**Review Article**

# The Privatization of Healthcare in selected First-world Countries and its Implications in the Kingdom of Saudi Arabia: A Descriptive-Comparative Study

**Saad Alflayyeh**

Management Department, College of Business Administration, Majmaah University

Received on: 10/9/2017 - Accepted on: 27/9/2017

Corresponding Author**:** Saad Alflayyeh: Alflayyeh@mu.edu.sa Mobile: +966 555 90 44 22

**ABSTRACT**

**Background:** A long-term debate persists in global health concerns about the proper balance in the delivery of health care services between the private and public sector to the people of the low and middle income countries. The private sector allies claim that private companies may be more efficient and receptive in fulfilling patient needs, while the public sector allies have stressed the incapacity of the poor people to pay that causes imbalances in access to health care.

**Aim:** This study aims to compare the healthcare privatization models of the United Kingdom, Germany, and Canada through health expenditure statistics. The findings will serve as a source of benefits from the privatization of health sectors in Kingdom of Saudi Arabia to strengthen its implementation.

**Method:** This is a descriptive-comparative research where the healthcare privatization model among the chosen first-world countries will be compared through the available health hospital, private insurance, privatization

الملخص:

لا يزال هناك نقاش طويل الأمد حول المخاوف الصحية العالمية بشأن التوازن السليم بين القطاعين العام والخاص فيما يتعلق بتوفير خدمات الرعاية الصحية للمواطنين في الدول منخفضة ومتوسطة الدخل. في حين يزعم مناصرو القطاع الخاص أن الشركات الخاصة قد تكون الأكثر كفاءة وتلبيةً لاحتياجات المرضى، بينما يؤكد مناصرو القطاع العام على وجود حالات من عدم التوازن في الحصول على الرعاية الصحية بسبب عدم قدرة الفقراء على الدفع.

الهدف**:** تهدف هذه الدراسة إلى مقارنة نماذج خصخصة الرعاية الصحية في المملكة المتحدة، وألمانيا، وكندا من خلال إحصائيات الإنفاق الصحي. سوف تكون النتائج مصدرًا للاستفادة من خصخصة القطاعات الصحية في المملكة العربية السعودية لتعزيز تنفيذها.

النهج**:** يُعد هذا البحث بحثًا وصفيًا مقارنًا؛ إذ سيتم مقارنة نموذج خصخصة الرعاية الصحية بين دول العالم الأول المختارة من خلال إحصائيات الإنفاق الصحي المتاحة.

النتائج**:** حققت الولايات المتحدة الأمريكية أعلى نسبة إنفاق صحي إجمالية إذ ارتفعت النسبة المئوية من الناتج المحلي

expenditure statistics.

**Results:** The United States of America (USA) has the highest Total Health Expenditure as a percentage of the Gross Domestic Product with 15-17% since 2006, and lasted until 2014. Saudi Arabia has only 3-5% as compared to the selected first-world countries. The United Kingdom (UK), Germany, Canada, and Saudi Arabia have significantly higher General Government Health Expenditure as a percentage of Total Health Expenditure. On the contrary, the Private Health Expenditure (PvtHE) of USA is higher with 52-55% than the GGHE with only 45-48%. Also, the private insurance as a percentage of PvTHE of the USA is the highest with 63-65% as compared to UK, Germany, Canada, and Saudi Arabia.

**Conclusion:** The healthcare system of Saudi Arabia is a mainly public-funded and public-owned similar to the UK, Germany, and Canada. Despite of the effectiveness of the public-contract model, the private insurance or provider model and the privatization of hospitals could notably change the healthcare system in Saudi Arabia. Thus, the resources and the quality of health care services in Saudi Arabia must be enhanced through these mechanisms.

**Keywords:** health care, healthcare services,

الإجمالي من **15 – 17 %** من عام **2006** حتى عام **2014**، في حين كانت النسبة في المملكة العربية السعودية من **3** إلى **5 %** مقارنةً ببلدان العالم الأول المختارة في الدراسة.

تمتلك كل من المملكة المتحدة، وألمانيا، وكندا، والمملكة العربية السعودية نسبة أعلى بكثير من الإنفاق الحكومي العام على الصحة كنسبة مئوية من إجمالي النفقات الصحية. وعلى النقيض من ذلك نرى أن الإنفاق الخاص بالقطاع الصحي الخاص للولايات المتحدة الأمريكية أعلى بنسبة تتراوح ما بين **52** و**53 %** من إجمالي الإنفاق الحكومي العام على الصحة الذي يأتي بنسبة **45 – 48 %** فقط. وكذلك نجد أن نسبة التأمين الصحي للقطاع الخاص في الولايات المتحدة الأمريكية هي الأعلى إذ تبلغ نسبته **63 – 65 %** مقارنةً بالمملكة المتحدة، وألمانيا، وكندا، والمملكة العربية السعودية.

خاتمة: إن نظام الرعاية الصحية في المملكة العربية السعودية ممول ومملوك بشكل أساسي للقطاع العام على غرار المملكة المتحدة، وألمانيا، وكندا. وعلى الرغم من فعالية نموذج التعاقد العام فإن نظام التأمين الخاص أو نموذج تقديم الخدمات وخصخصة المستشفيات يمكنه أن يغير نظام الرعاية الصحية بالمملكة العربية السعودية بشكل ملحوظ، وبالتالي يجب تعزيز موارد خدمات الرعاية الصحية في المملكة العربية السعودية ونوعيتها من خلال هذه الآليات.

## INTRODUCTION

The enduring and diverged debate that concerns the global health is the proper balance in the delivery of health care services between the private and public sector to the people of the low and middle income countries [1]. Up to present, the heat is becoming more intense regarding the disputes among the advocates of public and private systems. In 2007, the economic recession worldwide began that triggered major constrictions on government funds which significantly affected the health care expenditures in most countries [2]. The World Bank suggest to adhere to more realistic methods that is built on what is existing, thus, in countries where public sector services execute inadequately, the government must establish partnership with the private sector [3].

On one hand, the public hospitals have been developed and financed by governments to deliver all types of treatment either free or at subsidized rates to everyone regardless of their class or status [4]. On the other hand, the World Health Organization (WHO) differentiate the incremental or passive privatization with the programmatic or active privatization [5]. The first is perceived as the product of the public health care failure to meet the demands, while the second is associated with a purposeful and ideologically driven scheme. However, in practice, both types may occur [6]. Also, the European Observatory on Health Systems and Policies [7] described the health care services and hospitals privatization as the transfer of proprietorship of what was a part of the public into the hands of either private for-profit or private non-profit groups.

There is an enduring debate among the supporters that initiated their division. One group demands to pursue universal state-based health care accessibility, and the another calls for the private sector to deliver care in various areas where the public sector is unsuccessful. The supporters of the private sector have pointed to substantiation that the private sector is considered as the chief provider, because there are many underprivileged patients who choose to obtain care at private clinics [1]. Also, they have insinuated that because of market rivalry, the private sector may be more efficient and receptive to patient needs that possibly overcomes the ineffectiveness and corruption of the government [8]. In contrast, it is emphasized by the public sector supporters that there are inequalities in access to healthcare subsequent to the incapability of the poor to pay for availing private services. [8].

Certainly, the peak shares of private healthcare expenditure in the whole healthcare expenditure in 2006 were recorded by developing countries which include the Kingdom of Saudi Arabia. The total cost of health in Saudi Arabia is 3.8% of Gross Domestic

Product (GDP) with 77.1% from the government and the remaining 22.9% from the private sectors [9]. Both the government and private groups operate the hospitals and primary health centers in Saudi Arabia. In particular, the Ministry of Health assumes the primary obligation to deliver preventive, curative and rehabilitative services in the Kingdom's health care [10]. It is noteworthy that there was a notable increase in the involvement of private sector in health care in the Kingdom [11]. The Ministry of Health delivers the majority (60%) of the healthcare services, while the remaining 40% is jointly delivered by other government offices and the private sector [10]. However, the part of the private sector in delivering healthcare services is insignificant compared to the public sector. The private sector only accounts for the 21.1% of the 53,888 hospital beds in Saudi Arabia [12]. The population projection in 2020 is about 36 million [13]. Thus, it is essential that the involvement of the private sector needs to rise [14]. This study aims to compare the healthcare privatization models from select first-world countries through health expenditure statistics. The results of this research will serve as a basis of the possible benefits from the privatization of health sectors to the Kingdom of Saudi Arabia to reinforce its implementation.

## REVIEW OF LITERATURE

### The health care system and its privatization among selected first-world countries

#### *United Kingdom*

The four publicly financed healthcare systems in the countries of the UK are jointly the UK NHS which was founded in 1948, and is mainly funded through central taxation and remains free at point-of-care for the UK population, apart from charges on adults (>18 years old) for prescriptions, and optical and dental services. The health systems in the four UK nations have operated independently since 1999. Each nation has its government department to develop health policy. The UK Parliament sets the total budget obtainable to the NHS in England and assigns a block funding to each devolved national government to meet local needs. Each state is free to select how much of its block funding to devote to health care [15].

Approximately 13% of the population chooses to pay for additional private sector insurance and then use independent healthcare providers. Private health insurance is often funded by employers as part of an employee benefits program, and sometimes they provide coverage for the entire family [15].

Around 12 million people were covered for medical expenditures in 1997 by health insurance, friendly societies, and cash plan firms. An estimate of 7 million people (12%) were covered by private health insurance. This population is consisted of older

people and citizens who belong to social classes I-III, with a noted coverage varying from 2% and 22% for social class IV and social class I, respectively [16].

In 1996, the private sector delivered a remarkable ١٣,٧£ billion cumulative worth of services. The highest percentage of money (46%) is consumed for the benefits of elderly and physically incapacitated people, followed by pharmaceutical products and devices (22%), and last by acute hospitals (17%). However, it is noteworthy that the significant supplier of private beds is the National Health Service (NHS). Specifically, in 1997, there were an estimate of 1,400 allotted pay beds in NHS private units, and 39% were prominent in London. The Health and Medicines Act in 1989 did not restrict the NHS authorities from charging market costs for their provided services [16].

***Germany***

The Statutory Health Insurances (SHI) cover majority of the population (90%) in Germany that is known for a worldwide multi-payer healthcare system. The income-based contribution is the common means of SHI to raise their budget [17]. The self-employed and higher income earners have the option to opt out of SHI, which in turn they could be insured by Private Health Insurance (PHI) [18].

The government provided the 77% of healthcare funding, while the remaining 23% came from the private sources which include the insurance and direct payments in 2009. These percentages are almost the same in Canada with 71% and 29% respectively in the same year, according to Organization of Economic Co-operation and Development (OECD) data, even though the former has a higher percentage of its people who is more than 65 years of age [19].

In 2010, the German hospital sector is consisted of an estimated 2,064 acute care hospitals from three different sectors. These categories include the private for-profit that is owned by municipalities, the private not-for-profit that is frequently owned by religious organizations, and the public ownership [20]. The patients are free to choose where they will be treated in any public sector which led to the competition of hospitals. This practice had transformed the system into a patient-oriented health care that prevented the customs of rationing, prioritization of treatments, and waiting list. Thus, it resulted to a much lower waiting time for the medical procedures [21].

There is an ongoing transformation regarding the structure of ownership of hospitals in Germany. It is noteworthy that there was a continuous rise in the market share of private for-profit hospital in the past 20 years [22]. Many municipalities had decided to privatize their hospitals mainly because of the deleterious growth in their public finances [23]. Between 1991 and 2010, the number of

private for-profit hospitals had significantly grown around 90%, while the public hospitals had notably decreased by 43% [24].

***United States of America***

Most of the Americans below the age of 65 years obtain tax-exempt from their employers regarding health assistances. The employers choose the insurance companies and the plans for their employees, and they pay a portion of the premiums [25]. But the offer of this benefit is only voluntary, and not each employer prefers to do it. If this is offered to the employees, the assistances are not all-inclusive. Progressively, companies limit their contributions which increases the burden of rising costs on the employees [26]. As a result, the employees frequently turn down this benefit because of the additional cost to pay their rising part of the premiums.

It is noteworthy that most of the private insurers are typically owned by the investors of the for-profit companies. They attempt to retain the premiums low and the incomes up by stinting on medical services. Specifically, the best means for the private insurers to compete is by excluding high-risk patients in the coverage, diminishing the coverage of those they already insured, and giving back the costs to patients as deductibles, co-payments and claim rejections [25].

The Medicare, a single-payer program that is fixed within the private system, is the major part of the US health care system that is administered by the government. This system is considered to be the most efficient portion of the US system with above costs to government around 2% [27]. It is notable that it covers almost everyone above 65 years old for the full package of benefits including those that are high-risk or chronically ill patients. However, the US Medicare is not perfect, and it has been deteriorated by the past administration of Bush. There has been a significant rise in the out-of-pocket costs for Medicare recipients. Furthermore, many of similar inflationary forces affect the private insurance since the Medicare pays in a private, market-based system. One of these is the arrangement of the fee of the doctors to compensate specialists who are highly paid for doing many expensive procedures. As a consequence, the rise in the Medicare system is almost as high as the surge in the private sector [28].

***Canada***

In 1972, the Medical Care Act was commissioned by the Yukon Territory that resulted to the insurance coverage of all Canadians excluding home care and prescription drugs [25]. The other health care assistances were left to specific provinces if they were covered at all. Also, many hospitals and doctors added extra charges and costs to patients. However, the said practices were over in the Canada Health Act of 1984. This act necessitates federal assistances to the provincial expenses so that the health care services are

available to everybody, and it broadly eradicated the additional fees and charges [29].

During the 1990s, the Medicare in Canada became underfunded as a result of its economic recession. The waiting lists transpired into a political issue, and the public contentment dropped slightly. The economic situations became better in the near end of the 1990s as reflected by the rise in the publicity of the waiting lists and the start of the provinces to set more money into their health care system [29].

The supreme court of Canada specified its resolution in 2005 involving the *Chaoulli* v. *Quebec* [30]. It believed that there was a violation in the human rights by the province of Quebec with the 1-year delay for a hip replacement. Quebec would have to cut the waiting times or to authorize the procedure to be performed in a private system. The decision has been somewhat biased, but it added strength to a tough move throughout Canada most especially in Alberta and British Columbia. It caused to authorize the promotion of the coverage for private insurance, and the distribution of the delivery of care by doctors who are employed in the public and private systems in for-profit facilities. The doctors and the services would be capable of billing Medicare and increase extra charges [31].

## METHOD

This is a descriptive-comparative study where the health care privatization model among the selected first-world countries was compared through the use of health expenditure statistics from World Health Organization, World Bank, and Saudi Arabia Ministry of Health [32-34]. Then, these countries will also be compared to Saudi Arabia to determine its practical implications for its future implementation.

## RESULTS

### The comparison of the health expenditure among selected first-world countries and Saudi Arabia

Table 1 provides more details on health care financing and expenditure among select first-world countries and Saudi Arabia. The United States of America (USA) has the highest Total Health Expenditure (THE) in proportion with the Gross Domestic Product (GDP) with 15-17% from 2006 until 2014 among the select first-world countries, then the rest have nearly the same proportion. However, Saudi Arabia has only 3-5% of THE as a percentage of the GDP as compared to the first-world countries which is two to four times higher.

The United Kingdom (UK), Germany, and Canada have significantly higher General Government Health Expenditure (GGHE) in proportion with THE that ranges from 70-84%, with the UK as leading with as high as 84% in 2010. Further, these countries have lower Private Health Expenditure (PvtHE) as a percentage of THE that ranges from 16-30% only. On the contrary, it is noteworthy that the

**Table 1. Health expenditure data among select first-world countries and Saudi Arabia.**

| | United Kingdom | | | Germany | | | Canada | | | United Sates of America | | | Saudi Arabia | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2006 | 2010 | 2014 | 2006 | 2010 | 2014 | 2006 | 2010 | 2014 | 2006 | 2010 | 2014 | 2006 | 2010 | 2014 |
| **Indicators** | | | | | | | | | | | | | | | |
| **Total Health Expenditure (THE) % Gross Domestic Product (GDP)** | 8 | 10 | 9 | 10 | 11 | 11 | 10 | 11 | 10 | 15 | 17 | 17 | 4 | 3 | 5 |
| **General Government Health Expenditure (GGHE) as % of Total Health Expenditure** | 82 | 84 | 83 | 76 | 76 | 77 | 70 | 70 | 71 | 45 | 47 | 48 | 74 | 65 | 75 |
| **Private Health Expenditure (PvtHE) as % of Total Health Expenditure (THE)** | 18 | 16 | 17 | 24 | 24 | 23 | 30 | 30 | 29 | 55 | 53 | 52 | 26 | 35 | 25 |
| **Out of Pocket Expenditure (OOPS) as % of Total Health Expenditure (THE)** | 10 | 10 | 10 | 14 | 14 | 13 | 15 | 15 | 14 | 13 | 12 | 11 | 16 | 20 | 14 |
| **Out of Pocket Expenditure (OOPS) as % of Private Health Expenditure (PvtHE)** | 54 | 58 | 58 | 59 | 58 | 57 | 49 | 49 | 47 | 24 | 22 | 21 | 61 | 56 | 56 |
| **Private Insurance as % of Private Health Expenditure (PvtHE)** | 15 | 19 | 20 | 38 | 39 | 39 | 41 | 41 | 43 | 63 | 65 | 64 | 10 | 22 | 22 |

PvtHE of USA is higher with 52-55% than the GGHE with only 45-48%. On the other hand, Saudi Arabia is similar to the UK, Germany, and Canada, where the GGHE is greater with 65-75% than the PvTHE which is 25-35% only.

It is remarkable that the USA has the lowest Out-of-Pocket (OOPS) as a percentage of PvtHE with 21-24% compared to the UK, Germany, and Canada with as high as 47-59%. However, the private insurance as a percentage of PvTHE of the USA is the highest with 63-65% when matched to UK, Germany, and Canada with 15-43% only. On

the other hand, Saudi Arabia is also similar to the OOPS of UK, Germany, and Canada as a percentage of PvTHE with 56-61%, and it is significantly higher than the private insurance with 10-22% only. Further, it is also important to note that Saudi Arabia has the most top OOPS as a percentage of THE with 14-20% when compared to the first-world countries with only 10-15% only.

**The comparison of health care among selected first-world countries and Saudi Arabia**

The comparison of health care among the selected first-world countries and Saudi Arabia is depicted in table 2. It is notable that Saudi Arabia has the lowest life expectancy with 74.3 when compared to the first-world countries with 78.9-81.9. Further, Saudi Arabia has the highest infant mortality with 12.50 which is two to four times higher when compared to 3.2-5.8 only in the select first-world countries. On the other hand, Germany stands out regarding the number of physicians, nurses, and hospital beds which are two to three times greater than the rest of the select countries including Saudi Arabia. Further, Saudi Arabia has a similar number of physicians and hospital beds to the UK, Canada, and the USA, however, the number of nurses is two times lower than the rest.

## DISCUSSION

This study reviews the privatization of the health care among selected first-world countries and Saudi Arabia. The health care models of each country was also compared through health expenditure statistics. It was found that the USA has the highest Total Health Expenditure (THE) with proportion to GDP compared to other select countries in this study. The top health expenditure noted in the USA is neither the result of its supe-

**Table 2. The differences in health care among select first-world countries and Saudi Arabia (2014).**

| Measure | United Kingdom | Germany | Canada | United Sates of America | Saudi Arabia |
|---|---|---|---|---|---|
| **Life expectancy** | 81.4 | 81.2 | 81.9 | 78.9 | 74.3 |
| **Infant mortality per 1000 live births** | 3.9 | 3.2 | 4.3 | 5.8 | 12.50 |
| **Physicians per 1000 population** | 2.79 | 4.11 | 2.50 | 2.57 | 2.33 |
| **Nurses per 1000 population** | 8.19 | 13.24 | 9.78 | 8.99 | 3.72 |
| **Hospital beds per 1000 population** | 2.73 | 8.23 | 2.67 | 2.83 | 2.14 |

rior wealth nor the age of its people [35]. The Organization of Economic Co-operation and Development (OECD) works on relative price levels in health. It specifies that the prices and not the volumes of health services provide the most to explicating the greater spending of USA in health care [36]. Some of the possible reasons for the rise of the health price levels topping the general price levels includes: an extreme intense use of health-related technologies [37]; division in the insurance systems [38]; and an excessive level of provider concentration [39].

It is remarkable that although the trend of the Total Health Expenditure (THE) of Saudi Arabia is increasing, it has a much lower THE as compared to selected first-world countries. The rapidly rising population which grows annually at the rate of 3.6% has been a vital factor in the rise of health costs. Also, the free services for all Saudis significantly contributes to its rising costs. The free services exclusive of a co-insurance payment combined with practically no economic constrictions on the provider significantly raise the quantity and amount of used services [40]. A notable consequence of long waiting times for many services are brought about by the increased demand in addition to the slow construction for more capacity. Specifically, the typical waits for non-emergent care lasted for certain months or years. The projections indicated that Saudi Arabia necessitates nearly 25,000 new hospital beds before 2010 so as to meet the current and growing demands [41].

The UK, Germany, and Canada have a notably higher General Government Health Expenditure (GGHE) in proportion with THE compared to USA which has the highest Private Health Expenditure (PvtHE) as a percentage of THE among the rest of the countries in this study. The private insurance model that is evident in the USA has a voluntary insurance coverage wherein the excessive quantity of choice is joint with the weaker price control. Specifically, the USA except the Medicare does not possess a centralized authority to establish the health care budgets or to negotiate with providers [39]. In contrast, Canada, France, and Germany have a public-contract model that provides a centralized authority to the national government or social insurance administration. This model provides more control above all the health care institutions that results to a lower administrative expenditures compared to the multi-payer systems [42].

Saudi Arabia is similar to the public-contract model of Canada, France, and Germany, where the GGHE is greater than the PvtHE. Majority of the finances in health care are provided by the government (75%), and the rest are coming from the out-of-pocket expenditures (25%). It is noteworthy that there has been a low level of private insurance used in the delivery of health care, and almost all of

the expenses in availing private services in the hospitals and clinics have been out-of-pocket payments (OOPS) [40], which is reflected in the result of this study. Moreover, Saudi Arabia has the highest OOPS when compared to the rest of the first-world countries in this study despite having a significantly lower PvtHE. On a yearly basis, the government is distributing funds to specific ministries and programs. If additional funding is necessary to support particular health programs and projects, the royal decree may be published in public [40].

It is vital to note that although Saudi Arabia has the same public-contract model with Canada, France, and Germany, the life expectancy is lower and the infant mortality is two to four times higher than the rest of the first-world countries in this study. This implies that there will be a loss in the productive workforce, high dependency ratio, and the government spending will be higher in the health care. On the other hand, Germany is found to have the largest number of physicians, nurses, and hospital beds which is two to three times greater than the rest of the selected countries including Saudi Arabia. It is essential to note that in Germany, the private for-profit hospitals quality of care is superior when matched to both the public and private not-for-profit hospitals [43]. Particularly, the private for-profit hospitals in Germany have the most few waiting times in receiving care when there is a scheduled appointment with a specialist. They admit patients quicker than private not-for profit hospitals (16.4%), and public hospitals (3.1%) [44]. Moreover, previous studies have revealed that after privatization, the quality of previous public hospitals has notably improved, and there has been a rise in the number of physicians per hospital bed [45].

Moreover, Saudi Arabia has a comparable number of physicians and hospital beds to the UK, Canada, and the USA, however, the number of nurses is two times lesser than the rest. There has been a significant increase in the educational capability among Saudis, and yet, the enormous majority of health care providers in Saudi Arabia remains to be non-Saudis. It is notable that only about 17% represents the entire number of Saudi physicians and nurses despite of the rigorous efforts that have been created by the government [46]. As a consequence, a major drawback is continuity because expatriates tend to stay in Saudi for only a little time with an estimate of 2.3 years [47]. Likewise, the continuous turnovers led to the increase in the outdated and unused costly equipment left by expatriates because oftentimes the new physicians will require specific equipment as terms in their contract that later on will be underused and idle after exit [40].

## CONCLUSIONS AND POLICY IMPLICATIONS

In the light of the evidence presented in this study, it is important that the resources and the quality of service provided by both public and private health care institutions in Saudi Arabia must be improved. The health care system in Saudi Arabia is a predominantly public-funded and public-owned similar to the UK, Germany, and Canada. Even though the public-contract model is effective based on the statistics mentioned in this study, the private insurance or provider model and the privatization of hospitals could significantly change the healthcare system in Saudi Arabia. In particular, the motivation of the health care providers will be noticeably changed. Some of the positive outcomes would comprise additional national government incomes from the sale of hospitals, the growth in the drive to deliver more efficient health care, and the transfer of the accountability from the government to private companies. Also, privatization could decrease the waiting times in the hospitals which leads to faster admission and better quality care in general. Privatization could generate a more efficient system, hiring lesser employees, and significant decrease in the disbursement for health care from the national budget of the government. However, a careful note is that the private hospital may increase the charges if the government has no sufficient control. In turn, the health care expenses of the government may stay the same or worse it could essentially upsurge, as the consequence of greater costs for incomes and marketing.

Careful attention should be taken as the Saudi Arabia shifts to a more private health care system, to preserve the strong stewardship of the national government to the market conditions, and the tough framework in monitoring. It is frightening to profoundly shift the direction of a health care system. However, it seems that the political drive and the necessity exist in Saudi Arabia to initiate this process. It is vital that there will be an established continuous monitoring and adjustments as this complex process goes forward, since the health and the welfare of its people will be directly affected by these significant changes.

## REFERENCES

1. Berendes S, Heywood P, Oliver S, Garner P (2011) Quality of private and public ambulatory health care in low and middle income countries: systematic review of comparative studies. PLoS Med 8: e1000433. doi:10.1371/ journal.pmed.1000433.
2. Stuckler D, Basu S, Wang SW, McKee M (2011) Does recession reduce global health aid? evidence from 15 high-income countries, 1975–2007. Bull World Health Organ 89: 252–257.
3. World Bank (2009) World Bank responds to new Oxfam health report. Washington

(District of Columbia): World Bank.

4. Rachlis, M. (2007) "Privatized Healthcare Won't Deliver", *Commissioned Policy Research*, Toronto: Wellesley Institute.
٥. Øvretveit J. 1996. Beyond the public-private debate: the mixed economy of health. Health Policy 35: 75–93.
6. Øvretveit, John. "Nordic privatization and private healthcare." *The International journal of health planning and management* 18.3 (2003): 233-246.
7. European Observatory on Health Systems and Policies. (2008). Glossary. Geneva: WHO European Centre for Health Policy.
8. Rosenthal G, Newbrander W (1996) Public policy and private sector provision of health services. Int J Health Plann Manage 11: 203–216.
9. World Health Organization (2005) Saudi Arabia: national expenditure on health. Available at: http://www.emro.who.int/emrinfo (accessed 09 September 2017).
10. Aldossary A, While A, Barriball L. Health care and nursing in Saudi Arabia. International nursing review. 2008 Mar 1;55(1):125-8.
11. Al-Yousuf, M., Akerele, T.M. & Al-Mazrou, Y.Y. (2002) Organization of the Saudi health system. *Eastern Mediterranean Health Journal*, **8**, 4–5.
12. Ministry of Health, (2008). *Health Statistical Year Book*. Riyadh: Ministry of Health Press.
13. Schieber, G., (2001). "Vision 2020 Health Sector Report", in *Ministry of Economy and Planning's Future Vision for the Saudi Economy.* Riyadh: Ministry of Economy and Planning Press.
14. Albejaidi FM. Healthcare system in Saudi Arabia: An analysis of structure, total quality management and future challenges. Journal of Alternative Perspectives in the Social Sciences. 2010;2(2):794-818.
15. Wolfe I, Sigfrid L, Chanchlani N, Lenton S. Child Health Systems in the United Kingdom (England). The Journal of pediatrics. 2016 Oct 31;177:S217-42.
16. Doyle Y, Bull A. Role of private sector in United Kingdom healthcare system. BMJ: British Medical Journal. 2000 Sep 2;321(7260):563.
17. GKV Spitzenverband, *Statutory health insurance,* http://www.gkv-spitzenverband.de/ Statutory_health_insurance.gkvnet.
18. PKV Verband, *Zahlenbericht der Privaten Krankenversicherung 2010/2011*, 2011, http:// pkv.de/w/ les/shop_zahlenberichte/zahlenbericht20102011.pdf.
19. OECD, *Health at a Glance 2011,* 2011, p. 151.
20. Economist Intelligence Unit, *Germany: Healthcare and Pharmaceuticals Report,* December 2011.
21. Cathy Schoen, Robin Osborn, David Squires, Michelle M. Doty, Roz Pierson, and

Sandra Applebaum, "How Health Insurance Design Affects Access To Care And Costs, By Income, In Eleven Countries," *Health Affairs,* Vol. 29 (2010), No. 12, pp. 2323-2334; Karen Davis, Cathy Schoen, and Kristof Stremikis, *Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally,* Commonwealth Fund, June 2010, p. v.

22. Oliver Tiemann and Jonas Schreyögg, *Changes in Hospital Ef ciency after Privatization,* Hamburg Center for Health Economics, 2011, p. 2.
23. "Germany's local nances: Hundreds of mini-Greeces," The Economist, April 20, 2011.
24. Statistisches Bundesamt, *Grunddaten der Krankenhäuser,* Fachserie 12 Reihe 6.1.1, 2011, p. 13.
25. Angell M. Privatizing health care is not the answer: lessons from the United States. Canadian Medical Association Journal. 2008 Oct 21;179(9):916-9.
26. Geyman J. *Do not resuscitate: Why the health insurance industry is dying and how we must replace it*. Monroe (ME): Common Courage Press; 2008.
27. Potetz L. *Financing Medicare: an issue brief*. Washington (DC): Kaiser Family Foundation; 2008. Available: www.medicareadvocacy.org/Reform_08_01.Kaiser BriefReMAFinancing.pdf (accessed 2008 Aug 27).
28. Relman AS. *A second opinion: rescuing America's health care*. New York (NY): Public Affairs; 2007.
29. Marchildon GP. *Health systems in transition: Canada.* Toronto (ON): University of Toronto Press; 2005.
30. *Chaoulli* v. *Quebec* (Attorney General), no 29272, Sup Ct of Canada 130 CRR (2d) 99; 2005 CRR LEXIS 76.
31. Steinbrook R. Private health care in Canada. *N Engl J Med* 2006;354:1661-4.
32. World Health Organization (WHO). Health expenditure database 2004-2016. Available: http://apps.who.int/nha/database (accessed September 11, 2017)
33. World Bank (WB). World bank data. Available: https://data.worldbank.org (accessed September 11, 2017)
34. Ministry of Health, (2014). *Health Statistical Year Book*. Riyadh: Ministry of Health Press.
35. Lorenzoni L, Belloni A, Sassi F. Health-care expenditure and health policy in the USA versus other high-spending OECD countries. The Lancet. 2014 Jul 11;384(9937):83-92.
36. Squires DA. Explaining high health care spending in the United States: an international comparison of supply, utilisation, prices, and quality. New York, NY: Commonwealth Fund, 2012.

37. Chandra A, Skinner J. Technology growth and expenditure growth in health care. Cambridge: National Bureau of Economic Research, 2011.
38. Moriya AS, Vogt WB, Gaynor M. Hospital prices and market structure in the hospital and insurance industries. *Health Econ Policy Law* 2010; **5:** 459–79.
39. White C. Health care spending growth: how different is the United States from the rest of the OECD? *Health Aff (Millwood)* 2007; **26:** 154–61.
40. Walston S, Al-Harbi Y, Al-Omar B. The changing face of healthcare in Saudi Arabia. Annals of Saudi medicine. 2008 Jul 1;28(4):243.
41. Al-Shaikh, S. August 7, 2006, "Saudi health care Sector: need for More investment" Arab news.
42. Docteur E, Oxley H. Health-system reform: lessons from experience. In: Organization for Economic Co-operation and Development. The OECD health project: towards high-performing health systems. Paris: OECD Publishing, 2004.
43. Oliver Tiemann and Jonas Schreyögg, "Effects of Ownership on Hospital Effciency in Germany," *Business Research,* Vol. 2 (2009), No. 2, pp. 115-145.
44. Björn A. Kuchinke, Dirk Sauerland, and Ansgar Wübker, *Determinanten der Wartezeit auf einen Behandlungstermin in deutschen Krankenhäusern: Ergebnisse einer Auswertung neuer Daten,* Technische Universität Ilmenau, 2008.
45. Roeder FC, Labrie Y. The private sector within a public health care system: The German example. Health Care. 2012 Feb.
46. Saudi Arabian Ministry of health. 2005, health statistic book for the year of 2005. retrieved January 2007 from http://www.moh.gov.sa/statistics/1425/index.html
47. Mufti, M. 2004, healthcare development Strategies in the Kingdom of Saudi Arabia. Springer.