Abstract—In 1999, the Kingdom of Saudi Arabia enacted a law that compels private employers to cover non-Saudi employees with health insurance. In the 16 years that followed, the health sector in the Kingdom has seen a dramatic shift in how services are provided and paid for, and the change continues at an accelerated speed. Based on interviews with 12 large private sector providers in Riyadh, Jeddah, and Khobar, we found that a labor law enacted in 1999 led to rapid expansion of the insured population, both expatriates and Saudis, which led to a drastic change in how hospitals and other facilities are paid, and considerable more consistency in revenue stream. This article describes how the 1999 labor law, combined with other market conditions and public incentives, led to unprecedented growth in private sector capacity and how the insurance system changed the labor market for health care providers and put more pressure on physicians to engage in dual job holding in both the public and private sectors. The Kingdom later introduced another labor program, known as Nitaqat, designed to implement the Saudization initiative that started in 2011, which put pressure on all private companies to hire Saudi nationals. The interviews with large private health providers found the Nitaqat program to be the largest barrier to the growth of the sector. The Kingdom presents a striking case of how the health sector can be drastically impacted by laws and policies outside the sector and how health systems and reforms can, and should, take into account the whole range of policy instruments available to a country.

INTRODUCTION

In this article, we look at dynamic developments within the health system of Saudi Arabia over the last 15 years and how a labor law and a labor program have already dramatically changed the sector and are likely to have even more impact in the coming years. The analysis is based on a recent study commissioned by the Saudi Health Council and implemented in collaboration with the World Bank. The study focused on
the growth in dual practice among Saudi physicians, that is, the practice of a health worker engaging simultaneously in both the public and private sectors. As part of this study, and specifically in relation to the Saudi labor market, the analysis found that a labor law that was enacted in 1999 requiring all expatriate workers at private employers to be covered with private health insurance has had a considerable impact on the basic structure of the sector, including how services are delivered and financed and how physicians are employed. The study also found that a more recent labor initiative—announced in 2011—that led to the Nitaqat program, which limits the percentage of expatriate workers in private companies, has also been having a clear impact on the sector but in a very different way. This labor–health linkage, showing how policies in the labor sector affect the health sector, is not typically well researched in health systems analysis. More important, the 1999 labor law is not unique to Saudi Arabia; other countries in the Gulf Cooperation Council (GCC) have enacted or are considering similar laws, due to similar labor market conditions, large expatriate populations, and health system structures. Understanding the impact of labor laws and initiatives on the Saudi health system is valuable not only for the Kingdom but also for the other GCC countries and other countries around the world.

The Kingdom of Saudi Arabia, though larger than other GCC countries, shares important labor, demographic, and health sector characteristics, making it important to document, understand, and learn from its ongoing developments. The GCC countries share four interrelated characteristics. First, they are high-income countries rich in natural resources. This strong reliance on natural resources leaves them vulnerable to commodity price fluctuations but has historically provided considerable government revenues. Second and related, these countries have a fairly generous public welfare system. In the case of the health sector, and until recently, that translated to a highly subsidized health sector delivered through publicly owned hospitals and other facilities. Third, GCC countries have labor markets that include large proportions of expatriate workers, in some countries over 80% of the total population. This large share of the labor market covers all sectors of the economy and creates two separate demographic profiles. The GCC nationals profile is a standard population pyramid with a dominance of younger population, but the expatriate population profile is predominantly male and working-age population. The fourth shared characteristic, also shared with other Arab countries outside the GCC, is a common cultural heritage, including linguistic and religious. It is not surprising, therefore, that most GCC countries are facing similar challenges and opportunities in both labor markets and health system responses. Recent fluctuations in oil and natural resource prices, combined with generous welfare systems and a drive to diversify economies, have triggered new laws and new pressures to reform a number of sectors in the economy, including health. For all of these commonalities in starting points and triggering factors, the main findings highlighted in this article are directly relevant to all GCC countries and potentially relevant to the larger Middle East, especially as countries embark on reforms to labor laws and to financing health care.

CONTEXT AND METHODOLOGY

Fieldwork for this study included a facility-based informant interview survey in in the three largest urban centers in the Kingdom (Riyadh, Jeddah, and Khobar/Dammam). The survey was developed in the context of a broader Saudi Health Council study to better understand the labor market dynamics driving a perceived growth in dual practice whereby Saudi physicians working in the public sector, especially consultants, are also moonlighting at privately owned facilities. Dual practice is formally prohibited in the public sector except in university hospitals, with university consultants allowed up to three consultations per week. Saudi physicians working in other parts of the public sector are expected to work full time and are not allowed, by law, to work overtime in private practice. According to Article 8 of the Health Profession System issued by the Royal Decree number M/59 in 2006, physicians must attain a license from the Directorate of Health Affairs to practice in the private sector, with specific annotation of institutional affiliation.

An e-survey of 819 Saudi consultants, representing around 16% of all consultants in Saudi Arabia, was conducted as part of the dual practice study carried out by the World Bank in collaboration with the Saudi Health Council. This survey found that nearly 40% of public sector physicians are interested in and considering dual practice and may even leave public employment to join the private sector. Though the consultant survey captured a strong willingness of Saudi doctors to enter private practice, it was important to better understand why the demand for these physicians appeared to be growing dramatically and the extent to which this perceived demand by the private sector is real. The concern is that large numbers of Saudi consultants may abandon public sector hospitals to join the growing private sector, which would leave government hospitals with notable shortages; consultant physicians who speak Arabic and know the culture are
very difficult to replace on the international labor market. This survey allowed a better understanding of the supply factors from the consultant perspective. This article focuses on the informant interviews with a large sample of private hospital owners and managers across the Kingdom and allowed for a better understanding of the demand factors related to dual practice, as described below. The Saudi Health Council facilitated contacts with hospital owners or general managers in the private hospital sector. The Council reached out to the heads of the largest hospitals and requested a meeting with the research team explaining the objectives of the research and how the information will be used in informing the policy discussion. All requested interviews were granted.

Labor markets for highly specialized physicians (i.e., consultants) are typically relatively stable, given that high investment costs for multispecialty hospitals with advanced services usually result in a fairly static market for services and consequently for labor needed for the provision of such services. On the other hand, the relatively small size of such specialized labor markets—typically there is a limited number of consultants in a specific subspecialty who reside in a city or a geographic cluster—means that the consultants have a good understanding of the demand for their services and have strong bargaining power if demand grows. These two factors, low contestability for large hospitals and micromarkets with consultants willing to leave employment, point to two very different and mostly contradictory labor market descriptors: the labor market is either very static or very dynamic. The triggering factor for both is the nature of the growth in the demand for the skill. Understanding which of these two labor market conditions is dominant in Saudi Arabia represents an important input into the policy options for managing dual practice.

Demand for labor, or that of any input of production, is a derived demand reflecting changing market conditions for the final products being produced. In other words, the derived demand reflecting changing market conditions for the final products being produced. In other words, demand for inputs of production is derived from the perceived demand for the final services, in this case hospital services in the private sector. Consequently, we needed to better understand what is happening in the private sector that appears to have impacted the labor market for Saudi consultant physicians. Prior to embarking on the private hospital interviews, a number of meetings were held with the government, including the licensing directorate at the Ministry of Health (focusing specifically on licensing for hospitals), the Saudi Commission for Health Specialties (focusing specifically on certification of physicians), and the Health Committee in the Chamber of Commerce. It was important to get a clear picture of the development of the private sector and of the nature of the labor supply of Saudi consultants prior to conducting the facility-based private sector interviews. Information from these meetings provided the needed context for the dual practice study but also shaped the direction taken in the private sector interviews that followed.

Four important themes emerged. These themes were based on the frequency and consistency of answers from the different arms of government and the private sector agencies the team met with prior to embarking on the private sector interviews as well as the statistics provided by the different regulatory offices.

First, Saudi Arabia has experienced an unprecedented growth in the private sector for health care services, especially hospitals, in the last ten years. In 2015, the Kingdom had 144 registered private sector hospitals (based on data acquired from the Licensing Directorate at the Ministry of Health in Saudi Arabia). Established private health care providers in urban settings have been expanding geographically and in terms of services offered (providing an expanded menu of services with increased sophistication). This expansion put pressure on physicians to engage in dual practice, making it attractive for Saudi consultants to work with private hospitals, observed in the Kingdom—the expanding number of hospitals and services require additional physician hours. This early finding led to questions about the causes for this fast expansion of the private sector, the main theme of this article.

Second, there has been a steady and impressive growth in private health insurance in the country. The sub-sector (private health insurance) has developed fairly quickly, covering mainly expatriate workers, which is estimated to be a third of the resident population of the Kingdom. It is estimated that nearly 11 million residents of the Kingdom are currently insured, predominantly expatriates, but also a growing number of Saudis either working in the private sector or interested in further insurance are covered under the cooperative health insurance scheme. Though there are some dominant insurers, there is a large number of health insurance providers. As part of this study, we sought to understand the growth in this sub-sector, initiated and driven by the 1999 labor law, and how it has affected other aspects of the health sector in the Kingdom.

Third, the health sector has experienced a continued influx of Saudi physicians (consultants) in highly specialized fields of internal medicine and surgery. The Kingdom’s investments in Saudi doctors appear to be paying off, with a high percentage seeking and receiving postresidency fellowships in North America (Canada and the United States) and Europe and then returning to practice in Saudi Arabia. Despite the increase in highly specialized Saudi doctors, the market seems to be highly absorptive and lucrative for these physicians, with a much lower than expected number of Saudi
doctors selecting to remain general practitioners. In other words, an expanding input (Saudi consultants) is not only being quickly absorbed but at high wages.

Finally, the fourth theme was evidence of an accelerated increase in private sector hospitals in the next three years. Based on requests for licenses currently being processed by the Ministry of Health, we identified accelerated growth in the private sector. In 2015, there were already 144 licensed private sector hospitals operating in the Kingdom, but there were an additional 100 license applications for new hospitals. These new license applications take between one and three years to be processed, so the Kingdom is very likely to have a huge injection of new private sector hospitals in the not so distant future.

These early findings, based on meetings with government agencies, led to changes in the approach to the key informant interviews. The key changes included the following:

1. Expanding the regional coverage by interviewing hospital officials in the three major urban clusters, Riyadh, Jeddah, and Khobar/Dammam. Given the larger than expected private sector presence, we decided to include more locations in order to better understand the demand for Saudi consultants and to identify regional variations.

2. Expanding the number of private hospital officials to be interviewed to 12 (five in Riyadh, four in Jeddah, and three in Khobar/Dammam). It was important to capture a larger sample given the larger than originally known size of the private hospital sector (data from the regulatory arm gave a more precise estimate, which was larger than what was known).

3. Deciding to interview officials of well-established and large hospitals. Given the fast growth of the private sector in recent years, it was decided to get a better historic context by interviewing established private hospitals that were growing.

4. Using the interviews of the private sector hospital officials to better understand why the private sector is growing so fast. Because the original research question was about the demand for Saudi consultants and because, as noted above, demand for labor is a derived demand, it made more sense to explore more deeply the factors and market conditions leading private hospitals to grow and prosper.

FINDINGS

Though the original study focused on the drivers of dual practice in Saudi Arabia, this article focuses on a specific finding that emerged—the surprising and strong relationship between two labor laws/programs, one in 1999 and the other after 2011, and the development of the overall health sector in the country. We first lay out the overall drivers of the private sector growth, with a special focus on the structural transformation that appears to have been driven by the 1999 labor law. We then turn to the felt impact of the Nitaqat program and how it has the potential of negatively affecting the development of the private sector. The findings are based on key informant interviews with hospital directors at 12 large private hospitals.

Private Sector Growth Drivers and the 1999 Labor Law

One of the main objectives of the study was to understand how the health sector, specifically the private part, has changed over the years. Because the early findings found a surprising fast growth in private hospitals in the Kingdom, an important set of questions in the interviews focused on understanding what is driving that growth.

There is little doubt that the private sector for health, specifically the hospital sub-sector, has been growing rapidly in Saudi Arabia during the last few years. Every hospital representative interviewed spoke of recent expansions in services, physical capacity, and potential future growth options. The picture emerged of a highly dynamic and fast growing sector consistent with the information about the large number of new hospitals that will become operational in the next one to three years. The key informant interviews clarified the reasons behind this country-wide transformation in the private hospital sector. The consistency of the responses, despite interviewed hospitals being in three different urban markets, gives strong validity to the main findings.

The single most important reason behind this impressive growth of the private sector for health care services in Saudi Arabia has been the unprecedented growth in private health insurance in the country. This growth in private health insurance was initiated and driven by the implementation of the labor law that passed in 1999 requiring employers to provide health insurance to both expatriates and Saudi citizens working for them. This expansion of insurance coverage has had a transformative effect on the sector. All 12 private hospital directors were clear that the growth of private health insurance was the most important reason for the dynamism and optimism in the sector.

In addition to directly growing the private sector, expanding the capacity for hospital services across the country, and changing the composition and ownership of these services, the growth in private health insurance changed other aspects of how health care is delivered and paid for. All hospital
managers and owners interviewed pointed to a complete shift in how and how much private hospitals are being paid for providing services. The composite picture is of a shift from an original 80% fee-for-service out of pocket payment 10 to 15 years earlier to 80%–95% of revenue to private hospitals coming from private health insurance. In other words, private sector hospitals are being paid in a significantly different way since the labor law was implemented. This transformation in the source of funding means that private hospitals now have a guaranteed source of income and consistency in payment, which in turn allowed them to expand services. Whereas in the past, hospitals had thousands of different payers through a fee-for-service out-of-pocket approach (direct payment by patients), the growth in health insurance meant a much smaller number of payers (mainly the insurance companies) through negotiated prices and packages.

This transformation in how private hospitals are being paid created new incentives. The services covered by private health insurance became the main drivers for specific expansions as well as the skills and equipment needed. All 12 private hospitals interviewed noted that they have adjusted over time what they are focusing their services and investments on in a way that reflected the major shift of how they are being paid due to the 1999 labor law. Because employers had to cover expatriates and Saudis working in the private sector through private health insurance, the dominant funding for private health care shifted and created new incentives. The most direct way to capture how the 1999 law changed how the sector grew is that in the last 16 years investments in the private sector shifted from focusing mainly on what Saudi citizens are willing to pay for to focusing dominantly on what the private insurance covering the expatriates will pay for. This important point adds a new instrument for public policy and will be discussed in the final section of this article.

Though the 1999 labor law was the main driver for private sector growth and transformation, other factors aided in driving the development and structural transformation of the sector. Another driver for the strong development of private hospitals in the Kingdom is the perception among private hospital owners and operators that despite considerable new investments in large government hospitals, the demand for private care will continue to grow due to the inability of the public sector to extract efficiency from employees. They feel that the continued investments in the sector are a reflection of even more need in the population. A number of private providers in Riyadh and Jeddah referred to an “overflow” public–private partnership model where public hospitals contract out inpatient services in private hospitals due to the inability to provide care to a growing need. All private hospitals interviewed also reflected on a managerial culture in the public sector that does not maximize efficiency, giving examples of the small number of patients or procedures the same Saudi doctor would see/perform per day in a public sector hospital compared to a private sector one. The limited focus on efficiency in public hospitals appears to reflect a managerial culture not influenced by fee-based payment in the private sector and a lack of a profit motive.

A fourth driver of growth in the private sector is a growing population, where in 2015 the population growth rate stood at 2.1%. Though the total fertility rate in Saudi Arabia appears to be declining fast, dropping down from four births per woman in 2000 to 2.8 in 2014, the population is still very young, which means that the population will continue to grow fast due to “population momentum” as young citizens move into reproductive age in the coming years. When this population momentum is combined with a stated policy of the government to grow private sector employment through different measures including the Saudization initiative, private hospitals see a clear increase in the demand for private care services through private insurance and other forms of payment for private care.
A final universally agreed driver of growth in private hospitals (in other words, all interviewees provided a consistent answer) is an expectation that a “privatization movement” will continue in the Kingdom and in the health sector. Several interviewees noted a recent report by a global consulting firm recommending further privatization within the health sector. This expectation appears to be widespread, which gives the private sector an even more positive environment to look forward to. A factor identified by most hospitals in Riyadh and Khobar, but dismissed in Jeddah, is an incentive provided by the government for hospital construction. This incentive is in the form of interest free loans from the Ministry of Finance with a 20-year repayment schedule and up to 200 million Saudi riyals. It is interesting to note that, in sharp contrast to the private hospitals in the other two urban settings, none of the Jeddah hospitals indicated that such loans are attractive or have had an impact on the development of the sector.

Given all of the identified drivers for the growth in the sector, the exponential growth in private health insurance, challenges with public sector hospitals, the growing population, and the national trend for shifting the locus of activities from public to private mechanisms, it is not surprising to see how the balance of private and public services has been changing dramatically during the last few years. It is important to reiterate, however, that all 12 private hospital directors interviewed noted that the growth of private health insurance—triggered by the 1999 labor law—was the main reason for the development of the private sector.

### Challenges to the Private Sector for Health and the Nitaqat and the 2011 Saudization Initiative

The second line of inquiry during the interviews of the 12 private hospital directors focused on overall recruitment of health care providers and how they are compensated, with a focus on physicians working in highly specialized medical and surgical disciplines. A significant finding here was that though the private sector appears to be on a remarkable growth trajectory, recruitment of health care providers, especially nurses, is the main challenge faced by this sub-sector. This is important because it could have an impact on limiting overall growth. It is important also because it is driven by another labor-related program, Nitaqat, designed to help implement the Saudization initiative of 2011. Though this program is outside the health sector, the way in which it is implemented can have a potentially critical impact on the health sector.

In discussing human resources for health for the private sector, all 12 interviews with hospital directors raised the 2011 Saudization initiative and how it is being implemented. It is important to note that the topic of Saudization was usually brought up by the interviewees and not by the interviewers, reflecting the level of concern and challenge they are facing in implementing it. This initiative and accompanying labor program (Nitaqat) is having a strong effect on the private sector for health, primarily as it relates to nursing and technicians. Health care is a labor-intensive industry that pulls a large share of the human resources from highly skilled and trained labor pools. This makes the application of the Saudization policy very challenging. Though there is a good pool of Saudi physicians in the country, the real challenge is recruitment of Saudi nurses and technicians from a far smaller labor pool and in an environment where public sector employment offers a range of factors that are far more attractive than the private sector.

Every interview with private hospital directors highlighted the challenge of recruiting nurses as the single most difficult issue for the future development of the sector. Though some Saudi nursing schools are developing, especially in Khobar and Jeddah, it is relatively new, and graduates are not yet able to fill the growing need in the country. Even when Saudi nurses are recruited to the private sector, attrition is very high for two reasons. First, new recruits would prefer public sector employment and will leave as soon as they get offers in publicly owned hospitals. Reasons provided for this preference is a better benefits package (pension related), better hours and vacations, and much lower productivity expectations in the public sector. Basically civil service employment is highly valued in society. Second, attrition is high when nurses marry.

With a limited labor pool of nurses, both private and public hospitals have relied heavily on expatriate nurses, especially from the Philippines. Nurses from the Philippines are attracted to employment due to pay and, more important, because they see working in a hospital in Saudi Arabia as a stepping stone to employment elsewhere. Saudi hospitals are highly rated due to high quality and global accreditation, so a nurse with several years working in such a hospital has a strong résumé for employment elsewhere, especially in North America and Western Europe. The combination of a limited national supply of nurses and technicians and a challenge in retaining expatriate nurses presents the most difficult constraint facing the fast growing private health sector in the Kingdom. Nursing shortages are a global issue and not unique to Saudi Arabia, but the pressure this issue brings on the hospital sector in the country is a serious constraint that can potentially create a challenge for the expected further growth.
DISCUSSION AND IMPLICATIONS

Saudi health system development over the last 15 years provides a number of important lessons that are relevant to other GCC countries and to other countries around the world. Two lessons stand out, as described in the following sub-sections.

Unintended (or Secondary) Implications of Labor Laws

All laws or regulations have the potential to produce unintended consequences. The case of the Saudi labor laws and programs captures a rarely documented consequence where laws outside the health sector, in this case specifically labor laws/programs, have produced strong structural impacts on how the health sector has developed and is developing moving forward. The 1999 labor law, making it the responsibility of private employers to make sure that all expatriates and Saudi employees have health insurance, was designed to address a considerable public subsidy provided by the government to the private sector through the state provision of health care. It is important to note that this public subsidy to the private sector exists in all GCC countries, making this case highly relevant for the region. The 1999 labor law has been strikingly successful in its intended objective, with 7.6 million expatriates and 3.2 million Saudi citizens now receiving health care through private providers paid for through unsubsidized private health insurance. What this case also shows, however, is how the implementation of this law drastically transformed the health sector. This secondary impact may or may not have been intended, but it certainly was not the main rationale for the law.

Soon after the 1999 labor law was passed, a transformational process began. First, the private health insurance sector started growing as employers needed to comply with the law and needed to find insurance packages for expatriate employees. As private insurance started growing, insurance companies needed to contract with private hospitals to provide services to this expatriate population. This then led to a major shift in how private hospitals generated revenues. As noted above, the journey started with pre-1999 dominance of fee-for-service revenues from mostly wealthy Saudi families, as well as expatriates, to a complete dominance of payment by private insurers covering expatriates and Saudis working in the private sector. This revenue source transformation and the steady growth in private insurance allowed private hospitals to expand and new private hospitals to emerge. Moreover, the shift in revenue source oriented the growth in the private sector toward services that private health insurance is willing to pay for, consequently changing investment patterns and human resource recruitment decisions. It is hard to find a comparable transformation in a health sector that is so directly derived from a law outside the sector.

Though the Nitqat labor-related program is much more recent, the study found that it could have a considerable impact on the health sector moving forward. Here again, the potential impact is secondary and most likely unintended as it relates to the sector. Saudization was designed to increase Saudi employment in the private sector. The secondary impact on health, however, is risking to constrain the growth of the private sector. Health care is a highly skill-intensive sector, making it very hard for private hospitals to recruit and retain Saudi doctors, nurses, and technicians. Every hospital director interviewed identified Saudization as the biggest challenge they now faced.

The Strong Impacts of Health Financing Changes and Reforms

The Saudi case presents an unambiguous link between a shift in how health is financed and how the sector is reorganized. A consistent finding was that private hospitals had to adapt to the relative “youth” (development) of the private health insurance market. Two examples stand out and should raise some concerns for health sector policy makers in the Kingdom. First, the growth of the private sector produced what some key informants referred to as “immature” insurance incentives that focused more on short term indemnity-type insurance that paid for curative care and not for preventive care. Health financing reforms should focus on this problem and how to increase preventive care. Second, the limited regulatory framework for private health insurance companies and the lack of specification in the 1999 labor law about how expatriate employees are covered led to a short-term focus with insurance companies competing on premiums alone rather than facing fiscal challenges. This short-term focus has led in some cases to consolidation in the insurance market as well as closures of some hospitals (e.g., in Jeddah) when insurance companies failed to cover their obligations.

It is important to note that this article covered only one element of the amazingly dynamic health sector in the Kingdom of Saudi Arabia: the impact of labor laws and programs
on the health sector. The broader study conducted by the Saudi Health Council and the World Bank covered a number of other aspects related to human resources for health, labor markets, as well as the potential for public–private partnerships in health. The dynamic changes in the health sector in Saudi Arabia present a unique opportunity to better understand how policies, within and outside the health sector, can have considerable impact on how the sector is financed and organized and consequently how these policies can affect the efficiency and effectiveness of the health system.

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

No potential conflicts of interest were disclosed.

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