improve gradually to over 25.4. This would mean an additional requirement of 15.5k beds by 2030. We estimate that MoH will privatize around ~6000 beds by 2030, reducing the MoH beds count to ~41k from ~47k in 2024. In addition to these 6000 beds, private sector would need to add the additional 15.5k beds to fulfill the demand driven by population growth. As a result, private sector bed contribution will increase from 25% in 2024 to 43% in 2030.

MoH, Other govt. sector, Private sector beds ('000); Rate of beds/1000 population (2022-2030)



Source: MoH, BSFC Research

Listed Healthcare Companies: Aggregate Financials (FY20-25)

The table below presents consolidated financial data for the nine listed healthcare operators on TASI, comprising HMG, MEH, CARE, DALLAH, MOUWASAT, ALMOOSA, FAKEEHCA, SMCHEALTH, and ALHAMMADI. Figures represent high-level sector aggregates compiled from Argaam and company disclosures, covering FY20 to FY25.

Saudi healthcare sector financials	2020	2021	2022	2023	2024	2025
Income statement (SAR mn)						
Revenues	15,760	18,889	21,362	24,742	28,049	32,979
Cost of Sales	10,597	12,494	14,091	15,983	18,395	22,311
Gross profit	**5,164**	**6,395**	**7,271**	**8,759**	**9,653**	**10,668**
Selling and marketing expenses	456	452	568	713	867	855
General and administrative expenses	2,040	2,441	2,675	3,060	3,242	3,950
Others	(69)	(252)	(126)	(149)	(207)	54
Operating profit	**2,599**	**3,250**	**3,902**	**4,837**	**5,338**	**5,918**
Depreciation and amortization	1,060	1,125	1,176	1,310	1,527	1,958
EBITDA	**3,659**	**4,375**	**5,077**	**6,147**	**6,865**	**7,876**
Finance costs	178	209	334	603	801	911
Net income	**2,345**	**2,910**	**3,507**	**4,202**	**4,915**	**5,417**
Balance sheet items (SAR mn)						
Cash and cash equivalents	3,302	3,795	3,888	3,661	4,709	4,348
Operating current assets	7,561	8,003	9,061	10,593	11,108	12,742
Property and equipment	17,319	19,038	22,248	26,746	32,122	37,562
Other fixed assets	2,603	3,337	4,446	4,557	4,832	6,188
Total assets	**30,785**	**34,174**	**39,642**	**45,557**	**52,772**	**60,840**
Operating current liabilities	3,823	4,269	5,423	6,860	7,543	8,516
Loans	8,193	9,696	11,767	14,127	15,885	18,473
Leases	937	915	1,181	1,407	1,728	2,014
Total debt	9,131	10,610	12,948	15,534	17,613	20,487
Total liabilities	14,651	16,764	20,345	24,471	27,570	31,895
Total equity	16,134	17,410	19,297	21,086	25,202	28,945
Total liabilities and equity	**30,785**	**34,174**	**39,642**	**45,557**	**52,772**	**60,840**
Key items						
Interest bearing debt	9,131	10,610	12,948	15,534	17,613	20,487
Working Capital investment		(4)	(96)	95	(168)	661
Capex		3,579	5,493	5,920	7,179	8,754
Gross reinvestment		3,575	5,398	6,015	7,011	9,414
FCF to sector						
EBITDA	3,659	4,375	5,077	6,147	6,865	7,876
NOPLAT	2,394	3,026	3,649	4,623	5,089	5,731
EBIDA	3,454	4,151	4,824	5,933	6,616	7,689
Working capital investment		(4)	(96)	95	(168)	661
Cashflow from operations		4,155	4,920	5,838	6,783	7,028
Fixed capital investment		3,579	5,493	5,920	7,179	8,754
Free cashflow to sector		576	(573)	(82)	(395)	(1,726)

Key Ratios	2020	2021	2022	2023	2024	2025
Margins:						
Gross Margin	33%	34%	34%	35%	34%	32%
Operating Margin	16%	17%	18%	20%	19%	18%
EBITDA Margin	23%	23%	24%	25%	24%	24%
Net Margin	15%	15%	16%	17%	18%	16%
OCF Margin		22%	23%	24%	24%	21%
FCFF Margin		3%	-3%	0%	-1%	-5%
Leverage:						
Interest bearing Debt/Funds invested	30%	31%	33%	34%	33%	34%
Net Debt/EBITDA	1.6	1.6	1.8	1.9	1.9	2.0
Debt/Equity	0.6	0.6	0.7	0.7	0.7	0.7
Interest coverage	14.6	15.5	11.7	8.0	6.7	6.5
Returns:						
Return on invested capital	10%	12%	12%	13%	13%	12%
Return on equity	15%	17%	18%	20%	20%	19%

Revenues

Sector revenues have compounded at a 16% CAGR over 2020-2025, growing from SAR 15.8bn to SAR 33bn. Growth has been consistently driven by capacity expansion across listed operators, rising patient volumes, and the progressive ramp-up of new facilities. FY25 saw the second largest revenue growth in the last five years at 18% Y/Y, after 20% growth recorded in FY21. This was driven by full-year contribution of facilities launched in 2023-24. Revenue grew at 13%, 16% and 13% in FY22, FY23, FY24 respectively.

Profitability

Gross margins declined to 32% in FY25, the lowest level since 2020, despite having held broadly stable in the 33-35% range for most of the period. This reflects the cost drag of newly launched facilities, particularly the weight of pre-operating and ramp-up expenses on cost of sales, as well as wage inflation.

EBITDA margins have held in a narrow 23–25% band throughout the period, a reflection of the cost structure of healthcare: once a facility is staffed and operational, incremental revenue flows through at high margins. The stability of EBITDA margins despite gross margin compression is explained by the relatively fixed nature of SG&A costs, which have not scaled proportionally with revenue growth. FY25 EBITDA of SAR 7.9bn grew 15% Y/Y, sustaining the 24% margin.

Operating margins improved from 16% in 2020 to a peak of 20% in 2023, before moderating to 18% in FY25, again reflecting ramp-up cost absorption. Net margins followed a similar trajectory, peaking at 18% in 2024 before declining to 16% in FY25. The decline in net margin despite resilient EBITDA margin is partly attributable to rising finance costs, which have grown from SAR 178mn in 2020 to SAR 911mn in FY25, a 5-year CAGR of 39%, as aggregate debt levels increased materially (coupled with higher interest rate levels) to fund capacity expansion. Average finance costs as a % total debt (loans plus lease liabilities) increased from around 2% in FY20 to 4.8% in FY25.

Balance sheet and capital intensity

Total assets have nearly doubled from SAR 30.8bn in 2020 to SAR 60.8bn in FY25, driven almost entirely by property and equipment, which grew from SAR 17.3bn to SAR 37.6bn over the same period. This reflects the sector's highly capital-intensive nature, with cumulative capex of approximately SAR 31bn deployed over 2021-2025.

Annual capex has escalated sharply, from SAR 3.6bn in 2021 to SAR 8.8bn in FY25, a 25% CAGR. This expansion has been funded by a combination of operating cash flows and debt, with total interest-bearing debt rising from SAR 9.1bn to SAR 20.5bn over the period. Despite this, the sector's leverage

profile has remained measured. Net Debt/EBITDA has increased gradually from 1.6x in 2020 to 2x in FY25, reflecting the debt-funded expansion cycle, though the pace of increase has been modest given the quantum of capex deployed. The Debt/Equity ratio has been broadly stable at 0.6-0.7x throughout the period, and at 2x Net Debt/EBITDA, the sector retains sufficient balance sheet headroom to sustain the ongoing investment programme.

Working capital has remained relatively stable in the SAR 3.6-4.2bn range, indicating disciplined receivables management at the aggregate level, though individual operators, particularly those with high government and GOSI payer exposure, carry elevated DSOs.

Cash flows

Operating cash flow has grown from SAR 4.2bn in 2021 to SAR 7bn in FY25. However, free cash flow to the sector has been negative in four of the last five years, turning sharply negative at SAR (1.7bn) in FY25, as capex significantly exceeded operating cash generation. This is consistent with the sector being in an intensive investment phase, and free cash flow is expected to recover as new facilities ramp up and capex normalizes. OCF margins have declined from 23-24% in 2022-2024 to 21% in FY25, reflecting margin pressures and highest working capital investment in FY25 during the 2021-25 period.

Returns

Return on invested capital has been stable at 12-13% since 2021, suggesting the sector is generating returns modestly above its cost of capital on an aggregate basis. Return on equity has improved from 15% in 2020 to a peak of 20% in 2023-2024, moderating to 19% in FY25 as equity bases expanded following recent capital raises and retained earnings accumulation. Interest coverage has declined from 15.5x in 2021 to 6.5x in FY25, reflecting the tripling of finance costs over the period.

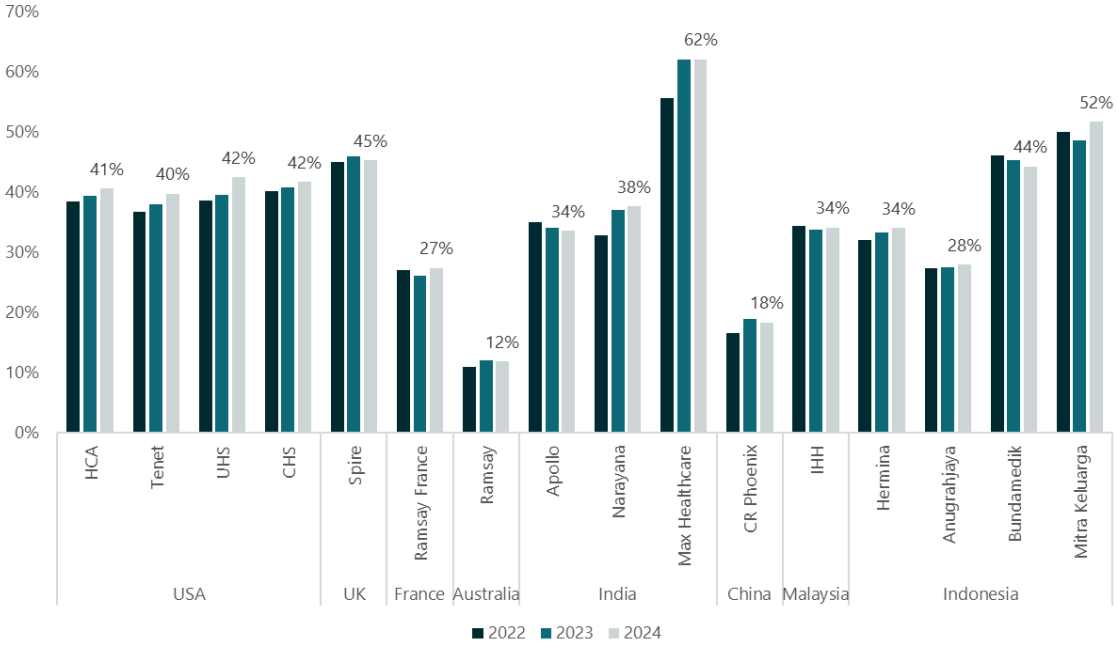
To conclude:

- The sector is in a high-investment phase, with capex running at approximately 1.1x EBITDA in FY25, depressing near-term free cash flow.
- Margin compression in FY25 is structural and expected to persist through 2026 as the largest wave of new facility openings completes ramp-up; recovery is anticipated from 2027 onwards.
- ROIC stability at 12–13% through the investment cycle is a positive signal; returns are expected to inflect upward as new beds reach utilisation thresholds.
- The sector's consistent EBITDA margin floor of ~24% underscores the durability of healthcare as a defensive, high-quality earnings stream despite near-term cost pressures.

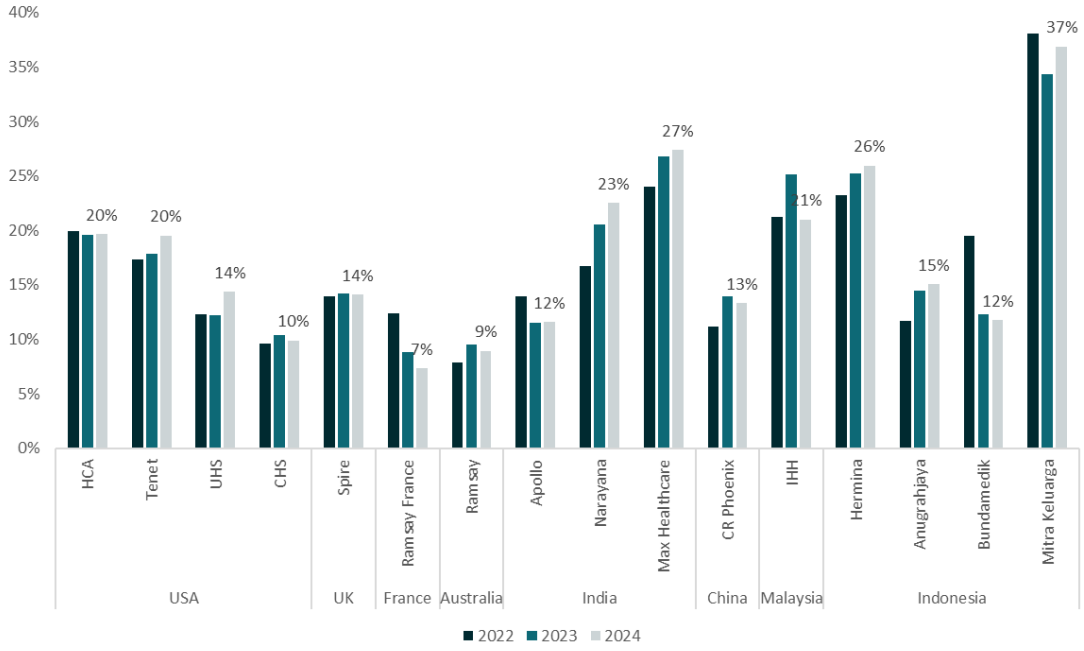
Saudi Healthcare Sector Margins in a Global Context

At a gross margin of 32% and EBITDA margin of 24% in FY25, the Saudi healthcare sector compares favorably with global peers despite absorbing peak ramp-up costs. The central question is whether these margins are sustainable as bed supply per capita grows toward Vision 2030 targets.

Gross margins for global healthcare companies (2022-24)



EBITDA margins for global healthcare companies (2022-24)



Source: Company reports

Developed markets

The developed market experience points to structural margin compression as private hospital markets mature. US operators generate gross margins of 38 to 43% but EBITDA margins of only 10 to 20%, with labour costs consuming approximately 60% of operating expenses (Chartis, 2025). Between 2022 and 2024, US hospital cost inflation rose 14.1% while Medicare reimbursement increased just 5.1%, a structural gap that persistently erodes margins (Healthcare 150, 2025). France's Ramsay Générale de Santé is the starkest example in the dataset: EBITDA margins compressed from 12% in 2022 to 7% in 2024 under mandatory wage indexation and government-administered tariff freezes that prevented operators from passing cost increases through to payers. Australia's Ramsay Health Care tells a similar story, operating below 9% EBITDA despite a fully privatised system, reflecting intense competition and constrained pricing under insurance-dominated payer structures. The pattern is consistent: once supply meets demand and governments exercise pricing leverage, developed market hospital EBITDA margins gravitate toward high single digits.

Developing markets

Developing market peers are a more appropriate reference given analogous insurance penetration trajectories and structural bed supply gaps. India has roughly 1.6 beds per 1,000 people, well below WHO recommendations, with nearly two thirds of spending still out of pocket, conditions under which private operators remain price-setters rather than price-takers (AlphaStreet, 2026). At the operator level, Max Healthcare sustains EBITDA margins of 27% and Narayana Health has expanded from 17% in 2022 to 23% in 2024. Indian hospitals have demonstrated that new capacity can be added without margin dilution when demand growth is structural rather than cyclical, as insurance penetration rises and incomes improve (AlphaStreet, 2026). Indonesia's Medikaloka Hermina sustains EBITDA margins of approximately 26% and Mitra Keluarga approximately 37%, both in a market with bed density broadly comparable to Saudi Arabia today. Malaysia's IHH Healthcare operates at 21 to 25% EBITDA across a diversified regional footprint.

Saudi healthcare sector margin sustainability

Saudi Arabia's structural position closely mirrors the developing market peer group. Private beds represent only approximately 25% of total capacity. The principal risks are DRG pricing, currently in shadow billing phase with full rollout at least two years away, and competitive intensity especially in Riyadh where approximately 2,700 new beds are planned by 2030.

The developed market outcome of single digit EBITDA margins requires a combination of market saturation, government price controls, and mandatory wage indexation that Saudi Arabia is unlikely to experience within the foreseeable investment horizon. The more realistic scenario is modest gross margin compression of 2 to 3 percentage points over 3 to 5 years as Riyadh competition intensifies and DRG implementation begins to influence payer negotiations, leaving sector EBITDA margins sustainably in the 20 to 25% range over the medium term

It remains evident however, that the government is intent on reducing healthcare costs overall and increasing sector efficiency. While DRG implementation is an example, the general objective of lowering healthcare costs points towards the possibility of the government continuing to undertake measures to reduce cost burden on the payer. This makes us take the view that healthcare pricing and margins are more likely to witness a declining trend over the longer term, with the most efficient players likely to be beneficiaries by gaining a larger market share.

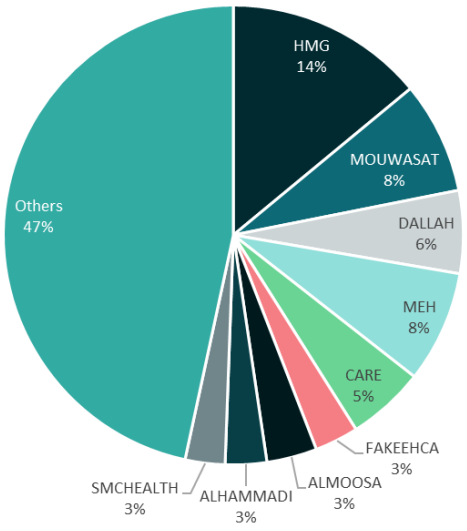
Listed Healthcare Companies: Financial and Operating Review

Comparison with Listed Domestic Players

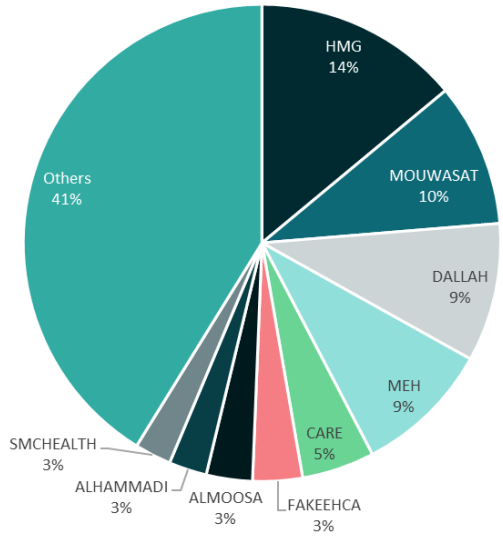
Competitive landscape in private healthcare market

There are nine TASI-listed healthcare companies operating in Saudi Arabia. The market leader is Dr. Sulaiman Al Habib Medical Services Group (HMG AB), with approximately 3,300 licensed beds as of 2025 and a private sector market share of 14% based on bed capacity. The second-largest operator is MOUWASAT Medical Services Co. (MOUWASAT AB), which increased its market share from 8% in 2024 to 10% in 2025, driven by the addition of approximately 650 beds during 2025. The third-largest operator is DALLAH Healthcare Co. (DALLAH AB), which expanded its market share to 9% in 2025, up from 6% in 2024, primarily through acquisitions. Middle East Healthcare Co. (MEH AB) also increased its market share by 1ppt, reaching 9% in 2025 compared with 8% in 2024. The fourth-largest market share belongs to National Medical Care Co. (CARE AB), which has maintained a stable 5% share over the past two years. Meanwhile, Dr. Soliman Abdel Kader Fakeeh Hospital Co. (FAKEEHCA AB), ALMOOSA Health Co. (ALMOOSA AB), Al Hammadi Holding (ALHAMMADI AB), and Specialized Medical Co. (SMCHEALTH AB) have each maintained market shares of approximately 3% over the same period.

Private healthcare market share based on bed capacity, 2024



Private healthcare market share based on bed capacity, 2025



**2025 share estimates assume no bed additiion from non-TASI listed companies*

Source: MoH Statistical Yearbook (2024), company data, BSFC research

Seven of the nine TASI-listed healthcare companies expanded their bed capacities at a double-digit CAGR between 2021 and 2025. ALMOOSA and Fakeeh recorded the fastest growth rates, at 33% and 18% CAGR, respectively, albeit from a relatively small base. ALMOOSA expanded its Acute Care Hospital from 230 beds to 430 beds in 2022 and subsequently launched its second facility, a PAC focused Rehabilitation Hospital, which added 300 beds in 2024.

HMG, the market leader, grew its bed capacity at a 14% CAGR over the same period. In 2024, HMG launched four new hospitals: Sahafa Hospital in Riyadh with 500 licensed beds, Fayha Hospital in Jeddah with 330 licensed beds (51% ownership, implying ~165 effective beds), a Women's Health Hospital in Riyadh with 145 beds, and a 140-bed hospital in Al-Kharj. In 2025, the company launched Muhammadiyah Hospital in Jeddah with 350 licensed beds, Al-Hamra Hospital in Riyadh with 90 beds, and initiated two O&M contracts within the Red Sea Development.

MOUWASAT and DALLAH both expanded bed capacity at a 20% CAGR between 2021 and 2025. MOUWASAT launched a 220-bed hospital in Knowledge Economic City, Madinah, in 2022, followed by PAC expansions at its Madinah (2022) and Dammam (2024) hospitals, adding 200 beds and 130 beds, respectively. Its most recent addition is the Yanbu Industrial City Hospital, with 210 licensed beds, launched at the pilot stage in 2025 and currently awaiting approvals for full commercial operations.

DALLAH's capacity growth was heavily skewed toward 2025, during which the company added approximately 750 beds through the acquisition of two hospitals in Khobar and Hofuf, with another 325 beds out of the installed capacity to expected to come online in Al Salaam (Hofuf) hospital. In the same year, International Medical Center, Jeddah, was launched, in which DALLAH holds a 27% stake, adding approximately 27 effective beds. Additionally, the company acquired the remaining stake in Kingdom Hospital from MAHARAH AB, raising its effective bed count to 2,193 by 2025 from ~1200 in 2024.

MEH also expanded rapidly, achieving a 19% CAGR over the past five years and doubling capacity from 1,094 beds in 2021 to 2,160 beds in 2025. The company launched its Makkah Hospital in 2022 with 300 licensed beds, added a 50-bed hospital in Hai Al-Jama'a, Jeddah, and expanded its Riyadh hospital by 143 beds in 2023. Recent expansions include doubling of Dammam hospital's licensed bed capacity from 150 to 300 beds.

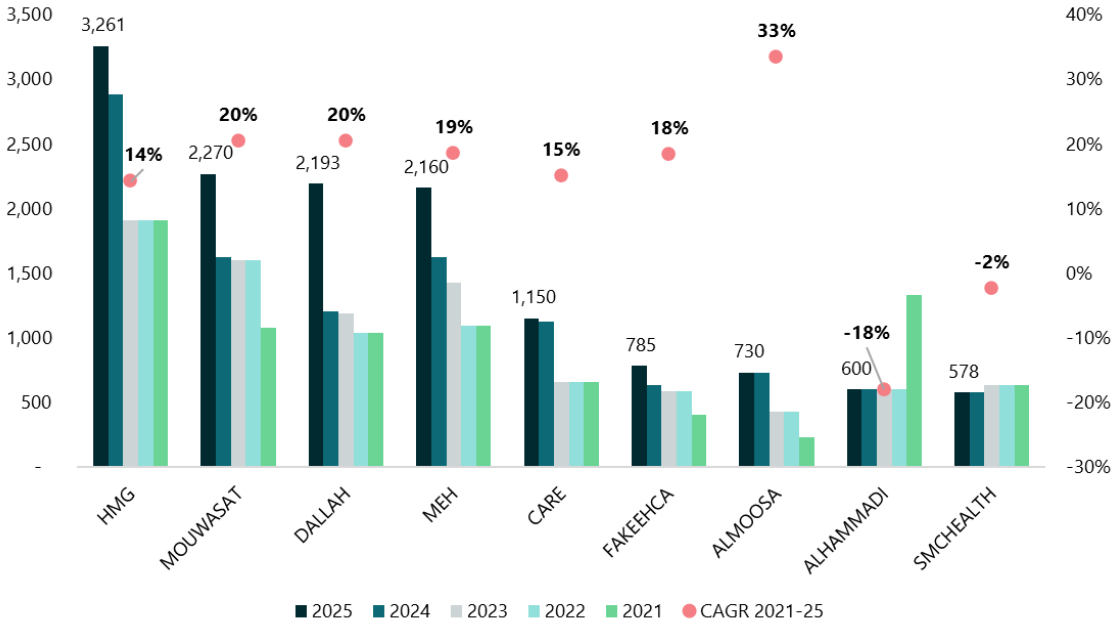
CARE grew its bed capacity at a 15% CAGR between 2021 and 2025, with most additions concentrated in 2024. The company acquired Al-Salaam Hospital, Riyadh, in 2024, adding 100 beds, and Al-Balad Chronic Care Hospital in Jeddah at the end of 2023, adding 175 beds. Around the same period, it acquired a 54-bed hospital near the Haram in Makkah, followed by the addition of a 42-bed ReLib Rehabilitation Hospital in Riyadh in 2024.

Fakeeh acquired its DSFH Riyadh hospital in 4Q22 adding 185 licensed beds and first foray into any region beyond its flagship hospital in Jeddah. More recently it launched its DSFH Madinah hospital in 2024 with a capacity of 200 beds. The company owns 51% of the facility and has 66 operational beds as of FY25.

ALMOOSA upgraded its capacity in its Acute Care hospital in 2021 by adding 200 beds. In 4Q23 it launched its Rehab hospital adding a licensed capacity of 300 beds, taking its total bed capacity to 730 beds growing at a CAGR of 33% from a low base.

In contrast, ALHAMMADI added no new capacity over the past four years. The company closed Olaya Hospital in late 2021, with a relaunch planned for 2026, reducing total bed capacity from 1,328 beds in 2021 to 600 beds in 2022. Similarly, Specialized Medical Co. (SMCHEALTH AB) reduced its bed capacity by reallocating portions of its LTC bed space toward higher-value outpatient clinics.

Licensed bed capacity of TASI listed healthcare companies; CAGR 2021-25



Source: Company reports

Geographical concentration of existing and planned capacity

Healthcare capacity in Saudi Arabia remains concentrated in the Central, Western, and Eastern regions. Listed healthcare operators reflect the same geographic pattern, with the top three players, HMG, DALLAH, and MOUWASAT, all anchored in these three regions.

HMG has the largest share of its licensed beds in the Central region, where nine hospitals totaling 2,137 beds account for approximately 67% of total capacity. This is followed by two recently launched hospitals in Jeddah (Western region) and one hospital in Dammam (Eastern region). The company also operates two smaller O&M facilities in the Southern region.

MEH is the most geographically diversified listed operator, with a presence across all five major regions of the Kingdom. Around 40% of its beds are in the Western region, spanning its original Jeddah hospital and subsequent facilities in Madinah, Makkah, and Hay Al-Jama'a (Jeddah). In the Central region, MEH operates a single Riyadh hospital that was expanded in 2023. Its remaining regional presence includes a hospital in Dammam (Eastern), and one each in Aseer (Southern) and Hail (Northern).

MOUWASAT has its largest footprint in the Eastern region, where 1,060 beds represent approximately 59% of total capacity. Its Dammam hospital, established in 1988, has 280 beds and was expanded in 2022 with the addition of 200 post-acute care (PAC) beds. The company also operates hospitals in Jubail, Qatif, and Al-Khobar within the Eastern Province. Outside this region, MOUWASAT has a 200-bed hospital in Riyadh and two hospitals in Madinah, one of which recently received an additional 130 PAC beds.

DALLAH has approximately 60% of its bed capacity in the Central region and 34% in the Eastern region. In Riyadh, the company operates its flagship Nakheel Hospital alongside Namar Hospital and Kingdom Hospital, and holds a 30% stake in Dr. Mohammad Al-Fageeh Hospital (equivalent to approximately 109 effective beds); this stake is currently being sold to Fakeeh Care, the majority shareholder. In the Eastern region, DALLAH expanded materially in 2025 through the acquisitions of Al-Salam and Al-Ahsa hospitals, adding approximately 424 beds on a current basis, with Al-Salam's capacity expected to scale by a further

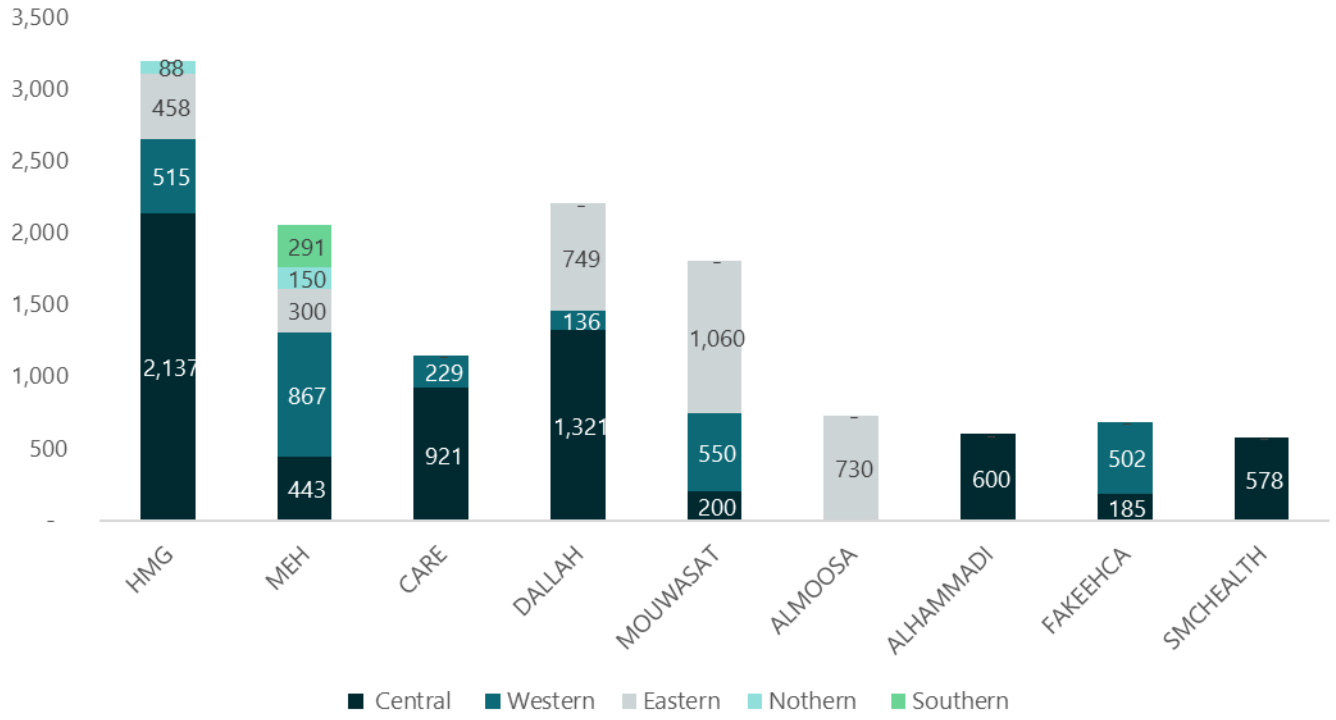
375 beds, bringing the total Eastern addition to approximately 800 beds. The remaining ~6% of capacity is in the Western region, comprising a hospital in Makkah (~109 effective beds) and a minority stake in a Jeddah facility (~27 effective beds).

CARE has approximately 80% of its bed capacity in the Central region. This includes its two flagship hospitals in Malaz and Rawabi, Riyadh, with a combined capacity of approximately 779 beds, alongside the 100-bed Al-Salam hospital (acquired in 2024, catering to Class C patients) and the 42-bed ReLib rehabilitation facility (also acquired in 2024), bringing total Central region capacity to approximately 921 beds. The remaining 20% is split between Al-Balad Hospital in Jeddah (acquired in 2024, focused on post-acute care) and a smaller facility near Al-Haram in Makkah (54 beds).

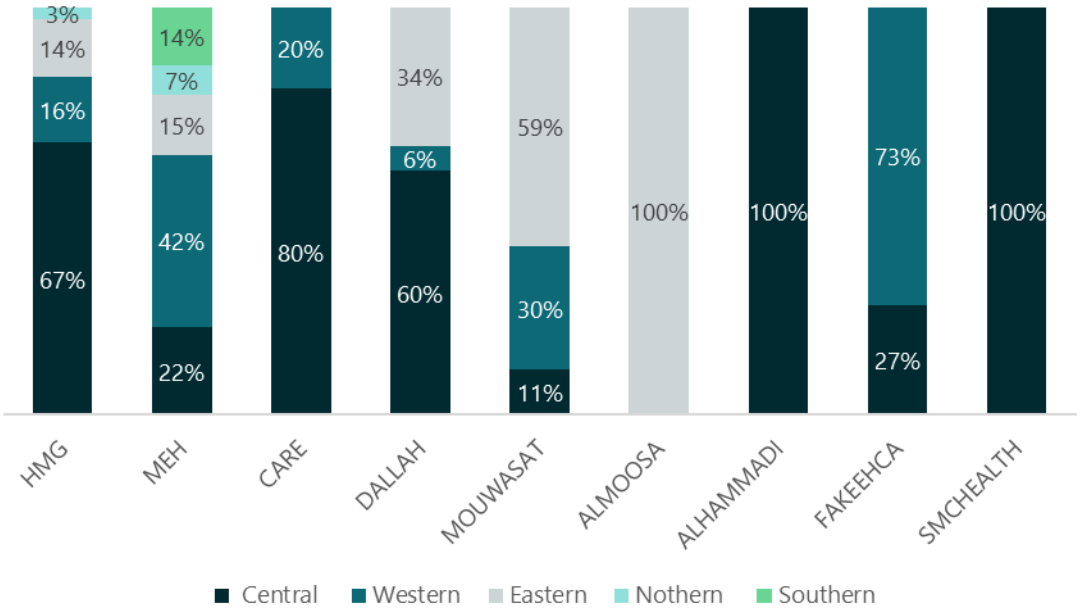
ALMOOSA and SMCHEALTH each operate within a single region, ALMOOSA in the Eastern region and SMC primarily in the Central region.

Fakeeh Care operates two hospitals in the Western region, in Jeddah and Madinah, which together account for approximately 76% of its bed capacity. Its Riyadh hospital represents the remaining 24%.

Geographical segmentation (beds), 2025



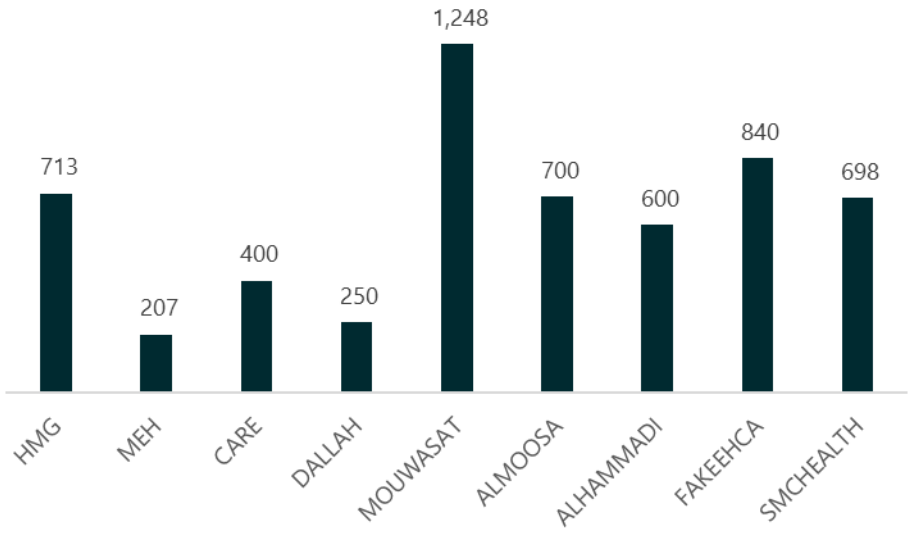
Geographical segmentation (%), 2025



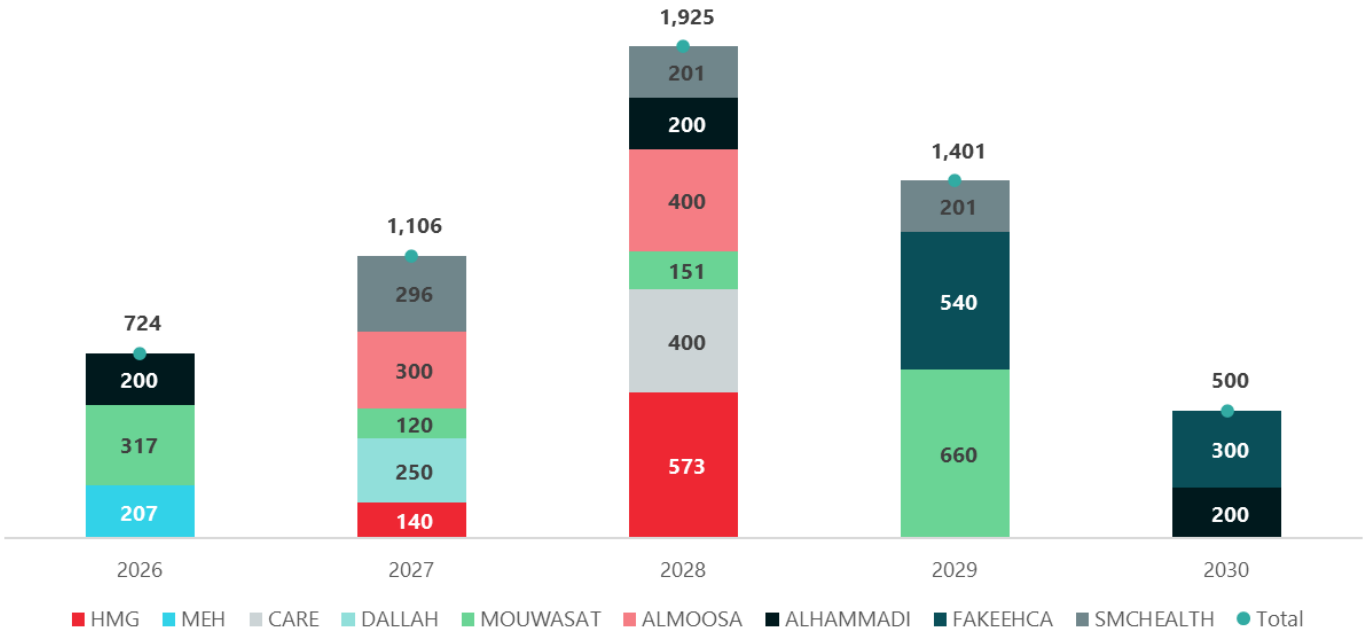
Source: Company reports

Expansion guidance

Planned beds, 2026-30



Planned beds by year, 2026-30



Source: Company reports

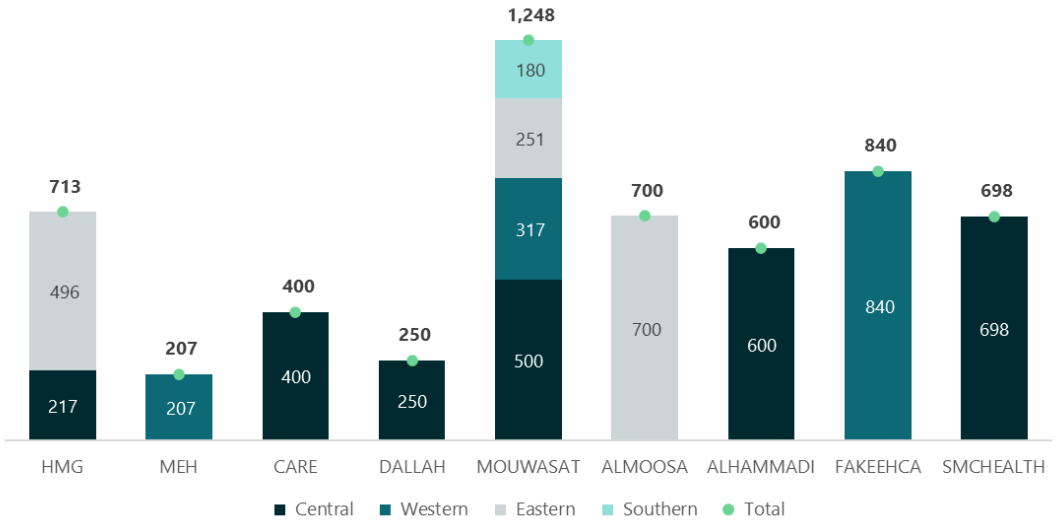
Most healthcare providers have expanded rapidly in recent years and continue to pursue capacity growth through 2030. HMG plans further expansion through the addition of more than 700 beds across four facilities in Tabuk, Jubail, Riyadh (Al Munsiyah), and Dammam. The Tabuk hospital is expected to come online in 2027, while the remaining facilities are scheduled to begin operations in 2028. The largest announced expansion pipeline belongs to MOUWASAT, which plans to add around 1,300 beds between 2026 and 2030. This will be driven by new hospitals in Jeddah, Yanbu, Qadisiyah, Al-Ahsa, Abha, and Riyadh (Al-Narjis), along with expansions in Qatif and Riyadh.

Fakeeh Care has the second largest pipeline, with approximately 840 beds expected to come online between 2029 and 2030, comprising a Jeddah PAC hospital, a Jeddah hospital expansion, a Makkah hospital, and a new South Obhur hospital.

HMG follows with plans to add around 700 beds across four new facilities. ALMOOSA and SMC Health are each targeting a similar quantum of approximately 700 additional beds. ALMOOSA plans to add these through new specialist hospitals in Al-Hofuf and Al-Khobar, while SMC Health will expand through its SMC3, SMC4, and SMC5 hospitals in Riyadh.

ALHAMMADI plans to add around 600 beds through its new Olaya hospital in Riyadh, along with expansions at its Al-Narjis and Al-Munsiyah hospitals. CARE plans to add approximately 400 beds through a new hospital in Al-Narjis, Riyadh. DALLAH plans to add around 250 beds through its Arid hospital in Riyadh. MEH plans to add 207 beds through a brownfield expansion of its Jeddah hospital.

Planned beds by region, 2026-30

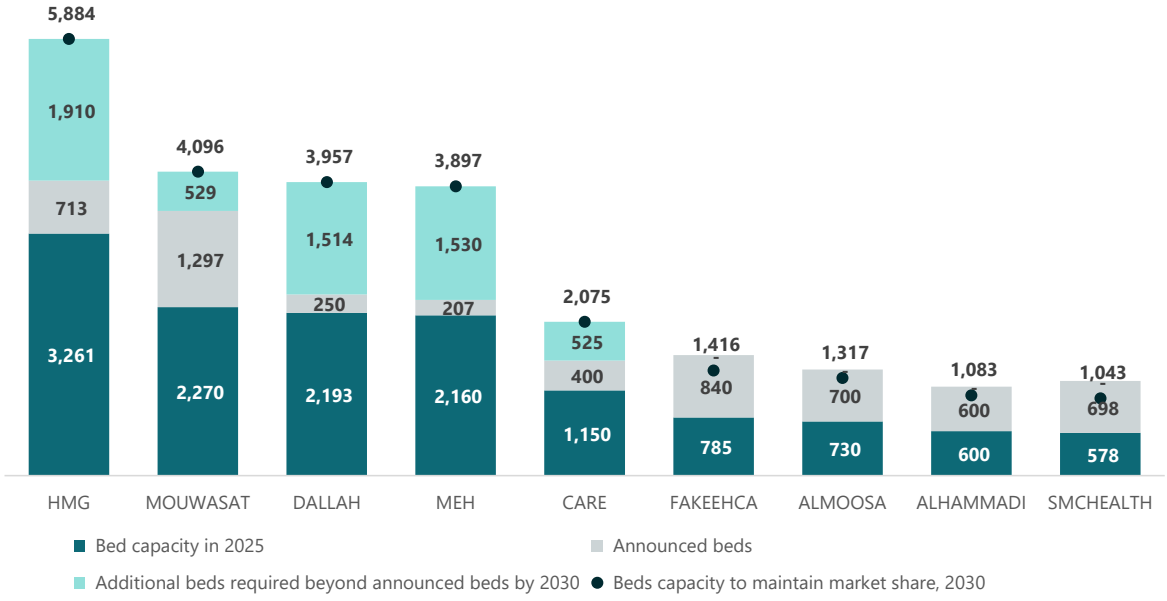


Source: Company reports

Looking at the regional distribution of expansion plans, MOUWASAT has the most diversified pipeline, with new capacity planned across the Central, Western, Eastern, and Southern regions. HMG plans to launch hospitals between 2026 and 2030 across the Central and Eastern regions. CARE, DALLAH, ALHAMMADI, and SMC Health have concentrated all their announced expansions in Riyadh. ALMOOSA, in contrast, plans to expand primarily in the Eastern region.

The Central region, particularly Riyadh, is expected to face the highest level of competition, with planned capacity additions of around 2,700 beds. The Eastern region is the second largest area of expansion, with approximately 1,500 beds expected to be added by 2030. The Western region, including Jeddah, Makkah, and Madinah, ranks third, with around 1,400 new beds expected from listed operators by 2030.

Bed capacity in 2025; beds announced; additional beds required beyond announced beds to maintain market share by 2030



Source: Company reports, BSFC Research

In terms of bed capacity, HMG is expected to have the highest number of beds by 2030, reaching approximately 3,974 beds. This represents a 22% increase, or an addition of around 713 beds, compared with its 2025 capacity. Based on announced expansion plans, however, more significant growth is expected at other operators. MOUWASAT is projected to increase its capacity by 57% relative to 2025 levels. Fakeeh is projected to more than double its smaller base by adding around 840 beds by 2030. Similarly, SMC Health is also expected to more than double its current capacity of around 600 beds, reaching approximately 1,043 beds by 2030.

Beyond these announced additions, several operators, including HMG, MOUWASAT, DALLAH, MEH, and CARE, would need to add further capacity if they aim to maintain their 2025 market shares by 2030. These additional beds could come through either greenfield expansion or participation in the government's privatization of public hospitals.

The largest incremental requirement is expected for HMG. To maintain its 14% private sector market share by 2030, the company would need to add more than 1,910 beds beyond its currently announced plans. HMG has outlined a capex plan of approximately SAR 10bn for FY26 to FY28, of which around SAR 3bn has been allocated for the 713 beds planned to come online by 2028. Assuming maintenance capex of approximately SAR 2bn over the three-year period, around SAR 5bn would remain available for deployment, which we believe is likely earmarked for additional unannounced projects to meet future bed demand.

The next largest incremental requirements are expected for DALLAH and MEH, each of which would need to add around 1,500 beds by 2030 to maintain their current market shares. In contrast, the announced expansion plans of Fakeeh, ALMOOSA, ALHAMMADI, and SMC Health appear sufficient to sustain their respective market shares through 2030.

Patient statistics

As the market leader, HMG recorded the highest patient count among listed operators, reaching 9.5mn in FY25, representing a CAGR of 21% over 2021 to 2025. This growth was driven by the launch of six new healthcare facilities over the period, which increased bed count from 1,684 in 2021 to ~3000 in FY25. Notably, the ramp-up at these new facilities has been faster than the company's historical average.

DALLAH recorded the second highest patient volume CAGR of 19% over the same period, with a particularly sharp jump in FY25 following the acquisition of two hospitals in the Eastern Province, which added 424 beds to its network.

ALMOOSA posted the third highest CAGR of 18%, with patient volumes reaching 1.4mn in FY25. Growth was supported by the expansion of its acute care hospital capacity as well as the launch of its rehabilitation hospital.

CARE grew its patient volumes at a CAGR of 17% to approximately 985k patients in FY25, driven by the addition of around 371 beds over 2023 to 2024 through a series of acquisitions.

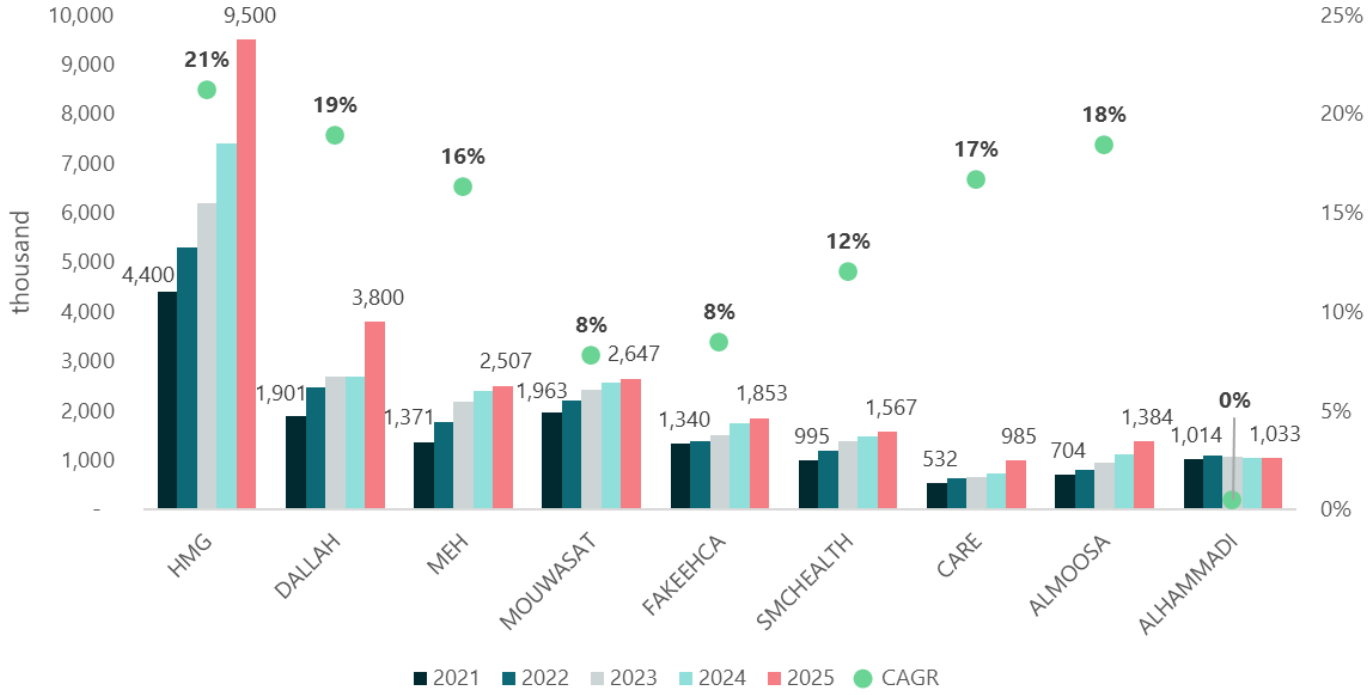
MEH recorded a patient volume CAGR of 16%, reaching 2.5mn patients in FY25. Growth was driven by the ramp-up and further expansion of its Makkah and Dammam hospitals, alongside the addition of an outpatient tower at its Riyadh hospital.

SMC Health grew its patient count at a CAGR of 12% to 1.6mn patients in FY25. This growth was entirely organic, achieved despite the phase-out of 217 long-term care (LTC) beds, of which 53 were converted to acute care. The company simultaneously expanded its outpatient clinics from 262 in FY23 to 323 in FY25, which supported sustained outpatient volume growth.

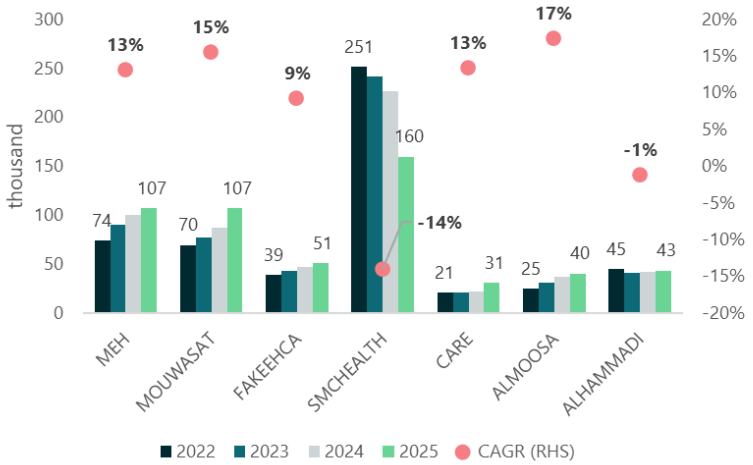
MOUWASAT and Fakeeh Care each recorded a patient volume CAGR of 8%. MOUWASAT's patient count reached 2.65mn in FY25, driven primarily by the launch of its Knowledge Economic City hospital in 2022 and the addition of LTC and rehabilitation hospitals in Dammam and Madinah, which together added approximately 550 beds over 2022 to 2024. Fakeeh Care's patient count reached 1.85mn in FY25, supported by the acquisition and scale-up of its Riyadh hospital and the launch of its Madinah hospital in 2022 and 2024, respectively.

ALHAMMADI is the only listed operator to have recorded flat patient volumes over the period, reflecting the absence of any new facility launches, as the company focused its investments on subspecialities to become a class A+ provider with aims to achieve better patient yields. The company's Olaya hospital in Riyadh, previously closed, is expected to reopen in 2026 and could serve as a catalyst for renewed patient volume growth. Medium term patient growth will be driven by two more hospitals planned in Al Narjis and Al Munsiyah districts, Riyadh planned for 2028 and 2030 respectively.

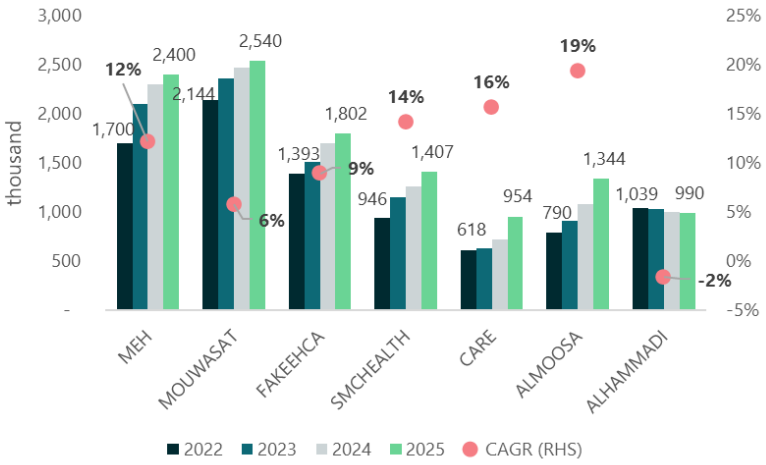
Patients ('000) and CAGR; 2021-2025



Inpatients and CAGR (2022-2025)



Outpatients and CAGR (2022-2025)



Source: Company reports

DALLAH and HMG do not disclose patient volume breakdowns. Among the remaining operators, ALMOOSA recorded the highest inpatient growth CAGR of 17% between 2022 and 2025, driven by the expansion of its acute care and rehabilitation beds, with the latter carrying a higher proportion of inpatients by design. This contrasts with SMC Health, which reduced its LTC bed count, resulting in inpatient volumes declining at a CAGR of 14% over the same period.

MOUWASAT recorded the second highest inpatient CAGR of 15%, supported by the addition of two LTC facilities during the period. MEH and CARE each followed at 13%, with CARE's growth further boosted

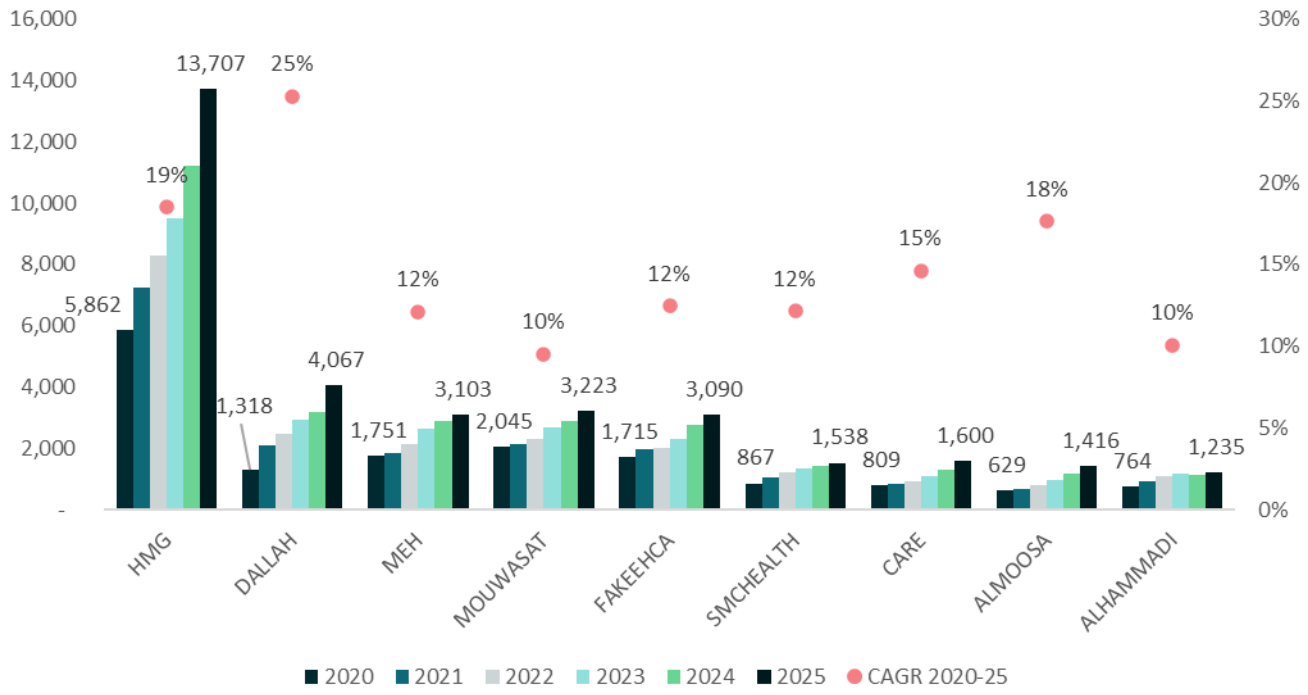
by the addition of a 175-bed LTC facility in Jeddah in 2024. Fakeeh Care's inpatients grew at a CAGR of 9%, supported by newly launched facilities as the company continues to focus on expanding sub-specialties and increasing case acuity. ALHAMMADI's inpatient volumes declined at a CAGR of 1%, reflecting the temporary closure of its Olaya hospital.

Turning to outpatients, MOUWASAT and MEH reported similar volumes in the 2.4mn to 2.5mn range in FY25. MEH grew at a faster rate, posting a CAGR of 12% driven by the ramp-up of newly launched facilities, while MOUWASAT's more moderate outpatient CAGR of 6% reflected a deliberate skew towards inpatient growth following the addition of two LTC facilities.

ALMOOSA recorded the highest outpatient CAGR of 19%, with volumes reaching 1.34mn in FY25. This was driven by a substantial expansion in clinic count, from 111 in 2022 to 365 in 2025, including 75 clinics added through two new medical centres in 2025. CARE posted the second highest outpatient CAGR of 16%, with volumes reaching 954k in FY25, supported by a larger step-up in 2025 reflecting the full-year contribution of Al-Salam Hospital, acquired in 2024. SMC Health grew its outpatient volumes at a CAGR of 14% to 1.4mn, driven by clinic expansion from 240 to 323 over the period. Fakeeh Care's outpatients grew at a CAGR of 9% to 1.8mn in FY25. ALHAMMADI was the only operator to record a decline, with outpatient volumes falling at a CAGR of 2% to 990k by FY25.

Revenues

Revenue (SAR mn) and CAGR; 2020-2025



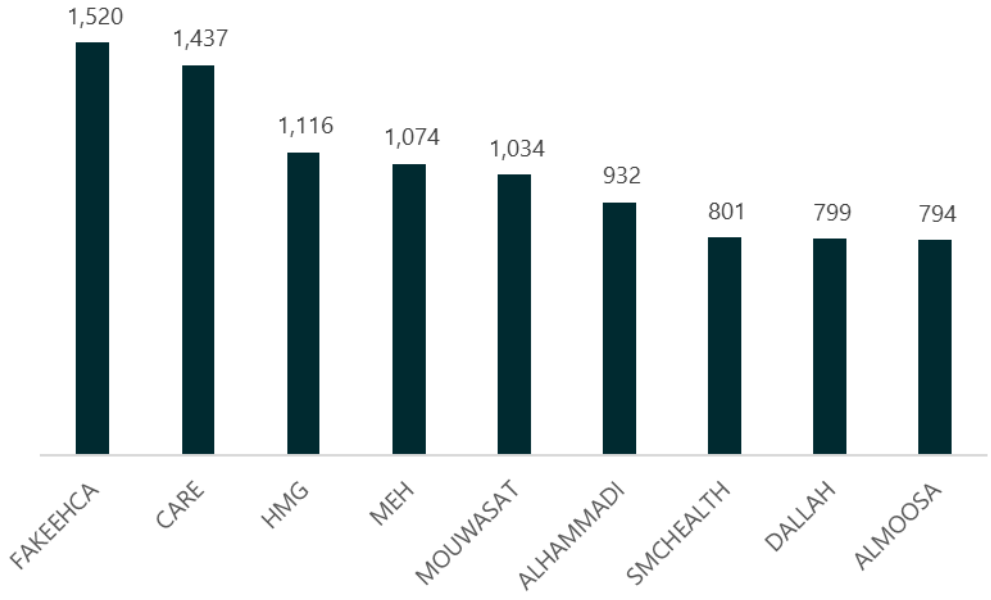
Source: Company reports

HMG remains the largest player, with FY25 revenue reaching SAR 13.7bn. The particularly large jump in 2025 reflects the ramp-up of four hospitals launched in 2024, alongside the launch of two additional hospitals during the year. HMG's revenue is 3.4x that of the second largest operator, DALLAH, which reported FY25 revenue of SAR 4.07bn. MEH, MOUWASAT, and Fakeeh Care each reported revenues in

the SAR 3.1bn to 3.2bn range. SMC Health, CARE, and ALMOOSA fall within the SAR 1.4bn to 1.6bn range, while ALHAMMADI reported the lowest revenue among listed operators at SAR 1.2bn in FY25.

All listed healthcare operators have delivered double-digit revenue CAGRs over the past five years. HMG recorded the most consistently high growth at a 5-year CAGR of 19%, surpassed only by DALLAH in FY25 following the consolidation of two hospital acquisitions, which lifted DALLAH's 5-year revenue CAGR to 25%. ALMOOSA also delivered a notable 5-year CAGR of 18%, followed by CARE at 15%. MEH, SMC Health, and Fakeeh Care each recorded a 5-year revenue CAGR of 12%, while ALHAMMADI saw a revenue CAGR of 10%.

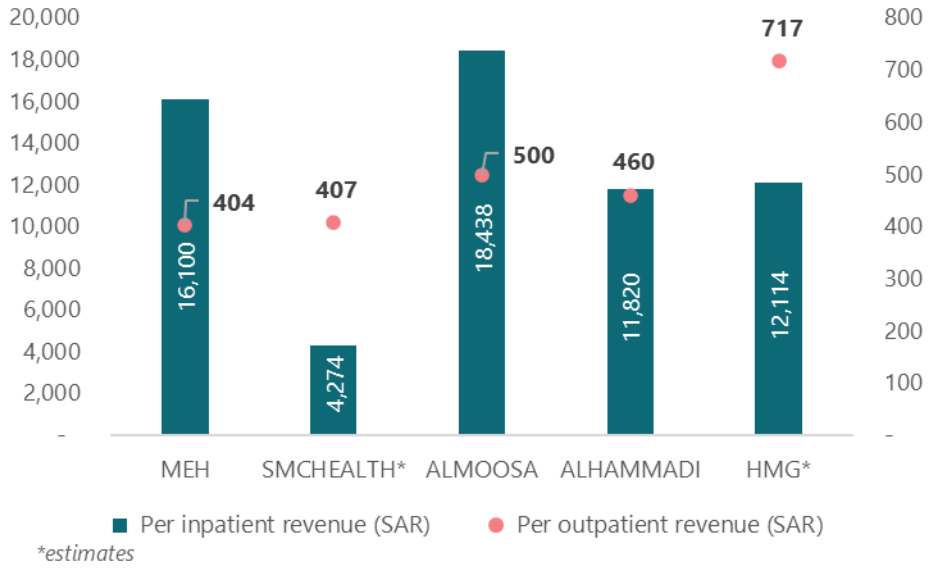
Revenue per patient (SAR; 2025)



Source: Company reports

On hospital revenue per patient, Fakeeh again leads at SAR 1,520, followed by CARE at SAR 1,437 and HMG at SAR 1,116. CARE's stronger revenue per patient is supported by a heavier contribution from higher-value inpatient and surgical activity, particularly from GOSI and MOH patients, while HMG benefits from premium positioning and pricing. MEH and MOUWASAT slightly lower than HMG at SAR 1,074 and SAR 1,034, respectively, while Al Hammadi stands at SAR 932. SMC Healthcare, DALLAH and ALMOOSA have hospital revenue per patient around SAR 800. *Revenue per patient is, however, a function of inpatient and outpatient mix as much as pricing.* Inpatient episodes carry materially higher per-visit revenue than outpatient consultations, and a higher inpatient revenue share will naturally lift the blended per-patient metric independent of underlying price levels.

Per inpatient and outpatient revenue (SAR; 2025)



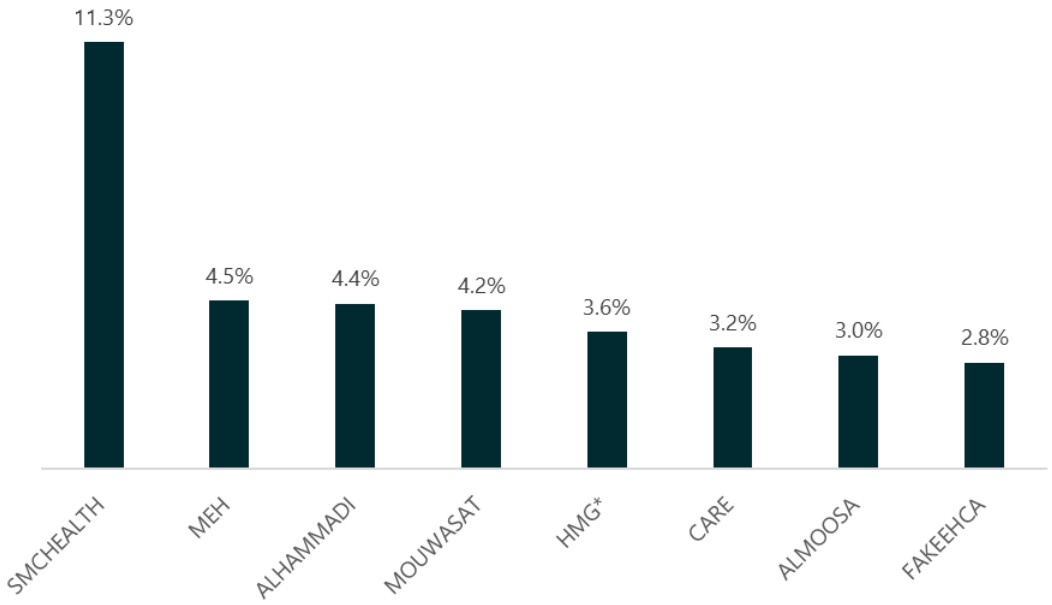
**estimates*

Source: Company reports

Per inpatient revenue varies across operators, reflecting differences in case mix and payer composition. ALMOOSA reports the highest inpatient revenue at SAR 18,438, supported by a higher-acuity service mix and strong growth in rehabilitation services. MEH follows at SAR 16,100, with its higher inpatient revenue partly driven by a larger contribution from government (MoH) patients, which accounted for 29% of revenue and typically carries higher pricing than insurance. HMG and Al Hammadi operate at mid-range levels (SAR 12,114 and SAR 11,820, respectively), consistent with more balanced service mix and payer exposure. SMCHEALTH (estimated) remains an outlier at SAR 4,274, reflecting its ongoing transition away from long-term care toward higher-acuity services, which affects comparability.

On the outpatient side, HMG (estimated) had average revenue of SAR 717 per visit, indicating stronger pricing. ALMOOSA (SAR 500) and Al Hammadi (SAR 460) follow, while MEH and SMC Healthcare are lower at SAR 404 and SAR 407, respectively.

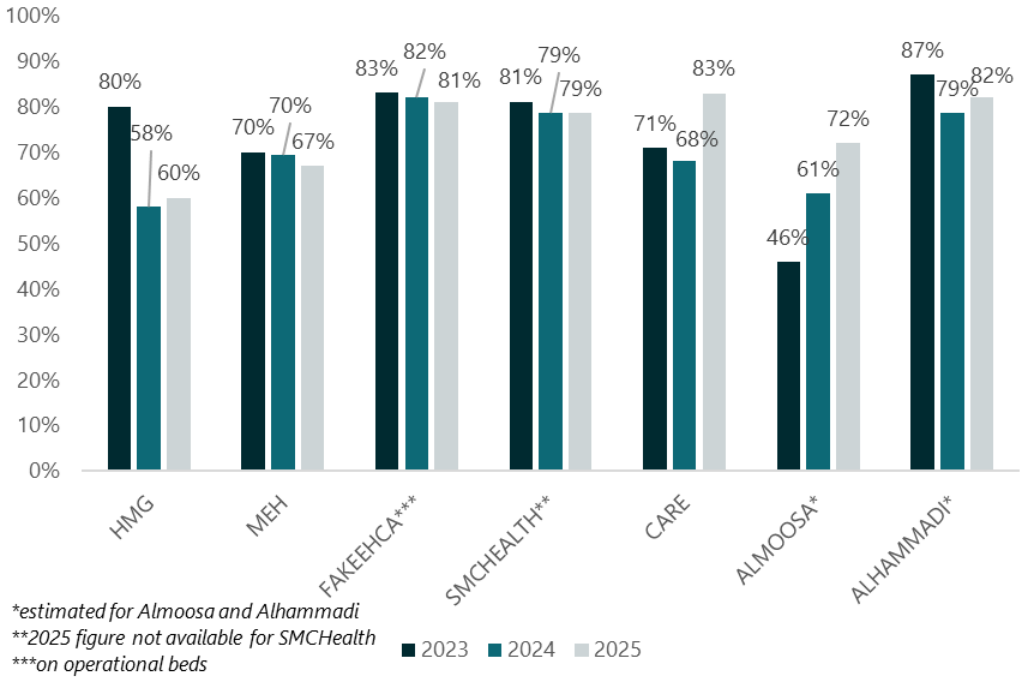
Outpatient to Inpatient conversion (2025)



Source: Company reports

Bed utilization

Bed utilization



**estimated for Almoosa and Alhammadi*
***2025 figure not available for SMCHealth*
****on operational beds*

Source: Company reports

Bed utilisation for HMG declined to 58% and 60% in FY24 and FY25 respectively, from 80% in FY23, driven by the launch of six new facilities over these two years. The company is progressively ramping up, with newly launched hospitals currently operating at 52% to 55% utilisation compared to 75% to 77% at mature facilities. HMG is adding operating beds incrementally as demand builds, which partly explains the lower headline utilisation rate.

MEH's utilisation similarly declined to 67% in FY25, reflecting capacity additions at its Dammam and Makkah hospitals alongside some softening in inpatient procedures.

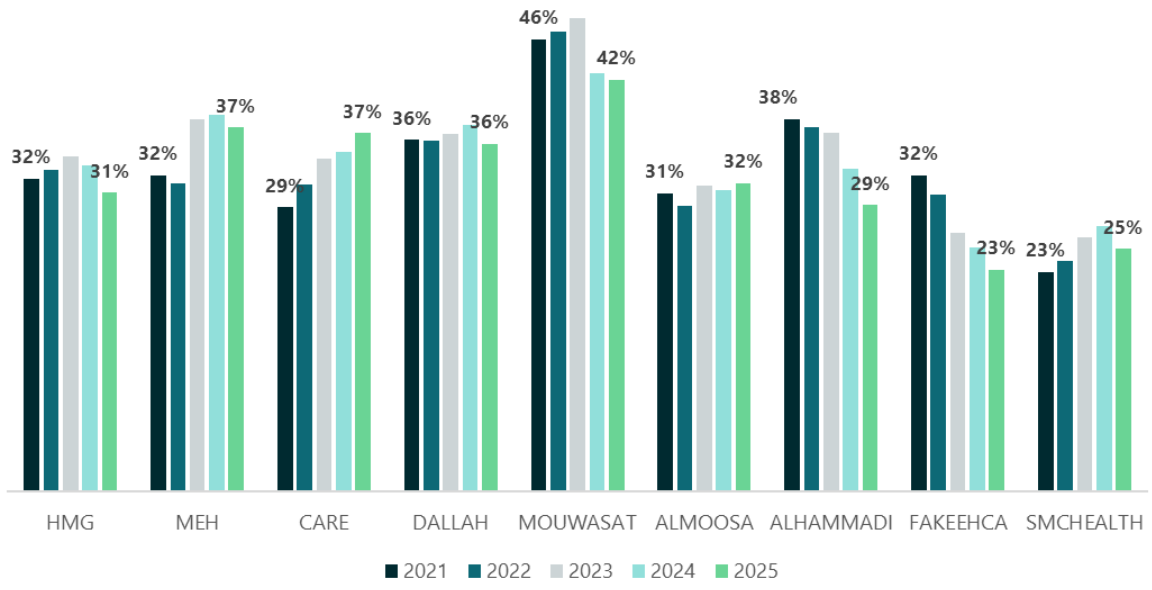
Fakeeh Care reports utilisation on operational beds rather than licensed capacity, which results in a higher headline figure. In practice, its Riyadh hospital is operating at 105 beds against a licensed capacity of 185 beds, while its Madinah hospital, launched in 2024, is operating with 66 beds against a licensed capacity of 200 beds (51% owned). All other operators report utilisation on a total licensed bed basis. SMC Health and ALHAMMADI utilisation figures are estimated from individual hospital occupancy levels.

ALMOOSA's occupancy has improved steadily over the past three years as both its acute care and rehabilitation hospitals have ramped up at a healthy pace. SMC Health is gradually phasing out LTC beds and converting capacity to acute care. While FY25 utilisation figures were not formally disclosed, management commentary during the FY25 earnings call indicated improved utilisation on a year-on-year basis.

CARE's utilisation improved to 83% in FY25 from 68% previously, driven by stronger performance at its legacy hospitals supported by growth in GOSI and MoH revenue. ALHAMMADI's utilisation also improved as inpatient activity increased across both its Al-Nuzha and Al-Suwaidi hospitals, with the latter currently operating 200 beds out of a scalable capacity of 300 beds.

Margins

Gross margins (2021-2025)



Source: Company reports

MOUWASAT commands the highest gross margins in the sector, averaging 46% over the five-year period, moderating to 42% in FY25 from a peak of 49% in FY23, as the company launched its Madinah LTC and Rehabilitation Hospital in FY24 and conducted a soft launch of its Yanbu hospital, with pre-operating costs weighing on margins in 4Q25. MEH, ALHAMMADI, and DALLAH had five-year average gross margins in the 35–36% range, followed by HMG, FAKEEHCA, and SMCHEALTH at averages of 33%, 27%, and 25% respectively.

The prevailing trend is one of margin compression driven by capacity expansion, with CARE being the standout exception, where gross margins expanded from 29% in FY21 to 37% in FY25. This was supported by three healthcare facility acquisitions completed in FY24, with the full-year contribution of Al-Salam Hospital materially lifting patient volumes and revenue scale. Management has guided for margins to be maintained or gradually improved ahead of the Al-Narjis hospital opening in FY28, with targeted insurance repricing in FY26, particularly at Al-Salam, expected to provide further uplift.

ALHAMMADI's gross margin contraction from 38% in FY21 to 29% in FY25 reflects a series of planned compensation adjustments that have progressively raised staff costs, despite the absence of new hospital launches. FAKEEHCA similarly saw gross margins decline from 32% in FY21 to 23% in FY25, largely driven by the ramp-up losses of the Madinah hospital, which alone contributed approximately SAR 76mn in losses in FY25. Management noted that excluding Madinah, group gross margin would have been approximately 25%, broadly flat year-on-year, and guides for overall margin stability in FY26 as Riyadh losses narrow and Madinah continues to ramp.

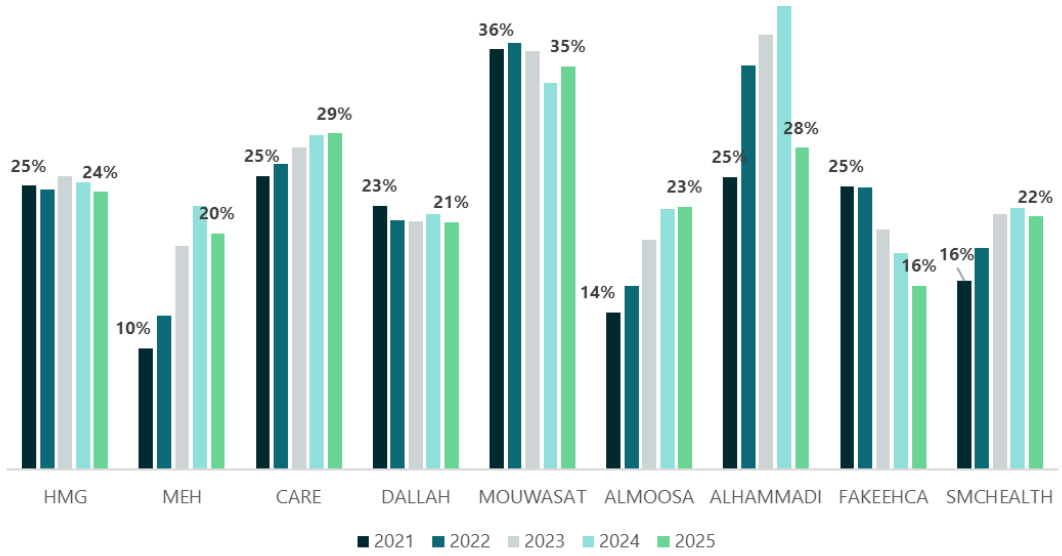
MEH's gross margins have also come under pressure in FY25, declining to 37% from a high of 39% in FY24. The compression reflects aggressive physician recruitment, over 400 new hires in FY25 alone predominantly across surgical subspecialties, alongside higher depreciation from Dammam capacity expansion and weaker MoH referral volumes as the Ministry transitions from direct case-based referrals toward insurance-priced tender mechanisms. Management expects margins to remain pressured through FY26, with recovery back-end loaded into 2H26.

SMCHEALTH presents a different trajectory. Although no new hospital has been added in recent years, gross margins have trended gradually upward, rising from 23% in FY21 to 25% in FY25, reflecting a deliberate shift in business mix, converting 217 long-term care beds into higher-acuity acute care beds and outpatient clinics since FY23. Inpatient revenue grew 5.1% in FY25 despite lower volumes, as higher-acuity procedures replaced lower-value LTC cases. The recent pressure in FY25 reflects the launch of 57 new clinics during the year, which front-loaded operating costs ahead of full utilization.

ALMOOSA's gross margins have been relatively range-bound at 29–32% over the period, with FY25 at 31.7%, a modest improvement on FY24. However, 4Q25 saw pronounced margin compression following the launch of two medical centers in 3Q25, compounded by delays in insurance payer negotiations that pushed most policy activations into 1Q26. Management has guided gross margins of 38–40% over the medium term as the new centers ramp up, though near-term execution risk remains elevated given two additional large medical centers planned for FY26.

HMG's gross margins have come down from 34% in FY23 to 33% in FY24 and 31% in FY25 due to the group opening six new facilities over the last 30 months. Management acknowledged ongoing margin pressure from newly launched hospitals, currently operating at 52–55% utilization versus 75–77% at mature facilities, but expects gradual improvement as utilization ramps through FY26 and fixed costs are absorbed more efficiently.

EBITDA margins (2021-2025)



Source: Company reports

A consistent picture emerges at the EBITDA level. MOUWASAT leads the sector with a five-year average EBITDA margin of 36%, followed by ALHAMMADI at 33% and HMG at 25%. SMCHEALTH, FAKEEHCA, ALMOOSA, and MEH cluster in the 19–22% range.

SMCHEALTH's EBITDA margin stands out as a notable improver, rising from 16% in FY21 to 27.1% in FY25, the sharpest expansion in the peer group, driven by the shift toward higher-acuity services, strong outpatient growth, and improved operating leverage. Notably, 4Q25 EBITDA margin reached 42.3%, though this included a SAR 60.6mn one-off gain from a land contribution to the Al-Wadi Real Estate Fund. On an adjusted basis the underlying improvement remains significant. Management has guided FY26 EBITDA margins of 23–25%, reflecting incremental cost from new clinic launches, before recovering toward a medium-term target of 25–30% as SMC3, SMC4, and SMC5 come online through FY28 to FY29.

FAKEEHCA's EBITDA margin declined from 25% in FY21 to 16% in FY25, the sharpest contraction in the peer group, almost entirely attributable to the Madinah hospital ramp-up. Excluding Madinah, EBITDA margin would have been 18.3%, broadly in line with the prior year, and the group maintains strong liquidity with a net cash position, providing capacity to absorb further near-term pressure from three new medical center launches planned from June FY26.

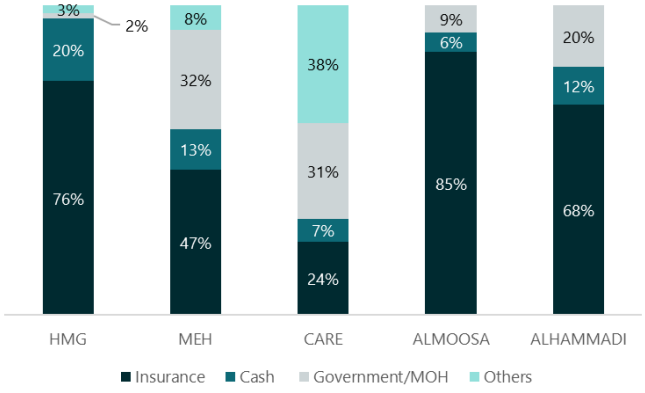
MEH's EBITDA margin declined to approximately 20% in FY25 from 23% in FY24. Management has guided FY26 EBITDA margins of 20–21%, reflecting continued investment in physician recruitment and the ramp-up costs of Dammam and Makkah expansions, with the Jeddah tower launch in 1Q27 expected to add another layer of near-term pressure. It is worth noting here that historically MEH has guided longer term EBITDA margins of 25-26%, and lately the shift in guidance could be due to impact of competition in their operating regions.

Across the sector, players with active expansion programs are experiencing EBITDA margin pressure as the higher fixed operating costs and staff costs of newly launched facilities flow through ahead of full

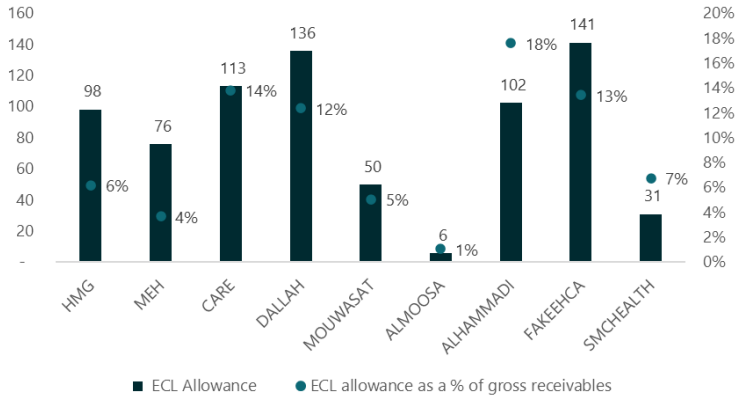
revenue ramp-up. The FY26 outlook across the group is broadly one of margin stability at best, with meaningful recovery deferred to FY27 and beyond as recently launched facilities reach maturity.

Working capital management

Revenue payer mix (2025)



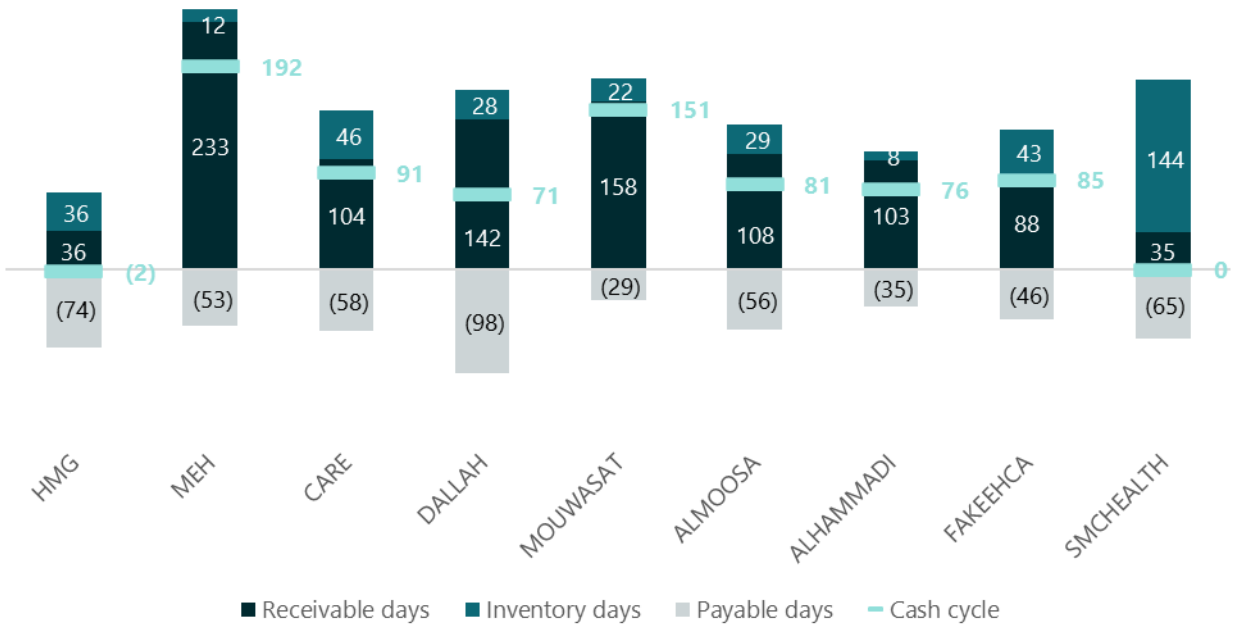
Impairment of receivables (2025)



Source: Company reports

The payer mix highlights the structural differences across operators. HMG and ALMOOSA are insurance-dominant at 76% and 85% respectively, with minimal MoH dependency. ALHAMMADI sits at a moderate 20% MoH with a 12% cash contribution. MEH stands apart with 32% direct MoH exposure, the highest in the peer group. CARE's composition is the most complex, as the 38% "Others" reflects GOSI, making its effective institutional payer exposure the broadest in the set. CARE was co-founded by GOSI and private shareholders before its listing on Tadawul, with GOSI retaining a 35% ownership stake. This founding relationship underpins CARE's position as a preferred provider for work-related injuries under GOSI's Occupational Hazards Branch. Notably, while CARE highlighted strong growth in MoH and GOSI referrals in 2025, MEH flagged a structural shift in MoH procurement, moving from direct referrals to competitive tenders priced at insurance-equivalent rates. This shift is compounded by a broader reorientation within the MoH network: data from the Saudi Medical Appointments and Referrals Center (SMARC) recorded 755,145 e-referrals during 2023–2024, with internal referrals rising to 87.5% of total from 80.1%, while external referrals fell to 12.5% following the rollout of the unified Medical Referral Center platform across MoH clusters from May 2024. These trends suggest stronger intra-MoH coordination and structurally reduced spillover to private providers. Moreover, MEH management highlighted a redistribution of MoH business toward smaller and less-accredited hospitals in select cities as a cost-saving measure; with Management pointing that overall national volume has not materially declined, allocation across providers has shifted.On ECL and impairment allowances, FAKEEHCA carries the highest absolute provision at SAR 141mn, followed by DALLAH at SAR 136mn. In relative terms, ALHAMMADI has the highest impairment-to-receivables ratio at 18% on SAR 102mn, reflecting delays in collections from certain major clients. CARE at 14% reflects a combination of MoH exposure, aging receivables, and the ramp-up of Al-Salam's insurance book. FAKEEHCA at 13% is driven by the scale of its receivables base across multiple hospital ramp-ups and certain non-recurring defaults during 2025. MEH at 4% on SAR 76mn and MOUWASAT at 5% on SAR 50mn are among the lower ratios in the group. SMCHEALTH at 7% on SAR 31mn reflects a gradually improving receivables profile as the LTC-to-acute transition reduces government-linked exposure. ALMOOSA at 1% and SAR 6mn is the lowest in the peer group.

Cash cycle (Days; 2025)

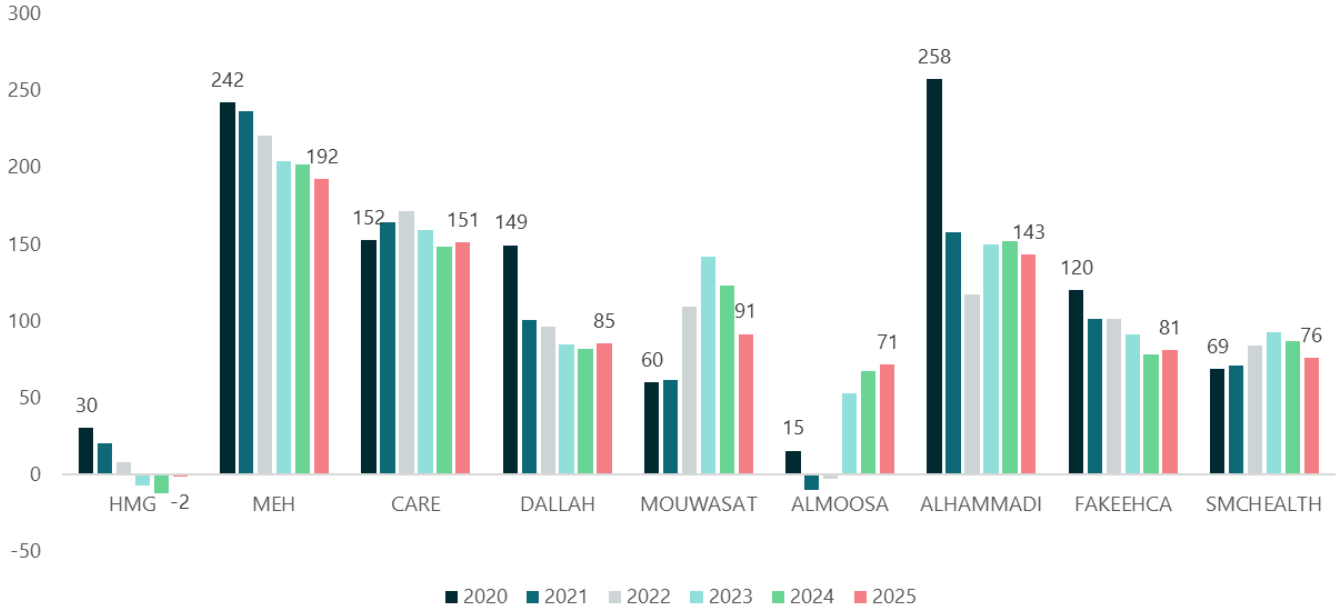


Source: Company reports

Receivable days are the dominant driver of Cash Conversion Cycle (CCC) dispersion across the sector, with MoH/GOSI payer mix the common thread among high-CCC names**.** MEH stands out with the highest CCC in the sector at 192 days, driven by receivables of 233 days. This reflects heavy exposure to government with slow settlement cycles, compounded by ongoing Dammam and Makkah expansion costs absorbing management bandwidth. The working capital burden is structural rather than cyclical. ALHAMMADI is the second most stretched at 143 days CCC, with receivables of 144 days and payable leverage of only 31 days, the lowest in the sector.

CARE carries a CCC of 151 days with receivables of 158 days, consistent with its payer mix of GOSI (37%) and MoH (31%) which structurally lengthens collection timelines. MOUWASAT and FAKEEHCA sit in the mid-range at 91 and 81 days respectively. MOUWASAT's receivables of 104 days are partially offset by payable leverage of 58 days. FAKEEHCA similarly balances receivables of 108 days against payables of 56 days, reflecting comparable payer mix dynamics. DALLAH and SMCHEALTH had 2025 CCC of 85 and 76 days respectively. DALLAH's inventory days of 43 are among the higher readings in the sector, partially a function of the mid-year acquisition of Al-Salam and Al-Ahsa hospitals introducing legacy balances onto the books. ALMOOSA prints a CCC of 71 days, supported by payable days of 98, the highest in the sector. However, this figure is inflated by construction-related contractor payables tied to its ongoing expansion programme. Adjusting for this, the underlying payable position is likely more in line with sector peers. HMG remains best-in-class at CCC of -2 days, with payable leverage of 74 days offsetting receivables and inventory of 36 days each. This reflects scale advantage and supplier bargaining power consistent with its position as the largest operator in the sector by revenue.

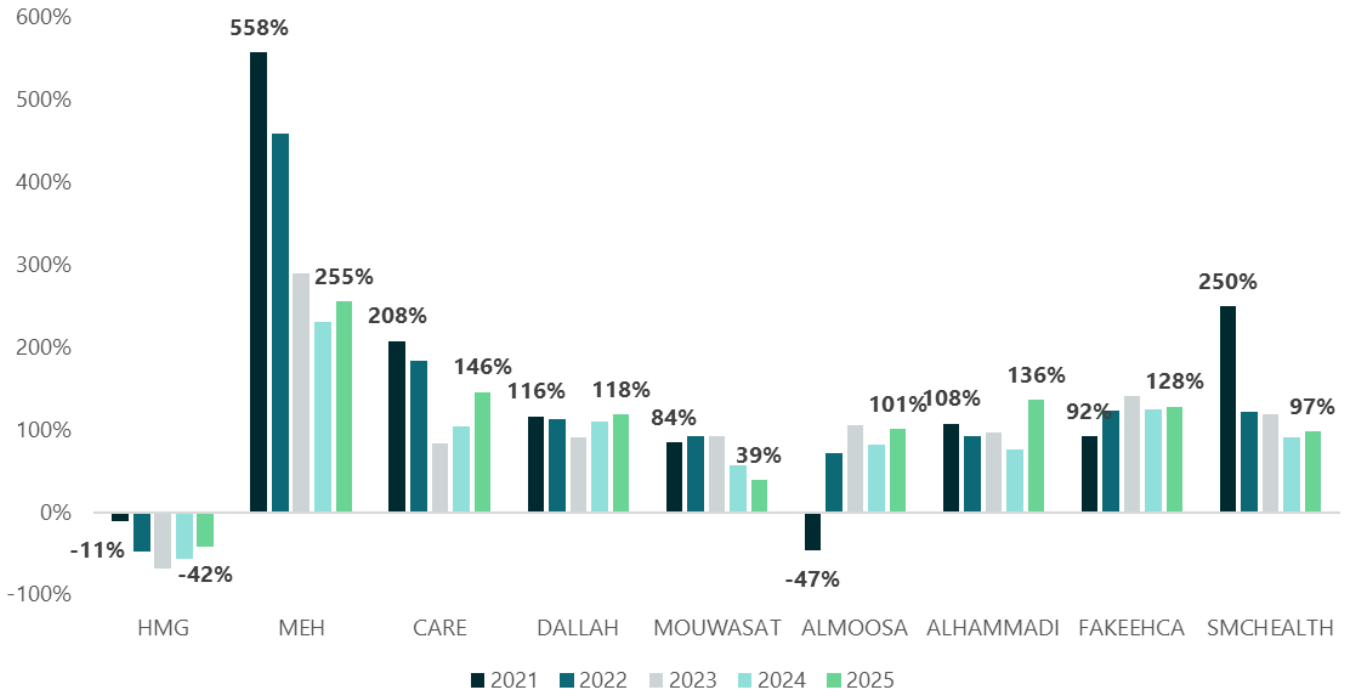
Cash cycle (Days; 2020-2025)



Source: Company reports

The 2025 CCC figures are best read alongside the multi-year trend, since a single year can be skewed by changes in revenue mix, acquisitions, or expansion activity. MEH has held the highest CCC in the sector every year from 2020 to 2025, declining gradually from 242 days to 192 days. CARE appears range-bound between 148 and 171 days, but this stability masks significant offsetting movements in both receivables and payables beneath the surface. ALHAMMADI made substantial progress between 2020 and 2022, dropping from 258 to 117 days, but has since plateaued in the 143–152 day range as receivables drifted back up and payable leverage continued to erode simultaneously. HMG has shown the most consistent improvement in the sector, moving from 30 days in 2020 to negative territory by 2023, with the modest uptick to -2 days in 2025 reflecting new hospital drag. FAKEEHCA has achieved the cleanest improvement, with both receivables and payables moving favorably over the period. DALLAH improved steadily from 149 to 85 days, with the slight 2025 reversal reflecting acquisition-related balance sheet consolidation. MOUWASAT's CCC worsened sharply from 62 days in 2021 to 142 days by 2023, coinciding with its expansion phase across Madinah and Dammam, before recovering to 91 days as revenue scaled across new facilities. SMCHEALTH peaked at 92 days in 2023 before returning toward its historical range, with movements in both directions driven by receivables rather than payable dynamics. ALMOOSA turned its near-zero or negative CCC through 2022 reflecting large contractor payables accumulated during construction, and as those settled, CCC climbed to 71 days by 2025.

Working capital /EBITDA



Source: Company reports

Across the sector, working capital as a percentage of EBITDA provides an important lens on capital efficiency, particularly as operators simultaneously manage earnings growth and capacity expansion. HMG and MOUWASAT stand out as the most capital-efficient operators over the cycle. HMG has maintained a negative ratio throughout the 2021–2025 period, averaging -45%, due to its managed receivables. The ratio has modestly deteriorated from -68% in 2023 to -42% in 2025, consistent with receivable build at six newly launched hospitals still ramping up. MOUWASAT has shown the clearest improving trend in the sector, declining steadily from 93% in 2023 to 39% in 2025 as revenue scaled across its expanded network, with a five-year average of 73%.

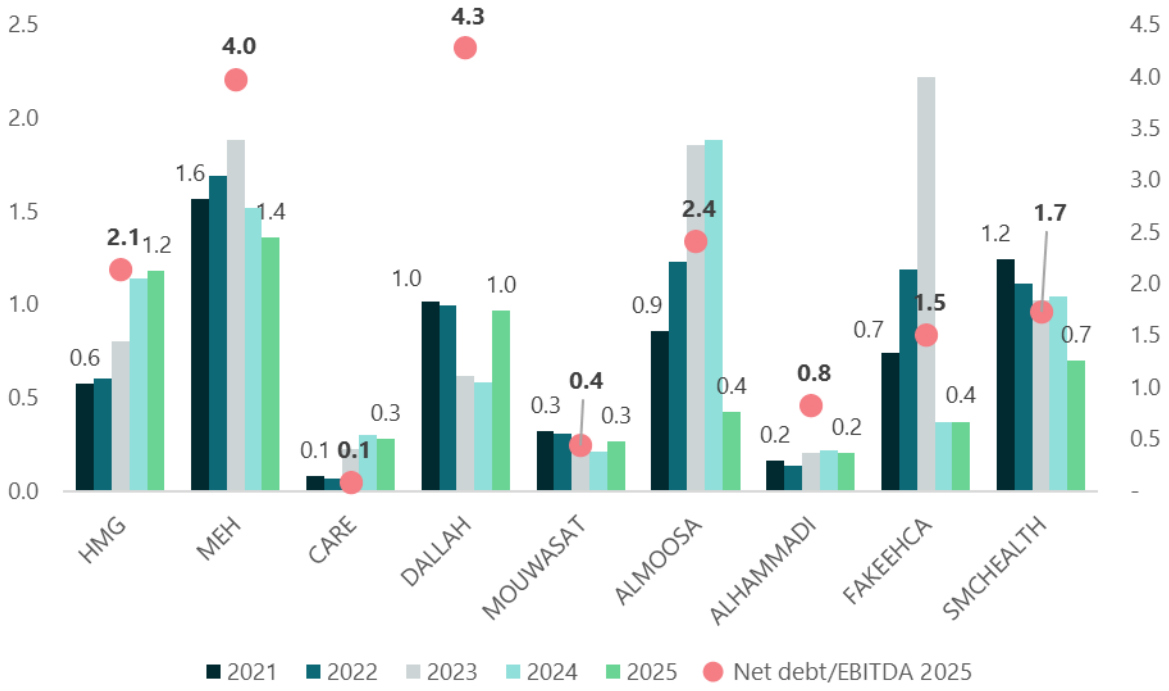
MEH carries the highest ratio in the sector by a significant margin, averaging 358% over five years. While the ratio has improved materially from 558% in 2021 to 255% in 2025, driven by both receivables moderating and a consistent decline in inventory days, the absolute level reflects the structural burden of its government-heavy payer mix where working capital requirements remain multiple times annual EBITDA. CARE improved sharply between 2021 and 2023, with the ratio falling from 208% to 84%, driven by a combination of receivables improving and payable days remaining elevated. The ratio has since reversed to 146% in 2025, driven primarily by a sharp contraction in payable days from 106 in 2022 to 27 in 2024, which significantly reduced the supplier credit offsetting receivables even as collections continued to improve.

SMCHEALTH has shown improvement, declining from 250% in 2021 to 97% in 2025 as receivables normalized with revenue growth. FAKEEHCA has drifted from 92% in 2021 to 128% in 2025, with the deterioration reflecting EBITDA margin compression from newer facilities rather than working capital accumulation, as receivable and payable days have both moved favorably over the period. ALHAMMADI improved steadily from 108% in 2021 to 76% in 2024, but deteriorated sharply to 136% in 2025, driven

by continued payable compression and EBITDA pressure rather than any receivables deterioration. DALLAH has ranged between 91% and 118% over the period, with the 2025 reading of 118% partly reflecting legacy working capital consolidated from the mid-year acquisition of Al-Salam and Al-Ahsa hospitals. ALMOOSA is the most volatile, swinging from -47% in 2021 when large contractor payables were outstanding, to 106% in 2023 as those payables settled, before rising again to 101% in 2025 as receivables inched upwards and payables slid downwards.

Leverage

Debt/Equity (2021-25); Net debt/EBITDA (2025)



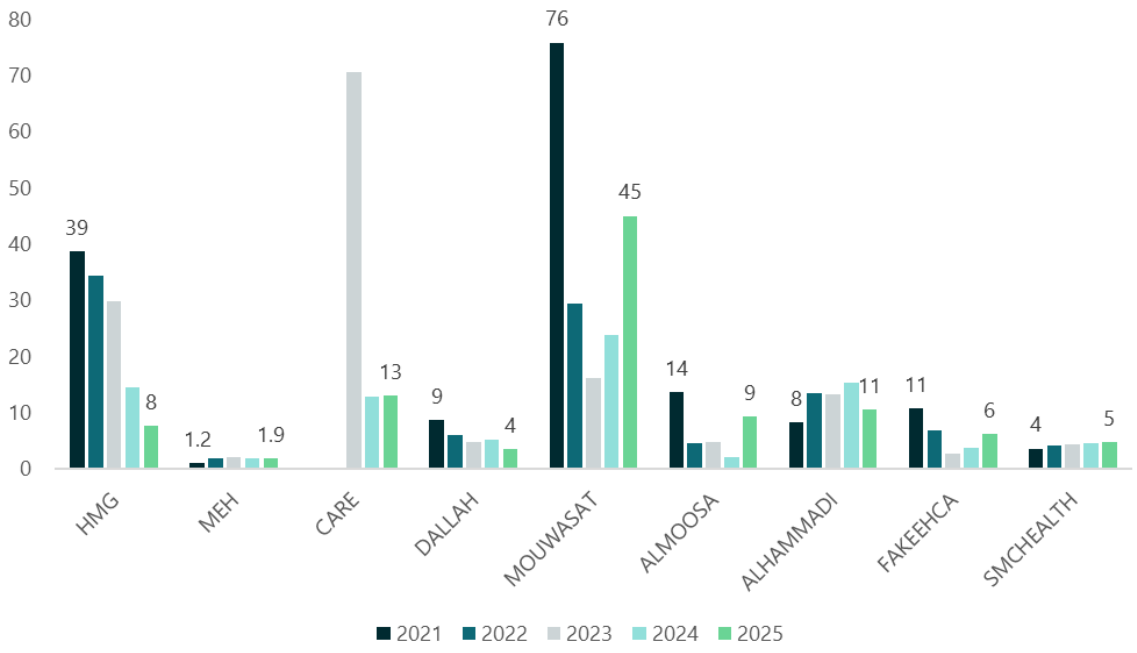
Source: Company reports

Given large capex cycles, healthcare operators have accumulated debt to fund growth, with MEH and DALLAH carrying the highest net debt to EBITDA in the sector for FY25. MEH launched three facilities in 2022 to 2023, which pushed net debt to EBITDA to approximately 8x in 2022, since moderating to 4x in 2025, still among the highest in the sector. Beyond expansion financing, MEH also carries elevated short-term debt to fund working capital given its lengthy collection cycles. Its debt to equity peaked at 1.9x in 2023 and has since eased to 1.4x in 2025, the highest in the sector. DALLAH's net debt to EBITDA of 4.3x is an FY25 event, doubling following the acquisition of two hospitals during the year. Debt to equity similarly rose from 0.6x in FY24 to 1x in FY25, reflecting the step-up in financing associated with the acquisitions. HMG has steadily added debt to fund six new facility launches, with debt to equity rising from 0.6x to 1.2x in FY25. Net debt to EBITDA nonetheless remains at 2x, supported by a strong cash position.

ALMOOSA and FAKEEHCA have materially deleveraged following their respective IPOs, using proceeds to repay debt and reducing debt to equity from 1.9x and 2.2x in FY23 respectively to 0.4x each in FY25. Net debt to EBITDA stands at 2.4x and 1.7x respectively, reflecting residual expansion financing. CARE is the most conservatively positioned with net debt to EBITDA of 0.1x and debt to equity of 0.3x, despite

recent capacity additions. MOUWASAT and ALHAMMADI have maintained stable leverage throughout, averaging 0.2x to 0.3x debt to equity over the past five years. Notably, MOUWASAT has sustained this despite adding 550 beds over the period, while ALHAMMADI has added no additional beds over the same timeframe.

Interest coverage (2021-2025)



Source: Company reports

Interest coverage across the sector has broadly compressed over the 2021 to 2025 period, reflecting a combination of rising financing costs as operators drew down debt to fund expansion and, in some cases, earnings growth that has not yet kept pace with the debt load taken on.

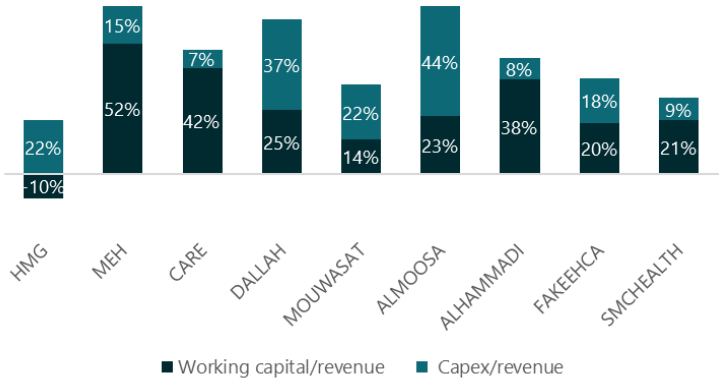
HMG shows the most pronounced decline, from 39x in 2021 to 8x in 2025, as debt drawdowns to fund its hospital pipeline have outpaced earnings growth. While 8x remains comfortable in absolute terms, the direction is consistent with continued capex intensity through 2027 and 2028. MOUWASAT is the standout improver, recovering from a trough of 16x in 2023 to 45x in 2025, underpinned by strong earnings growth and a conservative leverage approach with expansion funded predominantly through internal cash flows.

MEH remains the most constrained at a sustained 1 to 2x across the entire period, with no meaningful improvement despite revenue growth, leaving limited buffer against any earnings deterioration. DALLAH has drifted from 9x in 2021 to 4x in 2025, with the Al-Salam and Al-Ahsa acquisitions adding incremental financing costs in the near term.

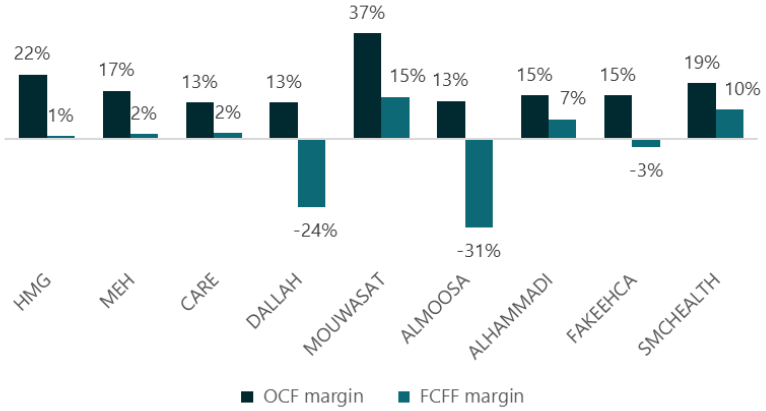
CARE carried no debt prior to 2023 and has since stabilized at 13x, reflecting a still-conservative leverage position. ALMOOSA recovered sharply to 9x in 2025 from a trough of 2x in 2024 post IPO debt repayments, and growth in earnings. FAKEEHCA similarly recovered to 6x from a trough of 3x to 4x in 2023 and 2024, supported again by debt repayments post IPO. ALHAMMADI and SMCHEALTH have been range-bound at 8x to 15x and 4x to 5x respectively, reflecting stable leverage profiles without significant debt-funded expansion to date.

Cashflows

Working capital and Capex as a % of Revenue (2025)



OCF and FCFF margin (2025)



Source: Company reports

Free cash flow generation in 2025 is heavily bifurcated by expansion phase, with operators in peak capex deployment generating negative to negligible FCFF despite healthy operating cash flows. ALMOOSA and DALLAH are the most capital-intensive at 44% and 37% of revenue respectively, producing FCFF margins of -29% and -22%, consistent with their active hospital pipelines. HMG, despite a 22% capex to revenue ratio, delivers only 1% FCFF margin, though working capital at -10% of revenue acts as a net cash source, reflecting its scale and collections efficiency.

MOUWASAT stands out as the strongest cash generator with an OCF margin of 37% and FCFF margin of 15%, underpinned by disciplined working capital management at 14% of revenue, the most efficient conversion in the sector. SMCHEALTH and ALHAMMADI have 10% and 9% FCFF margins respectively, both running low capex intensities of 9% and 8% of revenue ahead of more significant expansion phases coming online post-2027.

MEH and CARE present a common challenge: working capital constitutes 52% and 42% of revenue respectively, the highest in the sector, compressing OCF margins to 17% and 15% despite reasonable gross margins. CARE's low capex of 7% of revenue keeps FCFF marginally positive at 2%, while MEH similarly converts at 2% given its Jeddah tower and Dammam expansion spend. FAKEEHCA is marginally negative at -2% FCFF, with capex of 18% of revenue reflecting pre-opening costs for three new medical centres launching from mid-2026.

Stocks coverage: SULAIMAN ALHABIB and SAUDI GERMAN HEALTH

Dr. Sulaiman Al Habib Medical Services Group (SULAIMAN AB)

Rating Summary

Recommendation	HOLD
12-month Target Price (SAR)	235

Stock Details

Last Close	213.1
Market Cap (SAR bn)	74.6
Shares O/S (mn)	350.0
52-week high/low	281.2/211.5
Price change (YTD)	-17%
Reuters/BBG	4013.SE/SULAIMAN AB

TASI vs. SULAIMAN (rebased)

HMG's topline continues to grow, supported by the ramp-up of newly launched hospitals. However, occupancy remains relatively low at 62% versus 81% in 2023, continuing to weigh on margins. As a result, margins are expected to remain under pressure through 2026, with normalization likely by 2027. The company's entry into Jeddah has been disruptive, offering services at competitive prices and gradually gaining market share from peers. Competitive intensity is expected to rise further over the medium term, particularly in Riyadh, HMG's core market. The city is expected to see the addition of approximately 2,700 beds by 2030 through 12 new hospitals planned by listed peers. This supply increase could pressure industry margins as operators compete for patient volumes amid slower-than-expected population growth. The Solutions segment is also expected to contribute less than earlier forecasts as the company shifts focus toward its core healthcare operations. HMG has announced a SAR 10bn capex plan against the currently disclosed addition of 713 beds through 2029. The four announced hospital expansions in Riyadh, Tabuk, Jubail, and Dammam account for only about 30% of this capex, suggesting further expansion announcements ahead. Finance costs are expected to trend higher as the company funds this expansion cycle. Additionally, the current geopolitical environment, potential inflationary pressures, and a higher interest rate backdrop could weigh on valuation. Given slower-than-expected growth in revenue per patient, lower expected contribution from the Solutions segment, and margin pressure persisting longer than previously anticipated, we maintain our **HOLD** recommendation on the stock. We increase our medium-term average finance cost assumption due to the Fed's signaling and lower our TP to SAR **235/sh**.

Summary financials

SAR mn	2024A	2025A	2026E	2027E	2028E
Income Statement					
Revenue	11,200	13,707	14,420	15,637	18,283
Gross Profit	3,744	4,207	4,445	4,935	5,770
Operating profit	**2,356**	**2,619**	**2,706**	**3,105**	**3,668**
EBITDA	**2,777**	**3,291**	**3,591**	**4,076**	**4,862**
Finance costs	(163)	(339)	(445)	(502)	(456)
Profit after tax	**2,315**	**2,401**	**2,367**	**2,721**	**3,341**
EPS (SAR)	6.62	6.86	6.76	7.77	9.55
DPS	4.77	4.83	4.73	4.66	5.73
Balance Sheet					
Total current assets	5,319	5,427	5,594	4,035	4,714
Total Fixed Assets	15,239	17,778	19,042	21,184	23,180
Total Assets	**20,558**	**23,205**	**24,635**	**25,219**	**27,895**
Short-term loans	96	96	121	110	116
Total current liablities	4,162	4,719	4,389	4,703	5,455
Long Term loans	7,662	8,735	9,686	8,770	9,237
Total non-current liabilities	8,783	10,058	11,022	10,103	10,567
Total liabilities	**12,945**	**14,776**	**15,410**	**14,806**	**16,022**
Total Equity	7,613	8,429	9,229	10,420	11,883
Total liabilities and equity	**20,558**	**23,205**	**24,635**	**25,219**	**27,895**

Summary financials

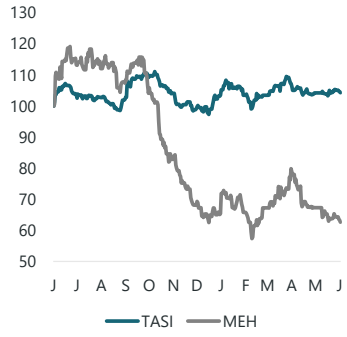
	2024A	2025A	2026E	2027E	2028E
Ratios					
Gross margin	33.4%	30.7%	30.8%	31.6%	31.6%
Operating margin	21.0%	19.1%	18.8%	19.9%	20.1%
EBITDA margin	24.8%	24.0%	24.9%	26.1%	26.6%
Net margin	20.7%	17.5%	16.4%	17.4%	18.3%
Return on equity	31.1%	29.6%	26.6%	27.1%	29.2%
Interest coverage (x)	14.5	7.7	6.1	6.2	8.0
Net debt/EBITDA	1.9	2.1	2.2	2.1	1.8
Debt to Assets	0.4	0.4	0.4	0.4	0.4

Middle East Healthcare Co. (MEH AB)

Rating Summary	
Recommendation	BUY
12-month target price	48

Stock Details	
Last Close	31.62
Market Cap (SAR bn)	2.9
Shares O/S (mn)	92.0
52-week high/low	60.70/28.66
Price change (YTD)	-4%
Reuters/BBG	4009.SE/MEH AB

TASI vs MEH (rebased)



MEAHCO's patient growth remains strong, driven by ramp-up of existing and new capacity. Outpatient yields have improved on accreditation-driven pricing, while per inpatient revenue remains under pressure from rising competition in Jeddah and a structural shift in MoH sourcing toward tender-based procurement at insurance-level pricing, which is reducing higher-margin referral volumes. The company is expanding subspecialties through ~400 physician hires to improve case mix, although impact is likely from 2027 given longer ramp-up and patient migration timelines. Offsetting margin pressure in 2027 is expected from Jeddah tower launch due to higher initial costs. In our view, increasing competition is likely to keep margins below historical levels over the longer term, despite subspecialty expansion, as peers are also enhancing service offerings to capture market share. Capex intensity remains elevated, with ~SAR 600–700mn invested across FY24–26 (out of total SAR 1.3bn capex) solely on renovations and upgrades of existing assets, raising the key question of whether incremental asset turnover and revenue uplift will justify this spend. Recovery in earnings is expected to be revenue driven primarily, with ramp-up time frame expected over 2026-2028. We do increase our medium-term finance cost assumptions however, ruling out any rate cuts in 2026 given latest signaling from the Fed. The valuation appears to capture ongoing margin weakness and provides an upside with an expected revenue ramp-up over 2026-2028. Maintain **BUY** with a TP of **SAR 48/sh**.

Summary financials

SAR mn	2024A	2025A	2026E	2027E	2028E
Income Statement					
Revenue	2,883	3,103	3,261	3,424	3,771
Gross profit	1,114	1,160	1,204	1,263	1,391
Operating profit	**441**	**387**	**331**	**309**	**384**
EBITDA	**749**	**773**	**579**	**592**	**680**
Finance costs	(222)	(201)	(175)	(164)	(139)
Profit after tax	**282**	**302**	**135**	**148**	**246**
EPS (SAR)	3.06	3.28	1.47	1.60	2.67
DPS	-	0.50	0.50	0.33	0.55
Balance Sheet					
Total current assets	2,173	2,256	2,219	2,049	2,190
Total Fixed Assets	2,952	3,210	3,349	3,396	3,434
Total Assets	**5,125**	**5,466**	**5,567**	**5,446**	**5,624**
Short-term loans	640	836	782	537	544
Total current liablities	1,262	1,457	1,416	1,203	1,277
Long Term loans	1,840	1,587	1,608	1,569	1,460
Total non-current liabilities	2,189	2,082	2,104	2,071	1,968
Total liabilities	**3,451**	**3,539**	**3,547**	**3,301**	**3,272**
Total equity	1,674	1,928	2,020	2,144	2,352
Total liabilities and equity	**5,125**	**5,466**	**5,567**	**5,446**	**5,624**
Ratios					
Gross margin	38.6%	37.4%	36.9%	36.9%	36.9%
Operating margin	15.3%	12.5%	10.2%	9.0%	10.2%
EBITDA margin	26.0%	24.9%	17.8%	17.3%	18.0%
Net margin	9.8%	9.7%	4.1%	4.3%	6.5%
ROE	17.0%	16.1%	6.8%	7.0%	10.7%
Interest coverage (x)	2.0	1.9	1.9	1.9	2.8
Net debt/EBITDA	3.4	3.3	4.1	3.8	3.2
Debt to Assets	0.5	0.5	0.5	0.4	0.4

Rating Framework

Buy

Shares of the companies under coverage in this report are expected to outperform relative to the sector or the broader market.

Hold

Shares of the companies under coverage in this report are expected to perform in line with the sector or the broader market.

Sell

Shares of the companies under coverage in this report are expected to underperform relative to the sector or the broader market.

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Saudi Fransi Capital

(Closed Joint Stock Company Owned by Banque Saudi Fransi)

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