

An Analysis of Public-Private Partnerships and Sustainable Health Care Provision in the Kingdom of Saudi Arabia

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ABSTRACT: This study considers the issue of health care provision in Saudi Arabia, looking in particular at the challenges for health care providers and ministry officials. Although the study concentrates on factors specific to Saudi Arabia, it also examines the problem from a broadly international perspective. In particular, the study explores the experience of health care modernisation in the United Kingdom to conceptualise the practicality of fusing public services with market ideals. There is a pressing need to modernise the Saudi health care system with the economic burden on the state-funded Ministry of Health being an unsustainable means of providing health care in future. The solution resides partially in opening the public health care system to alternative sources of management and revenue. In particular, public-private partnerships will be considered as a viable means of funding health care in Saudi Arabia and for improving standards and the quality of care. This study concludes that, whereas the move towards a public-private partnership approach to health care provision has been touted as a precondition for modernisation and development, the precise fusion between government and non-government forces remains a source of conjecture. As a result, the study advocates caution when evaluating the benefits and pitfalls of partnerships between public and private actors.

KEYWORDS: Privatisation, Saudi Arabia, public-private partnerships, health care system, health financing

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Background

Undertaking an in-depth analysis of any state's health care policies is an inherently complex task. Health policies are not created in isolation. Health policies are a complex interchange of political, social, cultural, and economic factors.¹ This is an important point to acknowledge in the Kingdom of Saudi Arabia (KSA), where the state plays an integral role in the health care system's administration, funding, and organisation.² Furthermore, the considerable economic expenditure the Saudi government has historically provided cannot be sustained in its current universal guise.³⁻⁷ Consequently, to understand the challenges facing welfare provision in the KSA, it is essential to emphasise the political economy of health care decision-making in the contemporary era.⁸

Previously, decisions regarding health care's funding and provision were based on needs/wants and demands. Today, there is a mix of related and inter-related social, economic, political, and cultural problems, so risk is a defining feature of health care policy economic management.⁹ Clearly, because illness and death are inevitable facets of humanity, health and wellbeing have always been subject to risk. However, this form of risk – the inherent risk of human existence – is best understood regarding uncertainty. In contrast, the type of risk that impinges on contemporary manifestations of health care economics is best understood regarding a probability that can be calculated, estimated, and, subsequently, legislated against.¹⁰ As a consequence, risk is both a concept and a policy, affecting individuals and governments, agents and structures, alike.¹¹

This study adopts a literature-based approach to examining the issue of health care provision in KSA in the contemporary era. After establishing the prominent health-related issues facing policymakers and health care providers, the study undertakes a detailed review of the literature available on the topic of public-private partnerships (PPPs) in a bid to ascertain whether they represent a viable, long-term solution to the social, economic, cultural, and political problems that influence decision-making in Saudi Arabia in forthcoming years and decades. However, before commencing the analysis, it is essential to undertake a brief overview of the Saudi health care system to establish a framework for the rest of the discussion.

Methods

This article is based on undertaking desk research. In exploring PPPs and health care provision in Saudi Arabia, researchers used keywords 'Saudi healthcare', 'healthcare', 'health sector', 'private sector', 'privatisation', 'health insurance', and 'public-private partnerships' to find relevant peer-reviewed articles and documents. The authors used different search engines and databases including Google Scholar, Scopus, JSTOR, Science Direct, PubMed, and ProQuest. The authors have mapped and reviewed the publications of peer-reviewed journals in English and have used commonly retrieved literature and agreed-upon literature. The article has made use of relevant official reports of the Saudi Ministry of Health, peer-reviewed journal articles, and publications of international organisations including the World Health Organization



(WHO), Organisation for Economic Co-operation and Development (OECD), and the European Union (EU). The exploratory investigation was not limited to any specific date. The review excluded articles which were not in the English language.

Overview of the Saudi Health Care System

Progress made in health care provision in Saudi Arabia has been remarkable. Over the past 60 years, health care in the KSA has morphed from a form of curative medicine to alleviate the spread of infectious diseases to preventive health care with some of the best hospitals and medical professionals in any Third World country.^{12,13} In 1949, there were only 111 doctors and fewer than 100 hospital beds; at the turn of the millennium, there were more than 487 hospitals, 72 981 health care beds, and 1700 primary health care (PHC) centres available across the Kingdom.^{14,15} Many of these PHC centres have cutting-edge facilities and state-of-the-art medical equipment.¹⁶

The Saudi Constitution stipulates that the government is responsible for providing health care services for all citizens and expatriates employed in the public sector through public health care services. Expatriates working in the private sector presently receive health care services from the private health care sector. Under the Saudi Labour law, all people working in the private sector should be insured by their employers, meaning that private companies and employers have to pay the health coverage costs (the insurance premiums) for all of their employees.¹⁷

The Saudi health care system is a fundamental right of Saudi citizens. Most of health care expenditure has been predominantly funded by the government via the Ministry of Health (MOH) with public revenue.⁶ The government has shown its deep commitment to enhancing health services in KSA, prioritising refining health care services at primary, secondary, and tertiary levels where the year 2018 saw the Saudi government apportion a fund of SAR 146.5 billion (US\$1 = SAR 3.75) for health services and social development, which translated to 15% of the government budgetary expenses.¹³ The state remains the main economic actor in health care provision with the MOH providing the bulk of the country's facilities.¹⁸ Private sector sources account for less than a quarter of the total expenditure on health care, which is much less than in other countries.¹⁹⁻²¹

Since the 1970s, health care expenditure in the KSA has risen to an estimated 8% of the state's overall gross domestic product (GDP).² This is much greater than other states' health care spending in the Middle East and North Africa (MENA) where state spending averages 5.2% of GDP. This surge in government spending has been funded almost entirely from the vast oil-rich resources that contribute to social and economic development.¹⁸ With the huge economic benefits of the 1970s oil boom, Saudi Arabia expected to quickly develop into a major economic power.²² However, rather than achieving

security, economic development is stalling due to fluctuating growth rates and population increases.²²

Furthermore, 'oil wealth has provided the basis for the growth of separate, rather isolated institutional recesses, sometimes called fiefdoms'.²³ This has provided the basis for the flourishing of nepotistic familial politics at the expense of administrative development at a regional level. More pertinently, it is also becoming increasingly clear that the vast oil resources in the Gulf region are rapidly dwindling which, in turn, demands that the Saudi government must find alternative means of providing economic and social security in a post-oil environment.²³

Therefore, it is important to underline the problem of political and economic stability in the KSA where a 'generational shift poses a major challenge to the cohesion of the elite'.²⁴ It is crucial to acknowledge that the sources of economic and political power that have hitherto provided a platform for funding frontline health care are less stable than was previously imagined.²³ The Saudi government has also recognised that relying solely on oil revenues to finance public health care services is unsustainable in the medium to long term. This has opened up a debate regarding health care financing reform. It has also led the Saudi government to consider additional and alternative financing options for the health care system to shift away from health care as a universal form of coverage to health care as a socioeconomic burden that will be increasingly shared between the public and private sectors. The government has set out a blueprint to reform the health care system through vision 2030. It intends to increase private sector participation, with a target of 35% expenditure by the private sector to be achieved by the year 2020.²⁵

Legislative reforms have already been enacted in a bid to increase the basis for partnership between the state and private revenue sources. Most obviously, the Supreme Economic Council (SEC) was established in 1999 to increase the private sector's participation in developing the national economy through the government's privatisation programme. The privatisation programme embarked on in the KSA represents much more than an effort to meet the state's budget deficit by selling off public assets.²⁶ Rather, the privatisation process has stressed the importance of establishing a regulatory framework for the private sectors, devising systematic methods for setting tariffs for services that were previously subsidised through government corporations, creating procedures for some public enterprises to be restructured prior to being sold, and bringing in strategic partners to help the government manage the largest and most cumbersome of the privatisation deals.²⁶ Therefore, it is apparent that privatisation is already a political reality in the KSA as the government aims to make the Saudi economy among the 10 most competitive in the world.²⁰

However, whereas the SEC does indeed telegraph a move towards economic liberalisation, the concentration of powers under the Kingdom's institutional framework suggests that the

state will remain an omnipresent force in PPPs. In particular, the continuing centrality of the state as the arbitrary legislative and administrative power hints at a perpetuation of bureaucratic red tape impeding the modernisation of the domestic health care system.²⁰ In addition, it should also be noted that, at the present time, partnerships between government and non-government organisations have been limited to embryonic agreements between Saudi Arabia and foreign investors in the water and electricity markets, with little by way of the opening up of public utilities such as the health care system. Therefore, it is clear that the Saudi government envisages a policy best understood regarding limited privatisation rather than a fully fledged partnership between the public and private spheres. Thus, the conceptual limitations of partnership approaches to the private financing of public assets in the KSA must be underscored.

The Ministry of Health: State Intervention and Regionalism

The MOH also maintains overall responsibility for managing the Saudi health system, including strategic and administrative planning, and forming new health care policies.^{19,27} The MOH is, therefore, a ubiquitous presence in the Saudi health care system: a controlling influence that dominates decision-making procedures at a national level.¹⁸ Consequently, it is apparent that Saudi health care provision is heavily influenced by state intervention.

However, in spite of the looming spectre of the MOH, the Saudi public health system represents an increasingly decentralised system of government. There are 13 autonomous health regions, each led by a Regional Director of Health Services who, in turn, is directly responsible to the Deputy Minister of Health for Executive Affairs.²⁷ Therefore, the bureaucratic body of the MOH incorporates a number of health sections, each supervising at least 1 general hospital and a number of health centres, school health services, regional health offices, and the private sector. Although the MOH sets the policy guidelines to be followed at a national level, the regions 'enjoy autonomy in the day to day running of health affairs'.² Understood in this way, it is clear that the Saudi health system is increasingly characterised by regional autonomy. The regionalisation of Saudi health care policy is of direct interest to this study.

Moving responsibility for administration and decision-making towards separate health regions, the MOH has maintained an ideological commitment to the principle of PHC which is constructed from the premise of community participation.² This, in turn, demonstrates a maturity level in the MOH system that bodes well for the long-term management of some of the most protracted health-related problems facing the government over the next 40 to 50 years. As we shall see, with non-communicable diseases already representing a significant logistical problem for the health care system, the

commitment to decentralised, primary conceptions of health care will offer a viable means of educating the local population and tackling the multitude of risks associated with the major chronic diseases, such as diabetes, overweight and obesity, and cardiovascular diseases.²⁸

Moreover, the commitment to regional autonomy suggests that, contrary to the published literature about the KSA political make-up, a *laissez-faire* ideology has influenced how public service provision has evolved.²⁶ In addition, the commitment to PHC will have a positive effect on efforts to reduce costs, with the expenses incurred at health centres representing only a mere fraction of those incurred at hospitals.² Consequently, it is prudent to observe the opportunities inherent in the Saudi health care system, particularly concerning the prospect of opening up public sector health facilities to external, private sources.²⁰

Regional autonomy has also created ideal conditions for endemic mismanagement. The huge economic benefits of oil exploration have seen the rise of regional fiefdoms. Very wealthy, politically powerful families have exerted enormous influence on public policy at a regional level, negatively impacting national ministries, such as the MOH in implementing administrative changes.²³ The Saudi health care system reflects a political ideology where a lack of open, democratic tradition has facilitated the rise of autocracy at national and regional levels.² This has major implications for implementing PPPs in developing countries.²⁹

At a regional level, government agencies other than the MOH act as health care providers. For instance, the Armed Forces Medical Services, the Security Forces Medical Services, the university medical services, and large multinational corporations such as the Saudi Aramco Oil Company each provide a significant number of hospitals, beds, and staff to provide health care to a select number of workers and their families. However, although these other government agencies perform similar functions to the MOH at a regional level, particularly in providing ambulance and inpatient care, frontline health services are not made available to members of adjoining communities.²⁷ This puts high patient demand on MOH hospitals, whereas other government sectors' hospitals have excess capacity.

The move towards local autonomy has created obstacles to health care reform in the KSA. In particular, it is apparent that the lack of coordination between the MOH and other health providers has created an economically inefficient health care system characterised by overutilisation of MOH resources and underuse of the excess capacity in other state-funded facilities.² This demonstrates a lack of a centralised strategy and policies for public service provision and managerial skills needed to run health care facilities.³⁰ This is a crucial point to consider. As will become apparent, one of the major benefits of PPPs is in the managerial expertise that market sector organisations are able to bring to public service provision.³¹ Thus, PPPs potentially

represent an ideal means of addressing the economic inefficiency of the regionalisation of the MOH administrative structure.

The MOH has huge influence on how private sector organisations operate in Saudi Arabia. In particular, it has the authority to set and regulate prices in the private sector.² Consequently, it can be argued that the bureaucratic structure of the MOH serves to quash the germination of the market mentality that is such an essential factor in the emergence of private sector solutions to public policy problems. Therefore, it is prudent to observe the link between democratisation, decentralisation, and the edification of a competitive neoliberal ideology that constitutes such an integral feature of productive partnerships between public and private actors.³²

Health Care Provision in the Contemporary Era: Intractable Problems

Frontline health care provision has undergone profound changes over the past 3 to 4 decades. Where, previously, governments were largely able to offer universal coverage to provide citizens with health care, in the contemporary era the social and economic burden of health care provision has facilitated a move away from health care as a fundamental right towards health care as a serious problem of sustainable social and economic development.³³ This is true not only of developing world countries such as the KSA but, rather, on a global scale as a number of interrelated issues have conspired to place significant upward pressures on states and health care providers as sources of long-term care. In particular, there are 6 sources of concern, each of which must be considered.

Ageing population

First, it is imperative to consider the impact that demographic changes have had regarding health care and welfare provision.³⁴ In particular, increased life expectancy coupled with a decline in mortality rates has yielded ageing populations that are having a profound effect on the public sector organisations' ability to fund frontline health care. Over the next 50 years, the world's ageing population (over 65) is predicted to rise from approximately 6.9% of the total global population to 15.6%.³⁵ This will put unprecedented pressure on health care systems to adapt these unprecedented demographic changes. In particular, specialisation in geriatric provision will be required to deal with increasing numbers of elderly people with chronic, degenerative diseases such as dementia.³⁶ This is a major logistical problem for health care providers across the globe. For instance, in developed countries, it is estimated that, by 2040, up to 81.1 million people will be afflicted with dementia with even greater numbers projected for the developing world.³⁵

The ageing population is important when considering the pressing need for the modernisation of the Saudi health care system. Improved treatment of communicable diseases coupled with vast expenditure by the MOH has increased people's

lifespan in Saudi Arabia to 70 years – a rise of almost 60% since 1960.² Moreover, in a study delving into the problem of patients with long stays in acute facilities in Riyadh, it was found that patients aged 65 years and more occupied 22% of the beds.² Consequently, it can be seen that the problems incumbent in an ageing population are already impacting on health care provision in Saudi Arabia and will continue to rapidly escalate.³⁷

Rising costs of health care provision

It is essential to draw attention to the problem of rising costs of health care provision in the contemporary era. Most countries feel constant pressure because expenditure is increasing and resources are scarce.³⁸ In particular, it should be noted that a fundamental imbalance between revenue and expenditure has created spending deficits in every major public authority in the world, including in the KSA.³⁷

Most notably, it is apparent that, as has been the case in Europe, an age of austerity has been forced on public spending, constituting a rapid retrenchment in public sector financing for health and social care, characterised regarding 'privatisation through the back door' (ie, the quick fire transformation of a public service into a commercial, profit-seeking market).³⁹ Indeed, in the case of the KSA, the problem is even more acute with its oil resources unsustainable for funding public health care in the long term.²²

Technological advancement

Health care systems worldwide are faced with the challenge of having to update equipment that has failed to keep pace with recent technological advancements.³⁵ The rising significance of new technologies is immensely important to consider as the latest, most up-to-date equipment is fundamentally altering our perceptions of the body and redefining health.⁴⁰ Not only do new technologies offer health care providers a means of increasing the quality of care offered to patients, they also provide means of screening patients that are yet to present any symptoms of illness. As a result, biotechnical innovations have been increasingly framed regarding the handmaiden of the medical profession.⁴¹

Installing the latest biotechnical advancements represents a pivotal means of providing cost-effective, high-quality health care.⁴² However, it should also be noted that there is a considerable distance to be travelled between the articulation of the need to modernise health care resources and installing the technological tools that are able to predict and prevent non-communicable diseases.⁴³ Although Saudi Arabia has state-of-the-art medical facilities, the need to expand this provision across the country and for ever-expanding numbers of people telegraphs a significant economic burden for the government. Hence, attention has increasingly turned towards private sector sources that are able to fund the acquisition and installation of cutting-edge medical technologies that provide a vital means

of realising sustainable health care provision in the 21st century.⁴²

Shortage of skilled health care professionals

It is important to consider the shortage of skilled health care professionals and how this impacts health care costs and quality. Staffing is crucial to delivering health care services and its costs are a major part of the budget. Although financial benefits have been offered to attract the best qualified professionals, there are staff shortages across the world.⁴⁴ The problem is particularly pronounced in the KSA.

Of the health care professionals working in the KSA, only 17% of the total is Saudi nationals, with an average tenure of 2.3 years.⁴⁵ The MOH fills the gap with foreign skilled health workers, paying them inflated wages, which negatively impacts the state's health budget.² Consequently, a shortage of skilled workers, coupled with the lack of stability of the vast majority of the professionals working in the KSA, represents a major obstacle standing in the way of the realisation of a modern, economically efficient health care system.^{13,37}

Changing status and expectation of service users

There is a shift from service users as 'patients' to being 'customers' to instil a sense of managerialism into health care provision.⁴⁶ Introducing managerial ideals, with emphasis on improving quality of care, has served to imbue a veneer of accountability and transparency in contemporary health care systems.³⁵ This is an important point and has a direct influence on understanding some of the issues that arise from blending public and private organisations. Rising consumer expectations have instilled values into health care systems where the patients' rights and choices outweigh equity and fairness when allocating scarce resources.⁴⁷ Consequently, it is essential to consider the link between privatisation, consumer choice, and the rise of individualism (at the expense of equity) in contemporary health care.⁴⁰

Rise in non-infectious diseases

When examining changes to health care provision, it is essential to refer to the rise in non-infectious diseases and the social and economic burden this has on health care systems. Cardiovascular illnesses are the leading cause of death and disabilities in the world, and the prevalence of 'lifestyle' illnesses, such as diabetes, has increased sharply in recent years.⁴⁸ This is seen with the diabetes rate predicted to rise by 183% in the KSA between 2000 and 2030.³⁰ Obesity is a major health problem in Saudi Arabia. Overweight and obesity rates among adults are especially high, running at 70% to 85% of the male population of 30- to 60-year-olds and 75% to 88% of the female population. Obesity is also high among young children with 8% to 9% of pre-schoolers being obese or overweight.⁴⁹

Isolated regions of the country still fail to consider the stark rise in non-communicable lifestyle illnesses and their debilitating effects.⁵⁰ There is a gap between the professional knowledge of many PHC staff and their practical skills, with considerable costs for funding health care.² Non-communicable diseases impact risk management, a central tenet of contractual agreements underwriting PPPs.⁵¹

PPPs in an International Context

PPPs' genesis and evolution

There has been a plethora of literature published about PPPs over the past 20 years. This has coincided with the recognition that there is a growing need to improve the quantity and quality of public service provision.⁵² Most of the literature focused on PPPs in western liberal democracies, where the blurring of the boundaries that had hitherto segregated the public and the private spheres has been most pronounced. In particular, academic interest has fixated on the partnerships procured between public and private actors in the United Kingdom, where the universal form of health care coverage manifest in the National Health Service (NHS) provides an ideal template on which to analyse the complexities of the modernisation of welfare services.⁵³

As Whitfield⁵⁴ detailed in a comprehensive overview of the changes that have occurred to public service provision in the contemporary era, in the United Kingdom, the beginnings of PPPs can be traced back to the public policies initiated by the Thatcher government in the 1980s where a radical conception of decentralisation facilitated the 'hollowing out' of the state. The Thatcher government reforms reversed the welfare policy to reduce state spending.³¹ By 1991, more than 50% of Britain's public sector had been transferred to the private sector with 20% of the population becoming shareholders in previously state-owned assets.⁵⁵ In this instance, the state's former assets became permanent entities of the private sector with responsibility for costs being shunted onto the corporations that had initiated the purchase. In this way, public services that meet basic human needs were turned into commodities traded on the free market. This has been to the ultimate detriment of welfare states throughout the developed world.⁵⁴

An additional number of academic papers deal exclusively with the UK Private Finance Initiative (PFI) model. The evolution from managerial reforms to a programme of innovation was a way to renew NHS facilities faster without using public funds.^{52,53} The long-term nature of contractual agreements between public and private sectors implied that facilities would be adequately maintained over their lifetime. From the public sector partner's perspective, the major benefit of the PFI or PPP is the private sector's capacity to absorb the risks of escalating costs.⁵⁶ Transferring risk ensures that the physical health care infrastructure can continue to support services during an epoch of rapid technological, demographic, political, and epidemiological change.^{53,57}

Exporting the public finance initiatives and PPPs to developing world countries

In considering the literature about the influence of the PFI model and PPPs for health care systems elsewhere in the world, there are cases for adopting the PFI model, based on its apparent success in the United Kingdom, and it has been exported to countries in the developing world.²⁹ The often-overlooked exportation of the PFI model offers insight of direct relevance to this research. Partnerships between public and private sectors is less of a solution for the problems affecting utility services, but more a placebo promulgated by politicians keen to accentuate the benefits of a mixed economy.^{54,58-60} The lessons learnt from the UK PFI experience and the benefits of PPPs are wildly exaggerated, as it is only possible to judge success when long-term contracts are completed.⁶¹

Assuming that the PFI model has been a success in the United Kingdom, there is little evidence that this form of PPPs effectively transfers to states with little democratic, free market tradition. Whereas the emphasis on indirect management is on PPPs, it is likely to be more demanding than direct state management. Therefore, it is unlikely that autocratic states would be willing to adopt a non-interventionist policy. It is important to consider PPPs on a country-by-country basis when using them in developing states.²⁹

Contractual concerns: relational versus transactional agreements

The ideal of partnership has been disseminated as a solution to the problems in welfare provision.^{29,61} Partnerships can be either organisational or economic. Organisational partnerships emphasise a network approach to governance, where economic partnerships emphasise risk-sharing contracts.⁶² This is an especially pertinent issue to consider as the PPP contract length can be binding for 25 to 60 years.^{62,63}

Attempting to legislate against the problems of long PPP contracts, public sector bodies have engaged in fixed-price contracts.⁵⁶ A fixed-price contract means that public-private agreements are transactional. This presents an ideological division between private organisations' desire to increase profits and the public sector's obligation to stakeholders and service users.⁵² Standard contracts for design and construction projects contain a liquidated and ascertained damages (LAD) clause so that contractors can avoid the perils of time and cost escalations.⁶⁴ Therefore, overruns have become a common feature of the PPP and PFI.⁵⁴ Fixed-price design, build and operate (DBO) contracts enable the corporate entity to absorb the construction risks and cost escalation, which has some inherent problems.⁵⁶

When examining PFIs and PPPs, the lucrative financial benefits offered to the private sector consortium far outweigh the contractual advantages to the public sector partner.⁶⁰ PPPs allow the contracting partner to make enormous profits by

refinancing lucrative design projects. If the service becomes obsolete or the project is terminated early, the private sector partner is reimbursed through a lump sum. Accelerated investor gains early in the contract's life act as an incentive for refinancing rather than for engaging in a relational agreement that takes all future possibilities into account. This risks PFI refinancing deals becoming a vehicle to directly transfer public monies to private investors instead of encouraging design innovation.⁶⁰

Before considering whether PPPs are viable for addressing health care problems in the KSA, it is essential to draw attention to the methodological problems relating to the benefits and pitfalls of PPPs. PPPs and PFIs have a lack of clear, empirical testimony from the political rhetoric that is used to the risks involved or the financial outcomes.⁶⁵ Part of the problem is that the projects that have been embarked on since the beginning of the 1990s remain in an early stage of development.⁶⁶ It is only over the next 30 to 40 years that concrete evidence of building infrastructure as the cost data for PPPs is not yet available for performance evaluation. This represents a major methodological problem for health economists.

It is also crucial to consider the subtle variations in how to measure the performance of PPPs at a methodological level.⁶⁷ In judging PPPs regarding value for money (VfM), there have been no empirical studies into the efficiency of PPPs. Much of the literature about PPPs remains conjecture about potential benefits and possible pitfalls rather than concrete facts and figures.^{31,68}

Discussion

After considering the health care system in Saudi Arabia and the problems facing the MOH, it is essential to consider whether PPPs can offer a sustainable concept of health care over the forthcoming years and decades. As far as this is concerned, 4 points are readily apparent.

First, as the literature review has demonstrated, there can be little doubt that there is an inherent dichotomy between the public and the private sectors' needs.⁶⁹ The public sector partner seeks to improve health-related outcomes, where the private partner is motivated by economic improvement. This has an adverse effect on the contracts between the public and private sectors.⁷⁰

On one hand, it is apparent that, in seeking to encourage innovation in building and design, private sector partners are offered lucrative refinancing terms if the project demonstrates it is on schedule.⁶⁰ Consequently, the reselling and refinancing of lucrative PPP contracts have become a worldwide capitalistic venture worth hundreds of billions of dollars a year.⁵⁴ However, this is to both the public sector utility provider's and the end user's ultimate detriment as the consortiums' skills and expertise vary greatly. Understood in this way, it can be argued that the contract binding private and public entities together favours the profit sector organisation over and above the

non-profit organisation, with the fusion of abstract notions relating to risk and innovation offering the private sector consortium an opportunity to 'cash in' on early project success.⁶⁰

On the other hand, it is also clear that the non-profit entity's attempts to bring about a relational agreement are hindered by the incongruous nature of the relationship between the 2 parties. The profit-seeking imperative that fuels corporate financiers ensures that the needs and demands of the non-paying service users are rendered secondary to the demands of shareholders.⁶² Moreover, in an age of increasing global economic uncertainty, it is unlikely that the private sector corporations will remain intact over a period of decades. The incorporation of the LAD clause in PPP contracts thus offers private sector organisations a route out of convoluted Build-Operate-Transfer and Design-Build-Operate agreements.⁶⁴ Consequently, when engaging in partnerships with private sector organisations, non-profit bodies increase the risks associated with time and escalating costs.⁶³

This is an important point to consider for potential health care reform in Saudi Arabia. Contracts procured between the state and private health organisations have been undermined by organisational inefficiency and contributed to escalating costs as the MOH selects companies based on the lowest bids.² Contracts offer the private sector no incentive to contain costs during its partnership with the state. Although an initial bid might appear to represent VfM, costs incurred after engaging in a partnership means that there is considerable cost to the Saudi state.²

Second, it is important to consider the consequences of the imposition of private sector values into a health care system such as that which exists in Saudi Arabia. In particular, there can be little doubt that privatisation – whether it is in the form of the selling of public assets or the procurement of contractual agreements in the guise of PPPs – engenders inequality, with quality of care inextricably linked to the patient's ability to pay their health care costs in direct conflict for the KSA to provide free health care services.^{14,47} It is also important to consider its impact on access as several studies showed that privatisation has negative effects on access to health care among indigent patients and might also diminish the quality of care.⁷¹⁻⁷⁴

Furthermore, opening up frontline health care provision to market-based corporations increases the choices open to consumers, which in turn has a direct impact on the perpetual rise of service user expectations.³⁵ Moreover, when the entire population is subject to the private health insurance, patients in Saudi Arabia will have a vast array of choices about which types of facilities they want to use and where.¹⁸ In particular, paying customers will not want to use the poorer-performing state-run hospitals whose facilities and infrastructures are unable to compete with cutting-edge private designs. Therefore, the MOH will either have to heavily subsidise or close poorer-performing hospitals, increasing the economic burden on the state, which would create inequality in public health care.⁴⁵

Understood in this way, it is essential to underline the consumerist perils of marketisation and the way in which this would create inequality in public health care.

However, it is increasingly difficult to relate health care management and, in particular, health economics, to universal welfare principles that were established more than 60 years ago.⁶⁹ Whereas universality might continue to represent a humanitarian ideal, the practical reality of ageing populations, changing disease patterns, rising costs, and the need to replace outdated equipment demand that health care systems adapt to rapidly changing social, cultural, economic, and political realities.¹⁴ Thus, it can be argued that the transfer from a national health care system to a national health insurance programme represents a concerted effort to reduce the government's expenditure on frontline care by introducing wage-based contributions to health care premiums.⁴⁵ Considering the demographic changes, coupled with the unprecedented rise in non-communicable diseases, this is an immensely significant point to underscore. Therefore, it is clear that opening up the public health care system to external private revenue sources is, at least in an ideological sense, a *fait accompli*.²⁰

Third, there is little by way of concrete empirical evidence to demonstrate that PPPs actually improve health care systems' efficiency, especially relating to infrastructure projects.^{29,61,65,66} Therefore, whereas opening up the Saudi health care system to private sources might be the best means of addressing the problems of providing health care, this does not necessarily mean that the MOH should become involved in a partnership with private sector organisations that have yet to demonstrate why PPPs ought to be understood as a viable, long-term solution.

However, it can also be argued that, because of the relatively new nature of PFIs and PPPs, there is little evidence to suggest that PPPs are detrimental to the long-term infrastructure needs of health care systems.⁶⁷ Whereas the lack of managerial expertise within the MOH might cause increased costs, it is also important to outline the opportunity for capacity-building that PPPs have for non-profit sector bodies in developing countries. To improve managerial and technical capacity, non-profit sectors must understand the ideals of markets and competition to yield the greatest benefits from association with PFIs.²⁰

Fourth, in analysing the potential for PPPs in the KSA, it is essential to re-emphasise how the state's adherence to regionalism has negatively impacted the effective use of governmental resources. Whereas hospitals and facilities operated by the MOH face increased pressure, other government ministries have underused hospitals and facilities. Policymakers must first seek to better use the resources available to the state before considering PPPs. This means that PPPs must be thought of as an appendix to administrative, organisational, and managerial reform rather than as a starting point for cutting costs and improving efficiency.

Conclusions

This study shows that the KSA faces social, cultural, economic, and political problems that impact on sustainable welfare provision. An ageing population, rising costs, the demand for new technology, a shortage of skilled workers, rising service user expectations, and the prevalence of diseases are the main issues facing health care providers. The study has demonstrated that the Saudi health care system has sought to address these issues by moving towards regional autonomy and embarking on a state-sponsored privatisation process to open up the public sector to market-based forces.

At the same time, the autocratic nature of political decision-making in the KSA and the bureaucratic nature of the MOH have perpetuated outmoded institutional practices that work against competition. Moreover, the lack of a managerial tradition within the MOH has facilitated the inadequate use of resources and contractual agreements with private sector service providers that do little to encourage innovation and efficiency at a practical level. It is essential to draw attention to both the constancy and change that characterise contemporary Saudi health care policy – a duality that renders forecasting the future of Saudi welfare exceedingly difficult to accomplish.

In addition to outlining the problems facing Saudi policy-makers and offering an overview of the domestic health care system, the research study undertook a detailed overview of the literature published about PPPs. The literature suggested that there was a dichotomy between the theory of public and private sector partnerships and the practical reality of managing contracts over such a long term. It is apparent that whereas the public sector partner must consider efficiency from the perspective of major stakeholders, the private sector partner is fuelled predominantly by a profit-seeking prerogative. Therefore, there is a conceptual grey area prevalent between economic efficiency and allocative efficiency in PPPs.

This, in turn, has impacted on the contractual agreements that bind public and private sector bodies together. The significant debt that must be taken on by private consortiums has created the ideal opportunity for a lucrative refinancing enterprise worth hundreds of millions of dollars a year. Thus, rather than becoming a means of engaging in a long-term relational contract, the sheer scale of PPPs offers an avenue for private sector profit. Consequently, it is essential to underline the deep-seated ideological difference between the theory and practice of managing commercial transactions between the public and private sectors.

The literature review revealed that PPPs have been exported to developing world states on the assumption that partnerships between public and private organisations demonstrate a solution. Not only has this not been the case, but also there are significant differences between PPPs in developed world economies and in states transitioning to democracy and economic liberalisation. For instance, the lack of managerial expertise and technical know-how, coupled with the absence of an open,

accountable, democratic tradition, renders the subtleties and complexities of indirect management difficult to implement in developing countries. Moreover, contracts based on politics, patronage, and profits rather than on competition, quality, and expertise hint at a divergence between the values of public service provision and the principles of private sector enterprise in non-democratic states.

Although the literature review revealed a predominantly sceptical view of PPPs, 2 key factors ought to be considered. First, it should be noted that it is much too soon to talk regarding the redundancy of PPPs. The long-term contracts signed between public and private partners, in addition to the extremely uncertain global economic climate, suggest that PPPs remain an evolutionary form to finance public services. Second, it is also clear that the KSA considers private investment as an opportunity to meet the welfare provision challenges. Establishing the SEC and the emphasis on regulatory frameworks are signs of its commitment to modernising public service provision.

Saudi Arabia's long and rich tradition of foreign investment, which is rooted in the oil boom of the 1970s, suggests that PPPs might indeed represent the most viable means of establishing a sustainable health care system. Moreover, unlike many developing countries, the KSA is already equipped with modern health care facilities funded by considerable government expenditure. The state is not, therefore, required to significantly overhaul decrepit physical infrastructures built 6 or 7 decades ago.

The research suggests that there is a pressing need to modernise the Saudi health care system. In particular, there is a need to instil a sense of managerial efficiency into the bureaucratic structure of public welfare provision and to procure greater investment from private sector sources to alleviate the state's burden. However, although the state is intent on opening up the health care sector to private sources, this does not mean that PPPs are a long-term solution. Rather, PPPs represent one of several privatisation options open to a country that has already made significant progress in the quality and standard of care provided under a health care system that is ideologically rooted in the egalitarian principle of universal coverage.


Limitations of the Study

This research is primarily based on secondary data. However, significant efforts were made to collect the necessary information for the appropriate analysis, explanation, and interpretation of the available literature. Future research could be undertaken using primary data.

Author Contributions

MKA and AMNQ were responsible for the overall manuscript preparation, made equal contributions, and have read and approved the final manuscript.

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