Five Decades of Five-Year Health Development Plans in Oman (1976-2025): A Narrative Systematic Review of Policy Evolution and Health System Outcomes

Thamra Al Ghafri[1*], Fatma Al Ajmi[2], Ahmed Al Qasmi[3], Laila Al Zedjali[4] and Ahmed Al Mandhari[5]

[1]Directorate General of Health Services, Ministry of Health, Muscat, Oman

[2]Oman Medical Specialty Board, Muscat, Oman

[3]Oman Eleventh Five-Year Development Plan (2026-2030), Muscat, Ministry of Economy

[4]Oman College of Health Sciences, Muscat, Oman

[5]Planning and Health Regulation, Ministry of Health, Muscat, Oman

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*****Corresponding author: thamra74@yahoo.com

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Abstract

Oman's health system has transformed since 1970 under ten consecutive five-year health development plans, but no appraised synthesis covers the full planning arc. This review followed the PRISMA 2020 statement and Popay et al. guidance, combined with structured analysis suited to an evidence base dominated by policy texts. Four databases were searched to November 2025, with a documented top-up search to February 2026, with grey literature searches. Two reviewers independently screened and appraised sources. Of 569 records identified, 56 sources met eligibility: 19 peer-reviewed articles, 26 government and policy documents, 10 WHO and international reports, and one doctoral thesis. Three phases emerged: infrastructure development and service expansion (1976-1990); decentralisation and quality improvement (1991-2005); and strategic planning with global alignment (2006-2025). Life expectancy rose from 49.3 years in 1970 to over 77 years, and infant mortality fell from about one in eight live births to 8.1 per 1000 Omani live births in 2024. Oman scored 70 out of 100 on the universal health coverage service index in 2021, and the 2025 national STEPwise survey found 27.3% of adults obese and 13.4% with diabetes or raised fasting blood glucose. Each phase engaged all six WHO health system building blocks, alongside sustained control of vaccine-preventable childhood infections, although these gains accompanied broad socioeconomic development and cannot be attributed to planning alone. Universal primary health care coverage is achieved for the Omani population. Two mechanisms appear transferable: adoption of health plans as legal instruments rather than administrative documents, and sustained primary health care prioritisation.

Keywords: Oman; health planning; five-year plan; primary health care; health system development; universal health coverage; Health Vision 2050; narrative review; document analysis.

Introduction

Oman's health system transformation is among the most rapid recorded. In 1970 the country had two hospitals, both established before 1958, and 13 physicians, approximately one physician per 50,000 population; approximately one in eight infants died before the first birthday; and life expectancy at birth was 49.3 years. These figures are reported in the same four-decade review of the system, which dates the physician, infant mortality and life expectancy values to 1970 and the two hospitals to the period before 1958.[1] In that founding year the Ministry of Health spent 534,282 Omani Rials on health service development, covering immunisation, vector control, water purification and health education.[1] Five decades later Oman ranks among global leaders, having been ranked first among 191 member states for performance on level of health, the disability-adjusted life expectancy measure, and eighth for overall performance in the World Health Organization's (WHO) World Health Report 2000.[2,3]

A Royal Decree of 22 August 1970 established the Ministry of Health (MOH) to organise national health services,[1] and in 1974 the Development Council was established to prepare long-term strategies and integrate sectoral policies into five-year development plans.[4] This architecture has underpinned ten consecutive five-year health development plans from 1976 to 2025.

Prior syntheses have addressed parts of this trajectory. A four-decade account documents the system to 2010 but predates the ninth and tenth plans and does not treat the plans as a sequence of planning instruments.[1] A 2025 analysis examines the Oman Vision 2040 health agenda but takes the current plan as its starting point rather than the planning tradition that produced it.[5] Neither analyses all ten cycles as a single trajectory, which is the gap this review addresses. Understanding how a sustained planning tradition was built, and where it fell short, is more useful to countries reforming their own systems than a record of outcomes alone.

The aim was to examine and synthesise evidence on the development, implementation and outcomes of Oman's ten Five-Year Health Development Plans (1976-2025), identifying the thematic phases, governance mechanisms and cross-cutting factors that shaped this trajectory.

Methods

Study Design and Reporting

A narrative systematic review was adopted because the evidence base is heterogeneous and contains no primary quantitative data amenable to meta-analysis. It was conducted and reported in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 statement[6] and the guidance of Popay et al. on narrative synthesis.[7] The term systematic review is used here to describe the search, screening, eligibility and appraisal procedures, which were prespecified, applied in duplicate and reported against PRISMA 2020. Because most eligible material consists of policy documents rather than empirical studies, extraction and synthesis followed established document analysis methods. Design and reporting are set out in full in Supplementary File 1, with the completed PRISMA 2020 checklist.

The review analysed publicly available documents and published literature. It did not involve human participants, patient records or identifiable data, and did not require ethical approval or informed consent. This review was not registered and no protocol was prepared in advance.

Search Strategy and Information Sources

PubMed/MEDLINE, Web of Science, Scopus and EMBASE were searched from inception to November 2025. A top-up search of the same databases and of the Ministry of Health and Oman News Agency archives was run in February 2026 to capture the eleventh plan launch in January 2026 and the 2025 national STEPwise survey. It added three records and altered no earlier eligibility decision. Grey literature searches covered Ministry of Health and Ministry of Economy publications, WHO Eastern Mediterranean Regional Office documents, World Bank reports, the National Centre for Statistics and Information, Royal Decree archives and the Oman News Agency, structured around the Grey Matters checklist. Grey literature sources were searched by one reviewer between September and November 2025 and independently re-run by a second. Complete search strings by database, with the date each was run, and the terms applied to each grey literature source, are in Supplementary File 1. Hand-searching reference lists yielded 19 additional records, included within the 82 records identified from sources other than databases in Figure 1. Forward citation searching was not undertaken.

Eligibility Criteria

Eligible sources addressed the plans between 1976 and 2025 and described planning processes, objectives, mechanisms, implementation or evaluation. Inclusion was restricted to documents in English, together with Arabic-language Ministry of Health planning documents where these were the only primary record of a plan period, assessed by the two Arabic-speaking members of the team. No systematic search of Arabic-language databases was undertaken. Opinion pieces were excluded where they offered no substantive account of plan content, objectives or implementation. Editorials and commentaries by authors involved in Omani health planning were eligible, appraised with the JBI Checklist for Text and Opinion and reported as expert commentary rather than empirical evidence. The criteria are set out in full in Supplementary File 1.

Study Selection and Quality Assessment

Selection followed the PRISMA process (Figure 1). Searches identified 487 database records and 82 from other sources, giving 569 in total. After removal of 257 duplicates, 312 unique records underwent title and abstract screening; 198 were excluded (87 not Oman, 65 not health planning, 46 outside 1976 to 2025). Full-text assessment of 114 records excluded a further 58 (28 insufficient detail on plan content, 12 not in English, 18 opinion without a substantive account of plan content), yielding 56 included sources: 19 peer-reviewed articles, 26 government and policy documents, 10 WHO and international reports and one doctoral thesis. Two reviewers (TAG and LAZ) screened independently at both stages, with disagreements resolved by consensus. Agreement at the title and abstract stage was almost perfect (Cohen's kappa = 0.84) on the benchmarks of Landis and Koch. A confidence interval is not reported because the agreement table was not retained, and full-text agreement was not formally quantified.[8]

Quality was assessed with instruments matched to source type: the relevant JBI Critical Appraisal Checklists for peer-reviewed studies and for text and opinion, and AACODS for grey literature.[9-11] Sources were rated high where all applicable domains were met, moderate where one or two were unmet or unassessable, and low where three or more were unmet. For grey literature, authority and accuracy were necessary for a high rating. Item-level scores were recorded only as summary ratings and are reported at that level. No sources were excluded on quality grounds alone, but ratings informed the weight given to each, with primary sources prioritised over secondary interpretations. Supplementary Table S1 lists the 56 included sources with appraisal ratings and summarises the distribution of high, moderate and low ratings across them.

Data Extraction and Synthesis

A standardised form captured plan period, themes, objectives, mechanisms, evaluation methods and indicators, reported outcomes, documented challenges and governance structures. The form was piloted on the first five included sources, and two fields were added, one recording adoption by Royal Decree and one recording stated targets separately from reported achievements. Extraction was performed by the primary reviewer and verified by a second. Narrative synthesis followed the four-element framework of Popay et al.[7] comprising theory development, preliminary synthesis by tabulation and chronological ordering, thematic exploration of relationships, and assessment of strength by triangulation. The theory developed at the first element is stated at the head of the Results, and the fourth element is reported there as a triangulation paragraph.

The three phases were not imposed a priori. Boundaries were placed at 1990 and 2005 because each marks a documented change in the stated organising logic of the plans rather than a convenient decade break. Selected national health indicators aligned to the ten plan periods are given in Supplementary Table S2, transcribed cell by cell from the Ministry of Health annual health report and the national statistical year book, with cells left blank where the source reports no value.[12,13]

Figure 1. PRISMA 2020 flow diagram of study selection

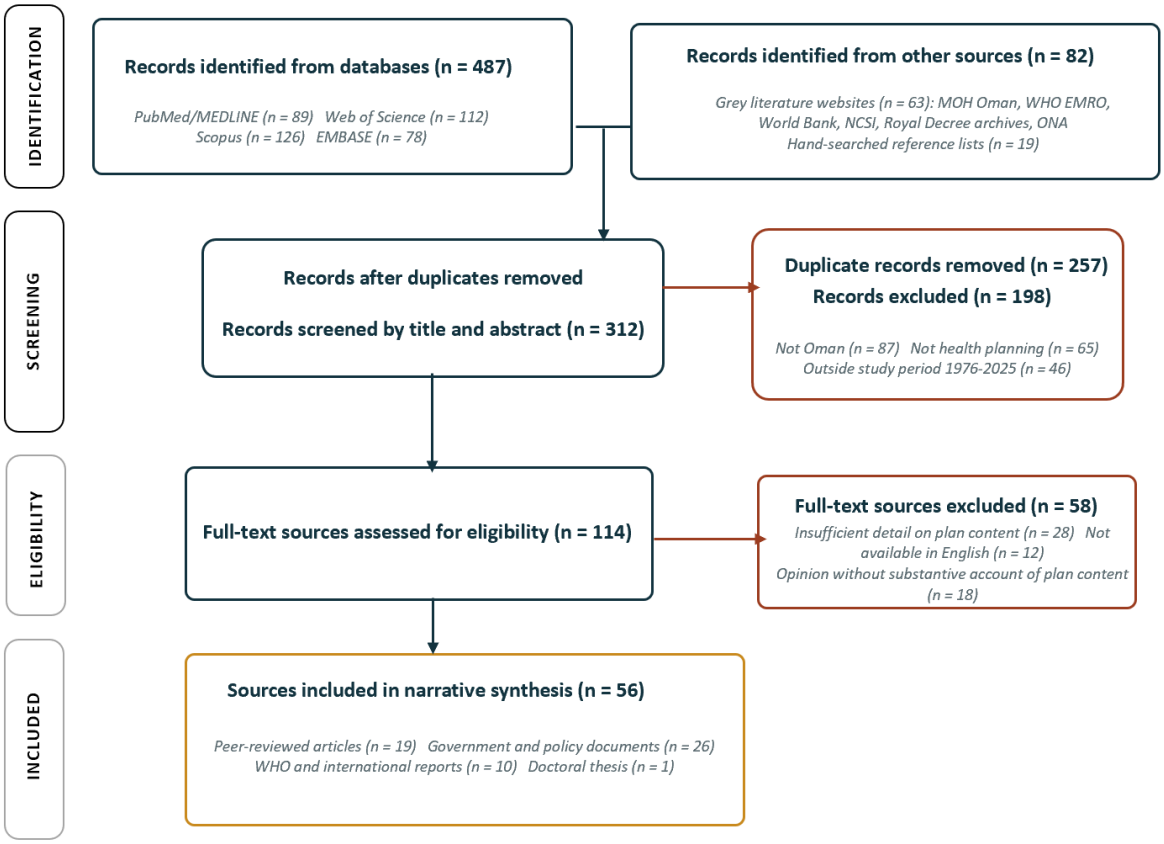

Figure 1: PRISMA flow diagram of study selection.

Results

Fifty-six sources met eligibility criteria. Three planning phases were identified across the ten plans (Figure 2). A summary of all ten plans, including themes, objectives, mechanisms, evaluation approaches, and documented challenges, is presented in Table 1.

Figure 2: Timeline of Oman's ten Five-Year Health Development Plan (1976-2025).

A Proposed Mechanism of Planning Evolution

We propose that Oman's planning trajectory is best understood as institutional layering under legislative path dependency. Adoption by Royal Decree gave each plan the standing of a legal instrument rather than an administrative intention, making discontinuation costlier than continuation. Successive plans therefore added institutions without dismantling earlier ones: the vertical disease programmes of the first two plans were not replaced by the regional directorates of the third, and the wilayat health system of the fourth was layered onto both. This accounts for two features the chronology alone does not explain, the persistence of one planning tradition across five decades and the coexistence of vertical programmes with decentralised governance that this review documents as a recurring source of coordination difficulty.

Phase I: Infrastructure Development and Service Expansion (1976-1990)

First Plan (1976-1980). Royal Decree 32/76 prioritised infrastructure. By 1980, 55 health centres were operating and free services for citizens had become standing policy (Table 1).[1,14-16] A verified health expenditure total for the plan period 1976 to

1980 could not be obtained from the sources available to this review, and none is stated here. Evaluation relied on annual follow-up reports by the Development Council.[4]

Second Plan (1981-1985). Royal Decree 82/80 moved the emphasis to primary health care (PHC) expansion and disease control, aligning planning with Alma-Ata. Vertical programmes for tuberculosis, immunisation, blindness prevention and diarrhoeal disease were established, and the National PHC Committee followed in 1985.[1,4,15,17-19]

Third Plan (1986-1990). The third plan emphasised maternal and child health and began decentralisation. Regional Directorates General of Health Services were established in 1990, moving planning authority below the central ministry for the first time.[1,15,16,19]

Phase II: Decentralisation and Quality Improvement (1991-2005)

Fourth Plan (1991-1995). Royal Decree 1/91 introduced approximately 23 targeted programmes and extended decentralisation to district level through the Wilayat Health System, with community participation and equity operationalised in the accompanying PHC framework.[1,15,20-23] Later analysis of district-level implementation identified the friction points of this design.[24]

Fifth Plan (1996-2000). The fifth plan prioritised PHC strengthening, established a health research framework with WHO, addressed gender equity under the Beijing Platform for Action and strengthened the Oman Medical Specialty Board.[25-31] By the end of the plan period, 116 health centres and 34 wilayat and local hospitals were in operation. This is cumulative national stock, not new establishments during the plan; Table 1 states which basis applies for each figure and marks cells where the source does not distinguish the two.[1,15]

Sixth Plan (2001-2005). Royal Decree 1/2001 continued service expansion while introducing quality management. Integrated Management of Childhood Illness was launched, quality assurance was institutionalised in PHC from 2001, and the private sector received financial and technical support.[1,31-36]

Phase III: Strategic Planning and Global Alignment (2006-2025)

Seventh Plan (2006-2010). A consultative process produced ten strategic visions. Recognition of the rising non-communicable disease (NCD) burden shaped priorities, participation was formalised through Wilayat Health Committees and Community Support Groups, and WHO engagement was structured through the Country Cooperation Strategy.[1,31,37-40] The recognition Oman received in the World Health Report 2000 predates this plan and reflected the cumulative achievements of the first four plans.

Eighth Plan (2011-2015). Royal Decree 1/2011 emphasised private sector involvement and NCD prevention. Public private partnership frameworks were developed, groundwork was laid for mandatory insurance for expatriates, and specialty care expanded beyond Muscat.[5,33,39,41-45] The plan directed substantial capital investment towards infrastructure. No monetary total is stated because the official financial annex of the eighth plan could not be obtained and no verified health-sector allocation was available.

Ninth Plan (2016-2020). The ninth plan concluded Vision Oman 2020 and prepared for Oman Vision 2040. Development engaged 40 workshops with government, private sector, civil society and youth, and evaluation reported implementation of 95% of 412 strategic programmes.[5,46-50] This period should be read against the fiscal contraction that followed the fall in oil prices between 2014 and 2016. After its 2016 Article IV mission the International Monetary Fund recorded planned spending reductions of about US$4.5 billion, close to 8% of gross domestic product, against a fiscal deficit of 17.1% in 2016, which constrained capital spending across sectors.[51] That implementation rate derives from a national progress statement rather than an independent evaluation, and the criteria for classifying a programme as implemented are not published, so it is best treated as a self-assessment.[52]

Tenth Plan (2021-2025). The tenth plan is the first implementation phase of Oman Vision 2040 and is aligned with Health Vision 2050. It employs a results-based approach of six strategic objectives and 43 expected results, evaluated through key performance indicators across accessibility, workload, outcomes, timeliness, satisfaction and safety (Table 1).[5,33,35,52-57] The first two years coincided with the COVID-19 pandemic, which diverted workforce and financing towards the emergency response and delayed parts of the planned service expansion.

Table 1: Summary of Oman's ten Five-Year Health Development Plans (1976-2025).

Plan Period	Theme / Focus	Main Objectives	Stated Targets	Reported Achievements	Key Mechanisms	Evaluation Methods	Key Challenges and Limitations
1st Plan (1976-1980)[1,4,14]	Infrastructure development	Renovate existing hospitals; establish a national network of health centres; universal population access	55 health centres by 1980	55 health centres reported in operation by 1980	Royal Decree 32/76; free health services; immunisation; vector control; water purification	Annual follow-up reports by the Development Council; economic and social indicators	Extreme shortage of facilities and trained staff at baseline; near-total reliance on expatriate workforce; no verified plan-period health expenditure figure available
2nd Plan (1981-1985)[1,15,17-19]	Primary health care expansion	Establish PHC as the system entry point; extend coverage to mothers, children and remote populations	National coverage of immunisation and maternal and child services; establishment of a national PHC coordinating body	National PHC Committee established in 1985; immunisation and coverage indicators reported in annual health statistics	TB control; Extended Programme for Immunisation; blindness prevention; diarrhoeal disease control	Coverage indicators; immunisation rates; health centre numbers; annual health statistics	Vertical programme structure limited integration across services; geographical access in mountain and desert areas remained dependent on mobile teams
3rd Plan (1986-1990)[1,15,16,19]	Maternal and child health; decentralisation	Expand the health centre network; national MCH programme; acute respiratory infection control; regional decentralisation	Establishment of regional health administration; national MCH and ARI programmes in operation	Directorates General of Health Services established in the regions in 1990; MCH programme launched 1987; ARI control programme launched	Regional Directorates General of Health Services; MCH programme; ARI control programme	Regional service expansion monitoring; MCH outcome indicators; programme implementation assessment	Regional directorates created before regional planning and financial management capacity was in place; facility-based delivery uptake uneven between regions
4th Plan (1991-1995)[1,15,20-24]	Comprehensive health programmes; risk groups	23 targeted health programmes; integrate curative services into PHC; establish the Wilayat Health System	23 health programmes implemented; Wilayat Health System established nationally	Wilayat Health System established; programme implementation reported by the Ministry. Devolution of budget and staffing authority not independently	"Components of PHC in Oman 1991-1995" document; Wilayat Health System; intersectoral school health programme	Programme outcome assessment; Wilayat system effectiveness; World Bank external reviews	Large number of parallel programmes strained district capacity; responsibility devolved to wilayat level ahead of budget and staffing authority

				documented as achieved			
5th Plan (1996-2000)[1,15,25-31]	Strengthening primary health care	Strengthen PHC strategies; expand the facility network; establish a national health research framework	Continued PHC expansion; establishment of a research function within the Ministry	116 health centres and 34 wilayat and local hospitals in operation by the end of the period (cumulative national stock); Department of Research and Studies established	Programme to Strengthen PHC; Department of Research and Studies; national health research workshop with WHO	Annual health reports; health centre and hospital numbers; research priority monitoring	Shortage of Omani family physicians constrained PHC staffing; research capacity newly established and not yet feeding routinely into planning
6th Plan (2001-2005)[1,31-36]	Service expansion; quality management	Implement the IMCI strategy; introduce quality management in PHC; continue service expansion	IMCI implemented in PHC; quality assurance programmes established	IMCI launched; quality assurance and improvement programmes introduced in 2001. Effect on quality outcomes not independently documented	IMCI launch; quality assurance and improvement programmes; private sector support through loans and technical guidance	IMCI evaluation; quality management indicators; service expansion metrics	Quality assurance introduced without an independent inspection function; private sector growth concentrated in Muscat
7th Plan (2006-2010)[1,37,38,40]	Strategic planning; disease prevention	Ten strategic visions; disease prevention; community involvement; NCD response	Ten strategic visions to be achieved; community participation structures in every wilayat	Consultative strategic planning process completed; Wilayat Health Committees and Community Support Groups established. Vision-level achievement not independently documented	Consultative strategic planning process; ten visions framework; Wilayat Health Committees; NCD preventive programmes	Outcome and performance indicators; strategic vision achievement metrics; international benchmarking	NCD burden rising faster than preventive service capacity; community structures established but with advisory rather than decision-making authority
8th Plan (2011-2015)[33,39,41-45]	Private sector investment; preventive care	Attract private sector investment; address the NCD burden; develop specialty care; strengthen preventive care	Increased private sector share of provision; mandatory health insurance for expatriate	PPP frameworks and private hospital development reported. Insurance cover for expatriate workers not in	PPP frameworks; groundwork for mandatory health insurance for expatriate employees; private hospital development	Private sector contribution tracking; NCD statistics; hospital bed capacity; infrastructure investment metrics	Official health-sector financial allocation for this plan could not be verified from primary sources; PPP capacity and regulatory readiness lagged policy intent; insurance cover for

			employees; new specialty capacity	force by the end of the period. Plan-period financial allocation not verifiable from primary sources			expatriate workers not yet in force
9th Plan (2016-2020)[46-51]	Universal health coverage; Vision 2040 preparation	Prepare for Vision 2040; integrate health services; support economic diversification in health	412 strategic programmes across six strategic health programmes	Implementation of 95% of 412 strategic programmes reported. This is a government self-assessment and the classification criteria are not published, so it is not independently documented	40 consultation workshops; six strategic health programmes; alignment with Vision Oman 2020	Reported 95% implementation of 412 strategic programmes; national priority achievement measurement	Fiscal contraction after the 2014 to 2016 oil price fall constrained capital spending; the reported implementation rate is a self-assessment and the criteria for classifying a programme as implemented are not published
10th Plan (2021-2025)[52,53,55-57,63,71]	Paradigm shift; digital transformation	Universal health coverage; governance restructuring; digital transformation; alignment with Health Vision 2050	43 expected results across 6 strategic objectives	Six strategic objectives operational and a KPI framework introduced across six domains. The universal health coverage service coverage index stood at 70 in 2021. Result-level achievement against the 43 expected results not independently documented	Six strategic objectives; National Health Plan covering public and private agencies; KPI framework; SDG alignment	KPIs across six domains (accessibility, workload, outcomes, timeliness, satisfaction, safety); digital health metrics	First two years coincided with the COVID-19 pandemic, diverting workforce and financing and delaying planned service expansion; universal coverage applies to the citizen population, with non-Omani residents largely covered through employer insurance and the private sector

Cross-Cutting Themes Across the Ten Five-Year Plans

Evolution from infrastructure to systems thinking. Phase I focused on physical infrastructure, Phase II on quality, decentralisation and evidence-based interventions, and Phase III on strategic planning, outcome-based evaluation and global alignment.[1,40] This mirrors international patterns of system maturation within a compressed timeframe (Figure 2).

Governance and institutional development. Sustained political commitment from 1970 has underpinned the planning enterprise,[1] and each plan was adopted by Royal Decree, giving planning legislative force.[14,17,22,32,39] The institutional architecture, MOH (1970), Development Council (1974), regional directorates (1990), Wilayat Health System (1991) and Health Vision 2050 (2014), represents cumulative investment in planning capacity.[1,15,53]

Global alignment. Plan frameworks track engagement with global health norms, from Alma-Ata (1978) and Health for All by 2000 to the Millennium Development Goals and Beijing Platform for Action,[1,29] and then to the Sustainable Development Goals, Oman Vision 2040 and Health Vision 2050.[52,53,55] The National Health Policy of April 2025 adopts a Health in All Policies approach.[58]

Epidemiological transition. Early plans addressed communicable diseases through vertical programmes; by the seventh plan NCDs were the primary concern, driven by urbanisation, dietary change, sedentary behaviour and ageing. Control of vaccine-preventable childhood infections was sustained across this shift, and WHO certified elimination of mother-to-child transmission of HIV and syphilis in 2022.[1,58,59] Cross-sectional studies published in 2003 and 2004 documented rising obesity and tobacco use and were among the evidence available when the sixth and seventh plans were drafted. They are cited as the contemporaneous basis for that shift in priorities rather than as current prevalence estimates, which are given by the 2025 national survey below.[60-62] The most recent national STEPwise survey, conducted between April and October 2025 among 10,174 participants aged 15 years and over with an 83% response rate, reported for adults aged 18 years and over that 64.7% were overweight or obese, 27.3% were obese, 25.7% had raised blood pressure, 13.4% had diabetes or raised fasting blood glucose and 12.1% currently used tobacco.[63] Ageing has produced an early burden of frailty relevant to primary care,[64] and the shift to prevention and NCD programmes across the eighth to tenth plans is a direct planning response.

Community engagement. Participation has moved from a peripheral concern to a central principle: the Wilayat Health System brought services closer to communities,[15] the seventh plan formalised participation through Wilayat Health Committees and Community Support Groups,[1] the ninth plan involved civil society consultation,[46] and the tenth articulates "health for all, by all", sustained by the community health nursing workforce.[15,52,65]

Financing. Financing evolved in three broad steps that the plans document unevenly. Through the first six plans, services were financed almost entirely from general government revenue derived from hydrocarbon receipts and were free at the point of use for citizens. From the seventh plan onward the plans record preparatory work on alternative financing, including groundwork for mandatory insurance for expatriate workers and public private partnerships for infrastructure. The tenth plan and Health Vision 2050 set out diversification of financing as an explicit objective. Plan-period health allocations are not documented consistently across all ten plans, and are reported here only where an official figure could be verified.[42,43,52,53]

Recurring Implementation Constraints

Three constraints recur across the plan documents and their evaluations without being resolved. The first is dependence on expatriate clinical staff. Omanisation is a stated objective from the third plan onward, yet workforce analyses continue to report difficulty retaining Omani staff in some specialties and outside the capital.[30,66] The second is intersectoral coordination. Successive plans identify coordination with education, water and sanitation, municipal services and labour as a requirement, and successive evaluations re-identify it as unfinished, indicating that the mechanism adopted in one cycle did not carry into the next. The third is the distribution of services between governorates: decentralisation was intended in part to address regional disparity, but evaluations report that responsibility was devolved more completely than authority over budgets and staffing.[21,24] A fourth pattern is that the pace of improvement in mortality has slowed while some indicators have moved the other way. National figures show infant mortality among Omanis falling from 118 per 1000 live births in the early 1970s to 16.7 by 2000, but only from 9.5 to 8.1 between 2015 and 2024, with under-five mortality moving from 11.4 to 9.9 over the same decade.[12] Two series run counter to the general trend. Low birth weight rose from 4.2% of live births in 1980 to 13.3% in 2024, and hospital beds fell from a peak of 24.3 per 10 000 population in 1990 to 15.7 in 2024, because bed numbers grew more slowly than the resident population, which more than tripled over the same period.[12,13] A national health system performance assessment conducted with WHO support attributes part of the slowdown in child health gains to stagnating

investment in maternal and child health and in vaccination.[67] Table 1 records, for each plan period, the challenges and unmet targets that the plan documents and evaluations report.

Discussion

This review indicates that Oman's transformation reflects institutionally embedded planning rather than episodic intervention, across three phases: infrastructure building (1976-1990), decentralisation and quality improvement (1991-2005) and strategic global alignment (2006-2025).

Other Gulf Cooperation Council states have national health planning instruments, but on a different timescale and in a different form. Saudi Arabia's Health Sector Transformation Program sits within Vision 2030, and the United Arab Emirates has pursued health objectives through the National Agenda of 2014 and the We the UAE 2031 vision.[68-70] What distinguishes Oman is not the existence of health planning but its continuity: ten consecutive cycles from 1976, each adopted by Royal Decree, rather than a smaller number of transformation programmes nested within a national vision. Oman's first-place ranking for performance on level of health and eighth place for overall health system performance in the World Health Report 2000[2] indicates that this produced measurable results by the end of the first four cycles. Because that composite index has been contested and has not been repeated,[3] it is set here alongside a current measure on which Oman can be compared: the universal health coverage service coverage index, on which Oman scored 70 out of 100 in 2021.[71]

Two Asian trajectories offer contrasts. Thailand achieved near-universal coverage through a single reform in 2002, the Universal Coverage Scheme, financed from general taxation, and the Republic of Korea reached universal coverage in 1989 through staged expansion of compulsory social health insurance.[72,73] Oman resembles neither. Coverage for citizens was established early and financed from general revenue without an insurance mechanism, and the planning system's function was not to extend entitlement but to build the delivery capacity it required. A planning tradition of this kind substitutes for coverage reform only where fiscal space allows universal public financing from the outset, the condition least likely to hold in the low- and middle-income settings to which the plans are held out as a model.

The gains recorded over this period should not be read as the effect of health planning alone. Life expectancy, maternal and child mortality and communicable disease control improved during five decades in which national income, education, housing, water supply, sanitation and transport all changed substantially. These act on the same outcomes through pathways independent of the plans, and a synthesis of documents without a counterfactual cannot separate them, so the association between plan content and outcome trends is descriptive. Designs capable of stronger causal inference include interrupted time series analysis around plan-driven interventions, synthetic control methods using comparator countries, and comparative case studies of neighbouring states with differing planning traditions.

The role of sustained political commitment is central. The decision in 1970 to establish the MOH and commit to free universal services set a trajectory operationalised by successive plans,[1] and its translation into institutional form[45] indicates that transformation requires durable institutions capable of planning, implementing and evaluating across multiple cycles.

The WHO health system building blocks framework[74] provides a lens for assessing comprehensiveness. The framework is set out in the 2007 WHO framework for action rather than in the World Health Report 2000, and is cited accordingly here. Across the ten plans Oman progressively engaged all six blocks, from a service-delivery and infrastructure focus in Phase I to integrated engagement in Phase III (Figure 3). Health Vision 2050 uses this framework, establishing 28 visions aligned with the six blocks.[53] The introduction of indicator-based evaluation in the tenth plan[57] aligns the national monitoring framework with the domains used in recent WHO health system performance assessment work, which makes external comparison feasible in a way that earlier plan evaluations did not.[67]

Figure 3: WHO health system building blocks across the three planning phase.

Sustained challenges warrant equal attention. Evaluations of Omanisation report continuing difficulty retaining Omani staff in some specialties and in peripheral governorates,[30,66] and decentralisation to the wilayat level has been found to devolve responsibility more completely than authority over budgets and staffing, so district managers carry accountability without full control of the inputs.[21,24]

Coverage requires precise statement. Universal primary health care coverage is achieved for Omani citizens, for whom services are free at the point of use, while non-Omani residents, more than two-fifths of the population,[75] access services largely through employer-provided insurance and the private sector. Coverage is therefore universal for the citizen population rather than all residents, and the equity gains of the planning era should be read with that qualification.[42,43]

Several lessons emerge for comparable settings. Planning with legislative force provides governance that outlasts short-term political cycles, and commitment to PHC as the foundation has protected equity and population outcomes.[31] Decentralisation balanced central coherence with local responsiveness, although evaluation has surfaced persistent implementation problems.[21,24] Research infrastructure established within the planning apparatus from the fifth plan enabled evidence-based planning and workforce analysis,[27,30,67] and integration into national vision documents and global frameworks supported coherence and accountability to external benchmarks.[46,52,55,56,66]

Epidemiological evidence from the 2000s onwards underpins this reorientation towards chronic-disease management and lifestyle-based prevention.[40,76-78]

Strengths and Limitations

The principal strength of this review is the duplicated application of prespecified procedures to policy material usually examined selectively, and the assembly of all ten plan cycles into one documented sequence. The search was systematic within its declared scope, which excluded Arabic-language databases, so the review synthesises the accessible documentary record rather than the complete national record.

Limitations include: a) the evidence base consists predominantly of policy and planning documents produced by the same bodies whose performance they describe, so it is vulnerable to selective reporting and this review cannot verify implementation independently of it, b) no systematic search of Arabic-language databases was undertaken, which is likely to have missed Omani policy material, c) the review was not registered and no protocol was lodged in advance. Several achievement figures derive from government progress statements without independent verification and are identified as such where they appear, appraisal was recorded at summary level rather than as domain-level scores, and a majority of included documents originate from the Ministry of Health, so agreement between them is not independent corroboration. Attribution of outcomes to individual plan periods is limited by continuous programme implementation, the absence of a counterfactual and the simultaneous influence of socioeconomic development. Transferability is constrained by Oman's population of approximately five million, and its centralized healthcare system. However, the transferable element is more plausibly the planning architecture than the resource base.

Conclusion

Five decades of continuous planning built a health system from a low base, but the problems now facing it are not those the planning tradition was designed to solve. The eleventh plan, in its first year of implementation, inherits four unresolved challenges: workforce sustainability, in particular retention of Omani clinicians outside the capital; a non-communicable disease burden that the 2025 national survey shows to be the dominant source of morbidity; financing in a fiscal environment that cannot assume hydrocarbon receipts; and the coverage of non-citizen residents, more than two-fifths of the population and largely outside the public entitlement. Each requires instruments the planning tradition has used least: intersectoral action, demand-side financing and regulation of a growing private sector. For other countries the transferable element is the adoption of plans as legal instruments and the sustained prioritisation of primary health care. What should not be copied is the assumption that continuity of planning is sufficient, instead, resolving the pre-identified challenges is the way forward.

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Supplementary File 1, Table S1. Source ledger with appraisal ratings and reconciliation to the reference list

Category	Old ID	Ref no.	Author or issuing body	Year	Title	Source type	Appraisal	Status and correction note
A	A1	**1**	Alshishtawy MM	2010	Four Decades of Progress: Evolution of the Health System in Oman	Narrative / Historical Review Article	High	Carried over
A	A9	**5**	Al Ghafari M, Al Alawi B, Aal Jumaa I, Al Awaidy S	2025	Oman Vision 2040: A Transformative Blueprint for a Leading Healthcare System	Policy Analysis / Strategic Review Article	High	Carried over
A	A2	**13**	Al-Zadjali M, Sinawi F, Sheeba M, Al Busaidi M, Al Jabri S, Silbermann M	2014	Community Health Nursing in Oman	Descriptive / Review Article	Moderate	Carried over
A	A14	**19**	Allawati NR, Mohamed N, Al Nadabi W	2026	An Evaluation of Three Decades of Health System Decentralisation in Oman	Evaluative Review / Health Policy Analysis	Moderate	Carried over. Volume, issue and pages verified: East Mediterr Health J 2026;32(1):12-18.
A	A16	**21**	Gadalla F	1993	Outlines of the Health Development Programmes of the Fourth Five-Year Plan (1991–1995)	Government Programme Document / Policy Paper	Moderate	Carried over
A	D2	**22**	Al-Balushi SM et al.	2014	Health system governance in Oman: a study of health policy implementation at the district level	Literature Review / Academic Study	High	Carried over. Reviewer 1, comment 4: peer-reviewed journal article, moves from category D to category A. The merged title has been split; the Lean implementation paper was a separate study and has been removed from this row.
A	D4	**28**	Al-Sawai A, Al-Shishtawy MM	2015	Health Workforce Planning: An Overview and Suggested Approach in Oman	Academic/Policy Paper (Published in SQU Medical Journal)	Moderate	Carried over. Reviewer 1, comment 4: peer-reviewed SQUMJ article, moves to category A.
A	A4	**32**	Al Nasiri Y, Al Balushi L, Al Farsi Y, Al Maniri A	2023	Integrated Management of Childhood Illness in Oman: Journey, Achievements and Lessons Learned	Review Article / Programme Evaluation	High	Carried over
A	A8	**34**	Al-Mandhari A, AlZakwani I, Al-Kindi M, Tawilah J, Dorvlo ASS, Al-Adawi S	2014	Patient Safety Culture Assessment in Oman	Cross-Sectional Survey Study	High	Carried over
A	D3	**36**	Ganguly SS, Al-Shafaee MA, Al-Lawati JA, Dutta PK, Duttagupta KK	2009	Epidemiological Transition of Some Diseases in Oman: A Situational Analysis	Epidemiological Analysis / Review (Published in EMHJ)	High	Carried over. Reviewer 1, comment 4: peer-reviewed EMHJ article, moves to category A.

A	A3	**55**	Al Rashidi B, Al Wahaibi A, Al Kharusi H, Al Kalbani A, Al Azri M, Al Kharusi B, et al.	2020	Assessment of Key Performance Indicators of the Primary Health Care in Oman: A Cross-Sectional Observational Study	Cross-Sectional Observational Study	High	Carried over
A	A5	**57**	Elgalib A, Al-Awaidy S, Kamoun O, Al-Jardani A, Al-Burshaid M, Al-Abri S, et al.	2023	Oman Eliminates Mother-to-Child Transmission of HIV and Syphilis	Short Communication / Policy Report	High	Carried over
A	A11	**59**	Al-Lawati JA, Jousilahti PJ	2004	Prevalence and 10-Year Secular Trend of Obesity in Oman	Trend Analysis / Epidemiological Study	High	Carried over
A	A12	**60**	Al-Riyami AA, Afifi MM	2004	Smoking in Oman: Prevalence and Characteristics of Smokers	Cross-Sectional Population Survey	High	Carried over
A	A17	**62**	Al-Sinawi H, Al-Alawi M, Al-Lawati R, Al-Harrasi A, Al-Shafaee M, Al-Adawi S	2012	Emerging Burden of Frail Young and Elderly Persons in Oman	Descriptive Epidemiological Study	High	Carried over
A	new	**63**	Al-Bulushi HS, West DJ	2006	Health system reforms and community involvement in Oman	Peer-reviewed article	Moderate	Added. Cited for community engagement across the plan cycles.
A	A15	**64**	Ghosh B et al.	2009	Health Workforce Development Planning in the Sultanate of Oman: A Case Study	Case Study / Health Policy Analysis	High	Carried over
A	A6	**65**	Lai T, Al Salmi Q, Koch K, Hashish A, Ravaghi H, Mataria A	2024	Health System Performance Assessment and Reforms, Oman	Health System Performance Assessment / Policy Analysis	High	Carried over. Pagination corrected to Bull World Health Organ 2024;102(7):533-7, verified against the Bulletin.
A	A7	**74**	Al Mawali AHN, Al Qasmi AM	2017	Oman Vision 2050 for Health Research: A Strategic Plan to Strengthen Research Capacity and Promote Evidence-Based Healthcare	Policy Analysis / Strategic Review	High	Carried over. DOI reconciled to 10.5001/omj.2017.18 per Reviewer 1, comment 46.
B	B1	**4**	Sultanate of Oman, Development Council	1980	Follow-Up Report on the First Five-Year Development Plan: Results of the First Four Years 1976–1979	Government Progress Report / Official Evaluation	High	Carried over
B	B2	**12**	Royal Decree 32/	1976	Royal Decree Regarding the Adoption of the Five-Year Development Plan for the Years 1976–1980	Legislative / Royal Decree	High	Carried over
B	B3	**15**	Royal Decree 82/	1980	Royal Decree Adopting the Second Five-Year Development Plan 1981–1985	Legislative / Royal Decree	High	Carried over
B	B11	**17**	Ministry of Health	1986	Annual Health Report 1985	Government Annual Health Report	High	Carried over

B	B12	**18**	Ministry of Health	1990	Annual Health Report 1990	Government Annual Health Report	High	Carried over
B	B4	**20**	Royal Decree 1/	1991	Royal Decree Adopting the Fourth Five-Year Development Plan (1991–1995)	Legislative / Royal Decree	High	Carried over
B	B7	**25**	Ministry of Health	1996	The Fifth Five-Year Plan for Health Development 1996–2000	Government Health Plan Document	High	Carried over
B	B5	**30**	Royal Decree 1/	2001	Royal Decree Adopting the Sixth Five-Year Development Plan 2001–2005	Legislative / Royal Decree	High	Carried over
B	C6	**31**	Ministry of Health, Centre of Studies and Research	2015	8th Five-Year Plan for Health Development	Government Health Plan Document	High	Carried over. Reviewer 1, comment 4: Ministry of Health publication, moves from category C to category B.
B	B8	**33**	Ministry of Health / Ministry of National Economy	2005	The Sixth Five-Year Plan for Health Development 2001–2005	Government Health Plan Document	High	Carried over
B	new	**35**	Ministry of Health, Sultanate of Oman	2006	The seventh five-year plan for health development 2006-2010	Government health plan	High	Added. Primary plan document for the seventh cycle.
B	B6	**37**	Royal Decree 1/	2011	Royal Decree Adopting the Eighth Five-Year Development Plan 2011–2015	Legislative / Royal Decree	High	Carried over
B	B21	**42**	Zawya	2015	Oman Moves to Broaden Healthcare Base	Financial / Business News Report	High	Carried over
B	B14	**44**	Ministry of Economy	2016	Ninth Five-Year Plan	Government National Development Plan Document	High	Carried over
B	new	**46**	Ministry of Health, Centre of Studies and Research	2020	Ninth five-year plan for health development (2016-2020) [in Arabic]	Government health plan	High	Added. Arabic-language primary record, admitted under the revised eligibility criteria.
B	B17	**48**	Times of Oman	2025	Oman Reports Major Strides in Implementing Tenth Five-Year Development Plan	Newspaper Report	Moderate	Carried over
B	B15	**50**	Oman News Agency	2021	Health Ministry Launches 10th Five-Year Plan for Health Development	News Agency Report / Media Communication	Moderate	Carried over
B	new	**51**	Ministry of Health, Sultanate of Oman	2014	Health Vision 2050: the main document	National vision document	High	Added. Added per Reviewer 1, comment 5, which found Health Vision 2050 claims cited to the wrong source.

B	B10	**52**	Ministry of Health	2012	Health Vision 2050 Oman: A Committed Step towards Reforms	Vision Document / Policy Statement	High	Carried over
B	new	**53**	Ministry of Health, Sultanate of Oman	2021	Tenth five-year plan for health development (2021-2025)	Government health plan	High	Added. Primary plan document for the tenth cycle.
B	C7	**54**	Implementation Follow-Up Unit	2020	Oman Vision 2040	National Vision Document	High	Carried over. Reviewer 1, comment 4: Omani government body, moves from category C to category B. Date corrected from 2016 to 2020 to agree with the reference list.
B	B19	**56**	Med Edge MENA	2025	Oman Launches New National Health Policy for Vision 2040	Online Media / Industry Report	High	Carried over
B	new	**61**	Ministry of Health, Sultanate of Oman	2026	Oman national STEPwise survey for non-communicable disease risk factors 2025: fact sheet	National survey report	High	Added. Added per Reviewer 1, comment 31. Cited for current epidemiology rather than plan content.
B	new	**73**	National Centre for Statistics and Information	2026	Monthly statistical bulletin, January 2026	National statistical bulletin	High	Added. Cited for the resident population composition. Context citation.
B	B13	**75**	Ministry of Health	2026	Strategic Plan under the Eleventh Five-Year Development Plan – Health Priority	Government Strategic Plan Document	High	Carried over
B	new	**76**	Oman News Agency	2026	Oman launches eleventh five-year development plan (2026-2030)	News agency report	Moderate	Added. Cited for the status of the eleventh plan. Context citation, outside the 1976 to 2025 study period.
C	C1	**2**	World Health Organizatio	2000	World Health Report 2000: Health Systems: Improving Performance	WHO Global Report / Framework Document	High	Carried over
C	C4	**14**	World Bank	1987	Oman: Health Project – Memorandum and Recommendation of the President. Report No. P-4505-OM	World Bank Project Document	High	Carried over
C	new	**16**	Japan International Cooperation Agency	1985	Appendix: second five-year development plan (1981-1985)	Agency technical appendix	Moderate	Added. Cited for second plan content.
C	C2	**23**	WHO EMRO	2013	Health-Promoting Schools Initiative in Oman: A WHO Case Study	WHO Case Study Report	High	Carried over
C	C5	**24**	World Bank	1994	Oman: Review of Recurrent Public Expenditure in Public Health and Education Sectors. Report No. 12163-OM	World Bank Sector Review	High	Carried over
C	C9	**27**	United Nations, Division for Advancement of Women	2005	Overview of Achievements and Challenges in Promoting Gender Equality and Women's Empowerment	UN Country Review Document	High	Carried over

C	B9	**38**	WHO Regional Office for Eastern Mediterranean	2010	Country Cooperation Strategy for WHO and Oman 2010–2015	WHO Country Cooperation Strategy Document	High	Carried over. Reviewer 1, comment 4, applied consistently: a WHO Country Cooperation Strategy is an international organisation report and moves from category B to category C.
C	C3	**41**	WHO EMRO	2021	Understanding the Private Health Sector in Oman	WHO Analytical Report	High	Carried over
C	new	**49**	International Monetary Fund	2016	IMF staff completes 2016 Article IV mission to Oman	International organisation press release	High	Added. Added in revision for the fiscal contraction of 2014 to 2016. Cited for context on the ninth plan period rather than as a record of plan content.
C	new	**69**	WHO Regional Office for the Eastern Mediterranean	2023	Health and the SDGs: Oman	WHO country profile	High	Added. Added during this verification pass to supply a current benchmark alongside the World Health Report 2000 ranking. Cited for context.
D	D1	**43**	Al Mashari H	2022	Enhancing Private Health Sector Preparedness in Oman: An Evaluation of Effective Public-Private Partnerships in Healthcare Disaster Management	Doctoral Thesis (PhD), Bournemouth University	High	Carried over

Appraisal rating distribution

- *A. Peer-reviewed journal articles: 19 sources, 14 high, 5 moderate.*
- *B. Government and policy documents: 26 sources, 23 high, 3 moderate.*
- *C. WHO and international organisation reports: 10 sources, 9 high, 1 moderate.*
- *D. Doctoral thesis: 1 sources, 1 high.*

All categories: 56 sources, 47 high, 9 moderate.

Supplementary File 2: Selected national health indicators aligned to the ten Five-Year Health Development Plan periods, 1970 to 2024

Every figure below is transcribed from one of two national sources, both published by Omani government bodies. No cell has been estimated, interpolated, back-calculated from a trend, or carried across from a neighbouring year. Column years are the final year of each plan period, so the columns read as the position reached by the close of each cycle. The tenth plan closed in 2025 but the latest published data are for 2024, which is stated rather than projected. Cells marked n.a. are reported as not available in the source itself or fall before the year in which the series begins. Two rows are arithmetic derived from other rows in the same table and are marked accordingly.

Indicator	1970 baseline	1980 1st	1985 2nd	1990 3rd	1995 4th	2000 5th	2005 6th	2010 7th	2015 8th	2020 9th	2024 10th	Source
Population and demographic structure												
Total population (thousands)	658	1 015	1 379	1 592	2 091	2 402	2 509	3 237	4 159	4 603	5 268	a
Omani population (thousands)	655	888	1 074	1 297	1 552	1 778	1 843	2 081	2 345	2 702	2 985	a
Non-Omani population (thousands)	3	127	305	295	539	624	666	1 156	1 814	1 901	2 283	a
Non-Omani share of total population (%)	0.5	12.5	22.1	18.5	25.8	26.0	26.5	35.7	43.6	41.3	43.3	d

Total fertility rate, Omani (live births per woman aged 15 to 49)	*n.a.*	10.13*	7.84**	*n.a.*	6.0	4.7	3.14	3.25	4.0	3.6	2.8	a
Crude birth rate, Omani (per 1000 population)	*n.a.*	50	48	44.7	34	32.58	24.75	29.2	34.1	28.6	21.2	a
Mortality and life expectancy												
Life expectancy at birth, Omani (years)	49.3	57.5	61.6	65.9	67.4	73.38	74.28	73.3	76.4	75.7	77.2	a
Life expectancy at birth, total population (years)	*n.a.*	*n.a.*	*n.a.*	*n.a.*	*n.a.*	*n.a.*	*n.a.*	*n.a.*	*n.a.*	77.1	78.3	a, b
Infant mortality rate, Omani (per 1000 live births)	118†	64	45	29	20	16.7	10.28	10.2	9.5	7.6	8.1	a
Under-five mortality rate, Omani (per 1000 live births)	181†	86	52	35	27	21.7	11.05	12.3	11.4	9.3	9.9	a
Maternal mortality ratio, Omani (per 100 000 live births)	*n.a.*	*n.a.*	*n.a.*	*n.a.*	22	16.1	15.4	26.4	17.5	29.4	14.5	c
Crude death rate, Omani (per 1000 population)	*n.a.*	13.3	9.9	7.6	6.1	3.65	2.53	2.9	2.9	3.2	2.5	a
Stillbirth rate (per 1000 births)	*n.a.*	16.6	16.4	13.3	11.8	10.0	9.1	7.9	7.3	6.6	5.6	a
Low birth weight, below 2500 g (% of live births)	*n.a.*	4.2	7.7	8.7	7.5	8.1	8.3	10.0	10.6	11.8	13.3	a
Immunisation coverage, children under one year (%)												
BCG	*n.a.*	54‡	93	96	96.3	98.1	99.0	99.0	100	100	100	a
Third dose of diphtheria, tetanus and pertussis vaccine	*n.a.*	19‡	60	98	99.0	99.9	99.9	99.0	99.0	100	99.6	a
Measles, first dose	*n.a.*	10‡	65	98	97.5	99.8	97.8	99.9	100	100	99.2	a
Service capacity												
Number of hospitals	2	30	44	52	53	55	58	62	70	84	94	a
Number of hospital beds	12	1 879	3 040	3 873	4 564	5 190	5 270	5 757	6 468	7 168	8 265	a
Hospital beds per 10 000 total population	0.2	18.6	22.0	24.3	21.8	21.6	21.0	17.8	16.0	15.6	15.7	a
Government health centres, clinics and dispensaries (number)	22	80	130	136	163	161	188	221	254	278	292	a
Private polyclinics and clinics (number)	*n.a.*	*n.a.*	255	334	471	560	713	814	1 045	1 230	1 987	a
Health workforce (excludes Armed Forces Medical Services)												
Total number of doctors	13§	514	958	1 441	2 477	3 258	4 182	5 862	8 914	9 058	11 287	a
Doctors per 10 000 total population	0.2	5.1	6.9	9.0	11.8	13.6	16.7	18.1	21.4	19.7	21.4	a
Total number of nurses	*n.a.*	1 096	2 288	4 147	6 036	7 829	9 277	12 865	19 331	20 111	23 477	a
Nurses per 10 000 total population	*n.a.*	10.8	16.6	26.0	28.9	32.6	37.0	39.7	46.3	43.7	44.6	a
Dentists per 10 000 total population	0	0.2	0.4	0.5	0.7	1.1	1.8	2.0	2.8	3.2	3.3	a

Pharmacists per 10 000 total population	*n.a.*	0.5	1.4	1.6	1.7	2.1	3.0	3.9	5.1	6.3	8.3	a
Financing												
Ministry of Health expenditure, total (million Omani Rials)	6	28.3	86.6	92.9	121.7	145.7	199.6	376	892.2	970.6	995.9	a
Ministry of Health expenditure as a share of total government expenditure (%)	*n.a.*	3.0	4.5	4.9	5.2	6.2	4.7	4.7	6.5	7.3	8.1	a
Ministry of Health expenditure per capita (Omani Rials)	9.1	28.0	63.7	52.2	58.2	60.7	79.5	116.2	214.5	211.9	189.0	a
Gross domestic product at current prices (million Omani Rials)	104	2 150	3 454	4 050	5 307	7 639	11 883	22 548	26 850	29 187	41 425	a
Ministry of Health expenditure as a share of gross domestic product (%)	5.8	1.3	2.5	2.3	2.3	1.9	1.7	1.7	3.3	3.3	2.4	d
Service utilisation												
Mean outpatient visits per person per year	0.04	4.7	5.1	5.4	5.8	4.1	4.2	3.8	3.7	2.3	3.0	a
Hospital bed occupancy rate (%)	*n.a.*	100	86	70	69	55.9	52.8	54.5	61.4	47.8	65.9	a

Sources

a. Ministry of Health, Sultanate of Oman. Annual Health Report 2024. Muscat: Department of Health Information and Statistics, Directorate General of Planning; 2025. Table 2-1, Health Indicators, pages 2-2 to 2-5.

b. National Centre for Statistics and Information, Sultanate of Oman. Statistical Year Book 2025. Muscat: NCSI; 2025. Population Indicators table, pages 57 to 58.

c. Ministry of Health, Sultanate of Oman. Annual Health Report 2024. Table 1-2, The Most Important Vital Statistics, page 1-5. Maternal mortality is not carried in Table 2-1.

d. Derived by the authors by arithmetic from two rows of Table 2-1 in the same source. Non-Omani share is the non-Omani population divided by the total population. Ministry of Health expenditure as a share of gross domestic product is Ministry of Health total expenditure divided by gross domestic product at current prices. Neither is a national health accounts measure and neither should be reported as total health expenditure.

Notes on individual cells

† Infant and under-five mortality in the 1970 column are reported in the source as data for 1972, the earliest year for which the series exists.

‡ Immunisation coverage in the 1980 column is reported in the source as data for 1981, the first year of the Expanded Programme on Immunisation series.

§ The number of doctors in the 1970 column is reported in the source as data for 1971.

** Total fertility rate in the 1980 column is reported in the source as covering the period 1976 to 1980, from the Child Health Survey 1992.*

*** Total fertility rate in the 1985 column is reported in the source as covering 1987 to 1988, from the same survey.*

Discrepancies between and within the two sources

The two documents do not agree on every cell, and the Annual Health Report does not always agree with itself. Where they differ, the figure above is taken from Table 2-1 of the Annual Health Report, because that is the only table spanning 1970 to 2024 and using one method throughout; taking single years from the other tables would mix series. The differences are recorded here so that a reader checking the sources can see them.

- *Life expectancy, Omani, 2020: Table 2-1 gives 75.7; Table 1-1 of the same report and the Statistical Year Book both give 76.0.*
- *Infant mortality, Omani, 2010: Table 2-1 gives 10.2; Table 1-2 of the same report gives 9.3.*
- *Under-five mortality, Omani, 2010: Table 2-1 gives 12.3; Table 1-2 gives 11.3.*
- *Doctors, nurses and hospital beds per 10 000, 2020: the Annual Health Report gives 19.7, 43.7 and 15.6; the Statistical Year Book gives 20.2, 44.9 and 16.0. The Annual Health Report series excludes Armed Forces Medical Services, which accounts for part of the gap.*
- *Ministry of Health expenditure as a share of government expenditure, 2024: the Annual Health Report gives 8.1 per cent; the Statistical Year Book gives 8.9 per cent.*