The Compliance of Healthcare Privatisation with Sharia and Saudi law: The 2030 Saudi Vision for Health

A thesis submitted to the University of Kent in the subject of Law for the Degree of Doctor of Philosophy

By Hayathem H. Bin Hasher
April 2019

Supervised by: Prof Didi Herman, Dr Yusuf Farah, and Dr Flora Renz

Total Word Count: 86,076

'Whoever saves one life, it is as if he had saved the whole of mankind'

Acknowledgements

'This is by the Grace of my Lord'

I would like to express my gratitude to my father, mother and brother, Nawaf, who taught me that I could achieve any thing I set my mind to. Dad, thank you for the privilege of living abroad and pursuing my education at some of the best universities. You have always told me 'Just decide what you want in life, and we will back you', and you did. Mom, you are my role model, you showed me what a strong independent woman with a dream and passion is capable of. You have always encouraged and taught me to stay focused on my goals no matter what. Nawaf, you are my rock and northern star. Your will power and hard work inspire me everyday. You have all played a vital role in the making of this thesis, in many ways. From travelling to collect resources I had reserved, being there for me whenever I needed you, to expressing, at every possible occasion, your pride in me and in the impact my PhD will have. I love you all dearly.

To my grandmother and uncle who I sadly lost during my PhD journey, thank you for your love and support. I know you would have been extremely proud.

I would like to thank my supervisors, the dream team, Prof Herman, Dr Farah, & Dr Renz for joining me on this journey and constantly encouraging and guiding me throughout the challenges, and numerous rewrites. Thank you for leaving a great mark in my educational path and for being the best supervisors I could ever ask for. A special thanks is due to Prof Herman, thank you for being

extremely supportive during the ups and downs, having faith in my abilities, seeing my potential and for everything you have done since the beginning.

Thanks are also due to Professor Donatelle Alessandrini, for her encouragement and guidance, and to Professors Judy Fudge and Robin Mackenzie and Mr Per Laleng who I have learnt a lot from during my time with them. I would also like to thank Lynn Osborne for all her help, wishes and smiles during my time at Kent Law School.

I would also like to thank my friends for their love, support and motivation through the tears and laughter. I am truly blessed to have such an amazing support system.

May this thesis be of the benefit intended, and may its impact be immortal.

'That which benefits mankind, remains on the earth'

Thesis Abstract

Saudi law, which is based on Sharia, considers healthcare provision a government obligation. Despite this obligation, and Sharia scholars' opinion against privatisation, the new 2030 Vision will privatise Saudi healthcare. This thesis argues that Sharia scholars have defined privatisation too narrowly, considering only one arrangement and neglecting other privatisation models which can be identified as Sharia compliant. The thesis will consider the basis for state provision of healthcare in Sharia law, define Sharia compliance in the context of healthcare, and highlight the limitations of Sharia scholarship on privatisation. This thesis argues that some healthcare privatisation models such as outsourcing and financial privatisation are Sharia compliant. The thesis also considers how in conditions of need, such as financial crises, some forms of privatisation may be considered exceptionally compliant with Sharia in order to ensure the Sharia obligations are maintained. This thesis engages with Sharia scholarship on *Takaful,* an Islamic joint guarantee system, specifically the Saudi Cooperative Health Insurance for Foreign Workers. Understanding *Takaful* showcases how some models of privatisation could be arranged and adopted in a Sharia compliant manner.

Table of Contents

Chapter One Introduction

1.1. Introduction

This thesis examines whether healthcare privatisation in Saudi Arabia is compliant with Sharia. In this chapter, I will introduce the topic, the aim of the research, and its significance. I will outline the key literatures, set forward the main arguments that have developed from the analysis of the literatures and present the arguments of Sharia scholars against privatisation which will be assessed and challenged in this thesis. This chapter will present the research questions and explain how the thesis will answer them.

1.2. Thesis Overview

Sharia obliges states to ensure the public benefit by providing services such as healthcare to all citizens. This requirement forms the basis of the Sharia scholars' opinion that privatisation prevents states from fulfilling their obligations.[1] Despite the Sharia opinion against privatisation, the 2030 Saudi Vision for Healthcare (2030VFH), a two-step agenda for healthcare privatisation, was passed in April 2016.[2] The 2030VFH consists of two privatisation models: an initial corporatisation followed by a total privatisation complimented with a national healthcare insurance scheme. These models will be explained later in this thesis.[3] The Saudi government announced that the

[1] AlShabani, *Privatisation from an Islamic Perspective: Selling the Public Sector to Individuals* (AlBayan
[2] AlDakheel, 'An opinion on the 2030 Vision: A Critical Analytical Reading' (Riyadh 2016); Almashabi, et al., 'Saudi Arabia's Deputy Crown Prince Outlines Plans: Transcript.' Bloomberg, 4 April 2016; Ramady Saudi Aramco 2030: Post IPO challenges (Springer 2017)
[3] ibid

purpose of this agenda is to relieve some of the financial pressure exacerbated by the drop in oil prices and to ensure healthcare is available, accessible and of high quality,[4] as obliged by Saudi law.[5] The clash between opinions is problematic, especially in Saudi Arabia, where laws must be Sharia compliant according to the Basic Law of Governance.[6] Notably, the 2030VFH was passed by Royal Decree rather than the traditional route, via the Council of Senior Scholars, Consultative Assembly and Council of Ministers, who ensure laws are Sharia compliant.[7] Therefore, passing the 2030VFH by Royal Decree could be considered a way to bypass Sharia verification. However, I argue the 2030VFH could be Sharia compliant, even though it did not undergo Sharia verification.

Since its announcement in 2016, there continues to be praising of the 2030 Vision and an emphasis on what will be achieved by 2030 and how the government plans to make the shift to privatisation.[8] However, the 2030VFH discussions do not include the existing problems with Saudi healthcare provision that may be exacerbated by privatising healthcare or provide solutions on how to overcome them.[9] For example, the existing differences in

[4] When healthcare is available and accessible it is considered equitable according to scholars such as Mooney; Mooney, 'The Health of Nations: Toward a New Political Economy' (Zed Books 2012)
[5] AlDakheel, 'An opinion on the 2030 Vision: A Critical Analytical Reading' (Riyadh 2016); Almashabi, et al., 'Saudi Arabia's Deputy Crown Prince Outlines Plans: Transcript.' Bloomberg, 4 April 2016; Ramady Saudi Aramco 2030: Post IPO challenges (Springer 2017)
[6] ibid
[7] Jadwa, Saudi Vision 2030, May 2016; Reed, Saudi Vision 2030: Winners and Losers (Canergie 2016); Saudi Gazette, Full text of Saudi Arabia's Vision 2030, April 2016
[8] Almashabi, et al., 'Saudi Arabia's Deputy Crown Prince Outlines Plans: Transcript.' *Bloomberg*, 4 April 2016; Banafea, et al 'Assessment of economic diversification in Saudi Arabia through nine development plan' (2018) 42 *OPECER* 42; Presley, et al. *A guide to the Saudi Arabian economy* (Springer 2017); Ramady *Saudi Aramco 2030: Post IPO challenges* (Springer 2017)
[9] ibid; Al-Darwish, et al. *Saudi Arabia: Tackling Emerging Economic Challenges to Sustain Growth*. (International Monetary Fund 2015); Safi, "The Challenges For Saudi Arabia Health Care System." (2016) 6 *Indian Journal of Applied Research*; Sajjad, et al. ' an assessment of the healthcare services in the Kingdom of Saudi Arabia: An analysis of the old, current and future systems' (2018) *International Journal of Healthcare Management*; Sons, 'In Dire Need for a New Social Contract: Saudi Arabia's Socioeconomic and Political Challenges in Times of Changing Energy Dynamics' in Jalilvand, et al., *The Political and Economic Challenges of Energy in the MENA* (Routledge 2017)

healthcare provision in Saudi Arabia due to geographical distribution of healthcare workers.[10] In this thesis, I will shed light on the existing obstacles, and provide insight on their effect on healthcare provision and recommendations on how they can be overcome before the intended privatisation.

It is essential to note that I acknowledge that health crises can be overcome and healthcare can be financed without resorting to privatisation. For example, governments may choose to allocate more of their budgets to healthcare and employ more healthcare professionals to resolve problems such as those facing the Saudi healthcare system today, which will be apparent in Chapter Three. Nonetheless, it is evident that the Saudi government will not change its budget allocation method, despite the present healthcare crisis. One example of this is the announcement of the National Transformation Program 2020 which as the name suggests is the first step of a transformation from a welfare state to privatized healthcare.[11] The state announced that by 2020 all hospitals will become corporations.[12] Moreover, I acknowledge that there are other methods for governments to finance healthcare and cut costs. Nonetheless, the 2030 Vision was announced in 2016, three years ago, and since then no alternatives to privatisation have been presented by the government. Therefore, this thesis

[10] Albejaidi, F. "Healthcare system in Saudi Arabia: An analysis of structure, total quality management and future challenges." (2010) 2 *Journal of Alternative Perspectives in the Social Sciences* 794; AlFaqeeh, 'Acess and utilization of primary health care services in Riyadh province, Kingdom of Saudi Arabia' (University of Bedfordshire PhD Thesis 2015); Aljuaid, et al. "Quality of care in university hospitals in Saudi Arabia: a systematic review." (2016) 6 *BMJ open* e008988; Walker, "The Right to Health and Access to Health Care in Saudi Arabia with a Particular Focus on the Women and Migrants" in Toebes, et al. *The Right to Health: a multi-country study of law, policy and practice* (Asser Press 2014); Yusuf, N. "Private and public healthcare in Saudi Arabia: future challenges." (2014).2 *International Journal of Business and Economic Development*
[11] ibid; 'Transforming Saudi Arabia: National Transofrmation Program 2020 Approve' Shearman and Sterling, 14 June 2016
[12] ibid; AlDakheel, 'An opinion on the 2030 Vision: A Critical Analytical Reading' (Riyadh 2016)

solely deals with the decision to privatise healthcare in Saudi Arabia and its focus is to assess the Sharia compliance of the models of privatisation in healthcare rather than to make a normative argument about privatisation or consider what might be possible in different circumstances.

1.3. Primary Research Questions

This thesis aims to assess if healthcare privatisation and transfers of finance through Sharia economic systems can be considered Sharia compliant. To achieve this objective, the thesis will answer the following questions:

1. **Can healthcare privatisation models maintain healthcare equity and quality while cutting costs?**

   The importance of the above question lies in the following points:

   - The aim of the 2030 Vision in Saudi Arabia is to effectively cut governmental costs. Nonetheless, according to both Saudi and Sharia law, healthcare provided by the government is required to be of equity and quality. Therefore, it is essential to ensure that the policies implemented are effectively encompassing both the aim of cost cutting and the legal requirement of ensuring equity and quality of the services provided. Fittingly, the following sub-questions must be answered:
     - What healthcare privatisation models relieve financial burdens?
     - How do these models affect healthcare equity and quality?

   - In response to the calls for privatisation, Sharia scholars against privatisation argued that cost cutting solutions could be found within

Sharia law, and that these Islamic economic systems would be efficient to finance the healthcare system. Furthermore, if the Sharia scholars are justified in their opinion against privatisation, it would be essential to find an alternative to the 2030 Vision that would be in accordance to Saudi and Sharia law. Therefore, it is essential to assess if these Islamic economic systems could be implemented successfully in the healthcare sector and ensure the equity of the services provided. Accordingly, it is essential to answer the following sub-question:

- What Islamic economic systems can be argued to relieve the financial burden while ensuring healthcare equity and quality?

2. How is privatisation understood in Sharia scholarship?

This question is essential to effectively analyse if the Sharia scholars are justified in their opinion against privatisation. The Sharia opinion regarding privatisation is essential to this thesis as Saudi law requires policies to be adherent to Sharia. Therefore, to lawfully permit the planned implementation of a privatisation in Saudi Arabia the Sharia opinion against privatisation would need to be critically analysed and challenged. Consequently, the following sub-questions should be answered:

- What are the shortcomings in the understanding of privatisation in Sharia literature, and how do they affect the validity of Sharia opinions?
- What are the problems with the Sharia opinion against privatisation?

3. How can healthcare provision Sharia compliance be assessed?

Upon analysis of the available literature, Sharia scholars did not assess privatisation in the healthcare sector, which allows this thesis to fill this gap. Therefore, it is essential to determine a method of assessing the degree of compliance of privatisation in healthcare to Sharia. However, to thoroughly determine if privatising healthcare is compliant with Sharia, the requirements and obligations of healthcare provision in Sharia must be identified. Once the obligations on the government and requirements of healthcare are determined, the models of privatisation in healthcare can be effectively and correctly assessed for compliance with Sharia. Answering this question will provide insight into how new areas can be assessed for Sharia compliance. The importance of this finding extends beyond privatisation of Saudi healthcare to include all areas which have not be assessed for compliance with Sharia, which will be beneficial to Sharia scholars and jurisdictions based on or influenced by Sharia. To achieve this it is essential to answer the following sub-questions:

- What is Sharia compliance in the context of healthcare provision?
- What are the Sharia healthcare obligations upon states?
- Which privatisation models are Sharia compliant, and how do they achieve this compliance?

4. Is the 2030VFH Sharia compliant?

Once the above questions are answered the thesis will be able to determine if the models of privatisation specified in the 2030 Vision for Healthcare are compliant with Sharia as Saudi law requires. The importance of this question goes beyond the 2030 Vision and the implementation of

privatisation in Saudi Arabia and extends to include future implementations of privatisation in countries whose jurisdictions are based on or influenced by Sharia, and countries that aim to cut costs yet maintain the provision of available, accessible healthcare of quality to their citizens. Moreover, this question will provide insight into the practicality of the assessment of the Sharia compliance of new areas. To adequately tailor the assessment of 2030VFH to Saudi Arabia it is essential to initially assess the current state of healthcare provision and highlight any existing problems within it as they may be exaggerated with the implementation of privatisation. Answering the following sub-questions is essential to reach a decision regarding 2030VFH:

- Are there any factors that are currently compromising the Sharia compliance of healthcare provision in Saudi Arabia and how can they be overcome?
- Will implementing 2030VFH compromise the Sharia compliance of healthcare provision in Saudi Arabia?

1.4. Main Arguments

To achieve the aim of this thesis and as a result of the questions above, I present six main arguments. First, I argue that the traditional two-fold *Maslahah* and *Maqasidic* methodology that determines state obligations is insufficient, and I propose the inclusion of the *Huquq* methodology to identify the obligations on the government in the context of healthcare provision.[13] When identifying

[13] All terms will be explained later in this chapter

Sharia compliance of healthcare provision it became apparent that utilising the traditional two-step method presented obligations and recommendations on the individual level and not those related to the government. Essentially, determining the obligations on the government in healthcare and assessing the Sharia opinion on privatisation in healthcare would be impossible by depending on the traditional method alone. Accordingly, by adopting this three-step method I was able to identify what Sharia compliance means in the context of healthcare provision and then assess models of privatisation for fulfilment of the criteria.

Second, I contend that the Sharia opinion is based on an incomplete definition and remains restricted to discussing privatisation as a total transfer of ownership to individual personal possession, which is a definition of deregulation rather than a model of privatisation. This argument is based on the analysis of both Sharia and non-Sharia literature discussing privatisation. Upon analysis of the meaning of privatisation in non-Sharia literature it became apparent that there are numerous understandings and arrangements of privatisation. However, the Sharia literature discussing privatisation was fixated on one definition which resulted in neglecting the array of possible understandings and arrangements of privatisation. Accordingly, the Sharia opinion is limited as is the Sharia literature discussing privatisation.

Third, I state that, due to Sharia ownership laws, Sharia scholars are justified in their opinion against the specific to the arrangement identified in the Sharia literature discussing privatisation.

Fourth, I maintain some neglected privatisation models can be considered Sharia compliant in the context of healthcare provision, including the models specified in the 2030VFH. I will demonstrate that some transfers in the healthcare sector allow healthcare provision to be Sharia compliant. These models do not prevent the government from fulfilling the obligations in the context of healthcare provision identified using the three-step method. However, Sharia scholars against privatisation have presented alternatives from within Sharia to finance the healthcare system which they claim can maintain the Sharia compliance of healthcare provision. The validity of the Sharia scholars' claims will be assessed.

Fifth, I demonstrate that the current state of healthcare provision in Saudi Arabia is not compliant with Sharia which constitutes a state of need and necessity for correction. The necessity for improvement stems from the fact that the reasons for noncompliance may continue or be amplified when healthcare is privatised. Moreover, I will explain how the shortage of staff and inadequate distribution of healthcare workers compromises the accessibility and availability of healthcare for patients in rural areas. Understanding that these problems compromise healthcare provision yet the Ministry of Health (MOH) has not corrected them illuminates the need for recommendations to overcome them and effective monitoring mechanisms which are essential with the upcoming privatisations.

Finally, I hold that *Takaful,* an Islamic joint guarantee recommended by Sharia scholars as an alternative to privatisation,[14] could be Sharia compliant in the context of healthcare provision. Through *Takaful* it is possible to cut governmental costs and maintain the Sharia requirements of healthcare provision. The remainder of the alternatives presented by Sharia scholars against privatisation have been less successful and will be challenged.

1.5. Thesis Significance And Originality

The significance of this thesis is derived from the importance of its subject and the scarcity of literature discussing healthcare privatisation from a Sharia perspective. To date, the available literature discusses privatisation in general from a Sharia perspective but does not discuss healthcare privatisation. This thesis also connects different topics and bodies of literature: Saudi law, Saudi healthcare, Sharia, healthcare provisions in Sharia and Islamic history, healthcare law, healthcare finance and non-Sharia literature discussing the privatisation of healthcare.

As claimed in the scholarship, governments like Saudi Arabia are aiming to improve services yet cut costs through privatisation. Furthermore, according to Sharia, governments are obliged to protect their citizens, including from malady and poor health. Therefore, identifying privatisation models that could be considered Sharia compliant is essential and will allow governments to fulfil their aims to improve services and cut costs while adhering to Sharia healthcare

[14] Ali, (2006). Basis And Models of Takaful: The need for Ijtihad. ICMIF Takaful; Murtuza, Insurance in Islam, Some Aspects of Islamic Insurance (IERB 1991); Siddiqi, Insurance in an Islamic Economy (IF 1985)

obligations. Accordingly, this thesis will be significant for the Saudi government when implementing the 2030VFH and will facilitate the assessment of privatisation models according to their Sharia compliance, or lack thereof. The significance of this work extends beyond the 2030VFH and Saudi Arabia to other Sharia-abiding governments, as well as those with Sharia-based legal systems. Additionally, as mentioned earlier, the significance of this work also extends to states who are aiming to cut costs while maintaining healthcare equity and quality.

Moreover, because this thesis will challenge an existing school of thought in Sharia law, I will provide a different perspective and conceptual horizon that has not yet been examined. This thesis will supply an important opportunity to advance the understanding of a Sharia perspective of privatisation generally and in healthcare specifically. Accordingly, this thesis is the first study to analyse the various meanings and purposes of privatisation from a Sharia perspective.

Furthermore, this thesis should make an important contribution to the field of Sharia law by proposing a new methodology to identify governments' obligations by adding a third step to the traditional *Maslahah* and *Maqasid* method. Consequently, this thesis will generate fresh insight into how to identify states' responsibilities. Although I focus on governments' healthcare duties, this method may be applied to other sectors. Therefore, this thesis could be beneficial to researchers discussing human rights in Sharia and the range of states' obligations to their citizens.

This thesis is also significant to Islamic health law because it will be the first work to define what is meant by Sharia-compliant healthcare provision. I will combine the findings of Islamic history related to *Maqasid AlSharia* (The Purpose of Sharia) and *Maslahah* (Public Benefit) and identify in modern terms how Sharia requires healthcare to be provided. Furthermore, this research will contribute to a deeper understanding of Sharia compliance and how the term is not exclusive to financial transactions.

Moreover, this thesis contributes to the campaign of Saudi women's empowerment and gender equality specifically in the context of healthcare because it will highlight the possible effect that the recently emerging claims of gender bias in healthcare. Unfortunately scholars discussing privatisation have neglected the existing inequity and differences between women and men in the context of healthcare provision in Saudi Arabia.[15] In this thesis, I will assess how the compliance of healthcare provision with Sharia, Saudi law and international conventions may be compromised if the claims of gender bias taking place in some Saudi hospitals are true.

Finally, this thesis will be important to the fields of healthcare provision and healthcare finance because it will argue that healthcare can undergo some forms of privatisation and be available to all citizens while remaining Sharia compliant. This thesis will be the first to combine healthcare privatisation

[15] *'Boxed In: Women and Saudi Arabia's Male Guardianship System'* (Human Rights Watch 2016); AlMunajjed, *Women in Saudi Arabia Today* (st Martins Press 1997); Bouachrine, *Women and Islam: Myths, Apologies and the Limits of Feminist Critique* (Lexington Books 2014)

findings and examples in non-Sharia literature with the Sharia healthcare requirements it will identify. Accordingly, I will discern possible methods of healthcare finance through privatisation that would allow healthcare to remain available to all citizens. Therefore, this thesis will be of interest to researchers in the healthcare and healthcare finance fields who are passionate about healthcare privatisation and universal healthcare.[16] Furthermore, this work will be beneficial to governments and healthcare and finance officials who are interested in implementing privatisation options while maintaining healthcare for all citizens.

1.6. Literature

The thesis connects different fields and their respected literatures: healthcare provision, privatisation in healthcare, healthcare finance, Sharia economic systems, Sharia, Saudi law, healthcare in Sharia, Saudi healthcare, Saudi healthcare laws, the Saudi 2030 Vision for healthcare, and privatisation in Sharia. In this section I will present the main literatures discussed and engaged with in this thesis which contributed to the arguments presented in this research.

The Sharia opinion on privatisation is essential as the Saudi government passed the 2030 Vision for Healthcare which includes a plan to privatise the healthcare

[16] According to the World Health Organization universal healthcare is healthcare that is of equity and quality to all with no discrimination; WHO 'Health Systems Financing: The Path to Universal Health Coverage' (2010)

sector.[17] The 2030 Vision was passed by Royal Decree and accordingly was not assessed from a Sharia law perspective despite the fact that the Saudi Basic Law of Governance states that all laws in Saudi Arabia must be adherent to Sharia.[18] One of the most prominent Sharia scholars is AlShabani who described privatisation as the selling of the public sector at a high loss and risk.[19] AlShabani and other scholars such as Ali and AlSaqa were the first to discuss privatisation from a Sharia perspective.[20] Their work was based on and with direct reference to Western literature discussing the effects of Thatcherism and Milton Friedman's work.[21] Sharia scholars, such as Ali, argue that privatizing an entity that is part of the public sector would result in putting citizens at risk of rights deprivation.[22]

All of these arguments by Sharia scholars against privatisation seemed logical based on the definition and explanations in Sharia literature. The arrangement the Sharia scholars focused on in their literature includes a transfer of ownership, management and provision with no government regulation. Such transfers are described as the least favorable in non-Sharia literature according to scholars such as Collins and Murray, and are not considered a form of

[17] The Saudi 2030 Vision by Royal Decree 25 April 2016;'Transforming Saudi Arabia: National Transofrmation Program 2020 Approve' Shearman and Sterling, 14 June 2016; Banafea, et al 'Assessment of economic diversification in Saudi Arabia through nine development plan' (2018) 42 *OPECER* 42; Presley, et al. *A guide to the Saudi Arabian economy* (Springer 2017); Ramady *Saudi Aramco 2030: Post IPO challenges* (Springer 2017)
[18] ibid; The Basic Law of Governance, Royal Decree No.A/90, 31st January 1992
[19] AlShabani, *Privatisation from an Islamic Perspective: Selling the Public Sector to Individuals* (AlBayan 1995) [In Arabic]
[20] ibid; Ali, *Education and Privatisation* (AlAhram 1996) [In Arabic]; Alsaqa, *The Experience of Privatisation in the U.K* (AlMujalad Kuwait University 1997) [In Arabic]
[21] ibid; Hatim, *Global Experience in Privatisation* (Cairo 1994) [In Arabic]
[22] Ali, *Privatisation* (AlAhram 1996) [In Arabic]

privatisation.[23] Non-Sharia literature discussing privatisation unveiled a wide selection of arrangements of privatisation and diverse points of view which were lacking in the available Sharia literature.

In non-sharia literature, Starr describes privatisation as 'a fuzzy concept' that can have several meanings and accordingly can be defined in various ways.[24] There appeared to be a general consensus amongst non-Sharia scholars that privatisation is defined according to the field of expertise and entity privatised. For example scholars such as Kemp and Saltman focused on ownership similar to Sharia scholars and defined privatisation accordingly.[25] As for healthcare privatisation, Scarpaci defines it as reduced levels of public provision, subsidy or regulation of either preventive or curative health services.[26] Unlike in Sharia literature, the definitions of privatisation are numerous and differ from one another in non-Sharia literature. Moreover, the main discussion in non-Sharia literature was focused on the side effects of privatisation, the pros and cons, rather than how to define it. [27]

Two of the most prominent scholars in favor of privatisation are Hemming and Mansoor who argue that the improvement of services is a main purpose to

[23] Collins, 'Strategic planning for state enterprises in Africa:public versus private options' (1989) 9 Public Administration and Development 65-82; Murray, 'Privatisation' (1997) 86 An Irish Quarterly Review 51-61

[24] Starr, 'The meaning of privatisation' (1988) 6 Yale Law and Policy Reviews 1101-1136

[25] Kemp, Privatisation: The Provision of Public services by the Private Sector (McFarland & Co 2007); Saltman, 'Melting public-private boundaries in European health system' (2003) 13 our J Public Health 24-29

[26] Scarpaci, *Health Services Privatisation in Industrial Societies* (Rutgers University Press 1989)

[27] Fariborz, et al. Privatisation for Development: Strategies and Techniques (International Law institute 1987); Murray, 'Privatisation' (1997) 86 An Irish Quarterly Review 51-61; Starr, "The limits of privatisation," in Prospects for Privatisation (The Academy of Political Science 1987) 124-137

privatise.[28] Non-Sharia scholars portrayed privatisation as a beneficial, and in some cases essential step, an opinion that is alien to that presented in Sharia literature discussing privatisation. Nonetheless, not all non-Sharia scholars are in favour of privatisation, some share the views of Sharia scholars against privatisation. Beinen and Waterbury consider privatisation purely an economical decision that disregards citizens' wellbeing.[29] While scholars, such as Lange, believe that the claimed improvement of efficiency is an excuse to privatise which can be achieved without the need to privatise.[30] Nonetheless, what is unique about non-Sharia literature in comparison to Sharia literature discussing privatisation is that these arguments in non-Sharia literature are supported with evidence.

There is evidence in non-Sharia literature that many governments have failed to achieve what they had aimed for through privatising.[31] For example, several scholars discussed the failure of privatisation in Egypt where sectors privatised during the reign of Mubarak were re-nationalised after his overthrowing in 2011.[32] The literature not only states examples but also demonstrates the reasons for the failure of privatisation.[33] According to Price, Karlaftis, and Terzi

[28] Hemming (n 8)
[29] Bienen, et al. 'The political economy of privatisation in developing countries' (1989) 17 World Development 617
[30] Lange, On the economic theory of Socialism (McGraw-Hill 1964)
[31] ibid; Angell, 'Privatizating health care is not the answer: lessons from the United States' (2008) 179 CMAJ 916; Eren, et al. 'Impacts of privatisation of management of health organisations on public health: turkish Health sector evaluation' (2013) Social and Behavioural Sciences 726; Kane, et al. 'Assessing the impact of privatisation public hospitals in three American states: implications for universal health coverage' (2013) 16 Value in Health S24
[32] Beer, 'Privatisation in health system in developing countries: whats in a name?' (2011) 19 Reproductive Health Matters 4; Price, 'The consequences of health service privatisation for equality and equity in health care in South Africa' (1988) 27 Soc Sci Med 703; Waterbury, et al. 'The political economy of privatisation in Developing Countries' (1989) 17 World Development 617
[33] Karlaftis, "Privatisation, regulation and competition: A thirty-year retrospective on transit efficiency." (2008) ITF Round Tables 67; Price, 'The consequences of health service privatisation for equality and

privatisation fails due to two reasons: poor governmental regulation, or the lack of funding to ensure accessibility to all citizens.[34] The work and evidence provided by these scholars against privatisation is of prime interest to this thesis as the Sharia scholar opinion is based on a form of transfer which fully lacks governmental regulation.

As privatisation is recognised in non-Sharia literature as a transfer of ownership, finance or services, this thesis also analyses transfers of ownership, services, and finance within Islamic history and Hadeeth. AlAlbani is one of the most prominent scholars discussing the actions of the prophet and those after him, which form a great deal of Islamic history and a foundation for many Sharia laws today. AlAlbani and AlShayaa state that the prophet delegated Rufaidah AlAslamiyah in Madinah to provide medical services. [35] This example and others found in Islamic history literature, such as that by Ibn Khaldoun, all included a transfer of services or finance.[36] These transfers will be discussed in Chapter Five to see how they resemble non-Sharia definitions of privatisation.

Saudi scholars from finance and healthcare fields have presented opposing opinions to those of Sharia scholars as will be discussed in Chapter Three.[37] Nonetheless, although the literature discussing the current state of healthcare

---

equity in health care in South Africa' (1988) 27 Soc Sci Med 703; Terzi, et al 'Privatisation of health care facilities in Istanbul' (2011) 19 European Planning Studies 1117

[34] ibid

[35] AlAlbani, The Life of The Prophet (Damascus 2001) [In Arabic]; AlShayaa, The Concise Life story of The Prophet (AlRayyan 2003) [In Arabic]; Mohammed The Healthcare System between Islamic Medicine and Natural Medicine (Dar AlHadi 2002) [In Arabic]

[36]ibid; Ali, Islam and the Arab Civilisation (Lajnah 1968) [In Arabic]; AlKatani, The Prophetic Government: Administrative Formalities (Dar AlArqam 2008) [In Arabic]; Hussain, Islam: Its Law and Society (Federation Press 2004); Mahmood, The Reference of The Arab Islamic Civilisation (AlSalasil 1984) [In Arabic]

[37] Chapter Three Section 3.4.1

highlights problems such as the urban-migration and shortage of staff, scholars debating privatisation do not include all of these in their discussions. One important problem that the scholars have neglected in their privatisation discussions is the existing inequity and differences between women and men in the context of healthcare provision in Saudi Arabia.[38] In Saudi Arabia a Royal Decree was passed that states that females should not be required to have a male guardian's consent to obtain services,[39] and the Saudi MOH issued an official statement that clarifies that females above 18 years and of sane mind have full autonomy, and therefore do not need a male guardian for healthcare.[40] Nonetheless, according to Al AlHareth, Said, Zurayk and Walker women in Saudi Arabia are subjected to male guardianship including when seeking healthcare.[41] In the context of healthcare, reported by Mobaraki and Said, the deprivation of women's rights due to gender inequity represents as the inability to seek healthcare when it is needed, or the inability to make her own decisions with regards to her own health.[42] According to a study by Abu Aisha, some hospitals refuse to admit Saudi female patients without the consent of a male guardian

[38] *'Boxed In: Women and Saudi Arabia's Male Guardianship System'* (Human Rights Watch 2016); AlMunajjed, *Women in Saudi Arabia Today* (st Martins Press 1997); Bouachrine, *Women and Islam: Myths, Apologies and the Limits of Feminist Critique* (Lexington Books 2014)

[39] A Royal Decree 33322 was passed in 2017 that stated women did not need a male guardian's approval to obtain public services, yet this was not adhered to and females were asked for male guardian consent regeardless. The 2019 Royal Decree was restating the 2017 law and making it illegal to ask for guardian consent.

[40] AlKhabrani, 'MOH: Female patients are allowed to give consent without guardian signature' *Sabq* 16 January 2019; Royal Decree 33322 7 March 2017

[41] Al Alhareth, et al. 'Review of women and society in Saudi Arabia' (2015) 3 *American Journal of Educational Research* 121; Said-Foqahaa, et al. 'Arab women: Duality of deprivation in decision-making under patriarchal authority' (2011) 9 *Hawa: Journal of Women of the Middle East and the Islamic World* 234; Walker, L. "The Right to Health and Access to Health Care in Saudi Arabia with a Particular Focus on the Women and Migrants" in Toebes, et al. *The Right to Health: a multi-country study of law, policy and practice* (Asser Press 2014) 165; Zurayk, et al. 'Women's health problems in the Arab World: a historic policy perspective' (1997) 58 *International Journal of Gynecology and Obstetrics* 13

[42] Mobaraki, et al. 'Gender inequity in Saudi Arabia and its role in public health' (2010) 16 *Estern Mediterranean Health Journal* 113; Said-Foqahaa, et al. 'Arab women: Duality of deprivation in decision-making under patriarchal authority' (2011) 9 *Hawa: Journal of Women of the Middle East and the Islamic World* 234

and deprive them of healthcare.[43] Despite the severity of this injustice and the fact that almost half of the Saudi population are female,[44] neither the scholars in their privatisation debates or the 2030 Vision have discussed ending the patriarchy in healthcare provision to ensure healthcare for all is achieved as 2030VFH aims.[45]

Accordingly, based on the literature discussing the state of healthcare provision in Saudi Arabia and the opinions of scholars regarding privatising healthcare in Saudi Arabia it is evident that after privatisation the existing problems may be exacerbated and the state of healthcare may be contrary to that required by Saudi law and Sharia.

Sharia scholars remained firmly against privatisation and in response to the calls to privatise called for solutions from within Sharia.[46] Lutfi argued that Sharia was sufficient and suitable for all times and places and therefore solutions should only come from within it. [47] He argued that donations (*Sadaqah*) would be sufficient to finance healthcare.[48] Saleh proposed resorting

[43] Abu Aisha, 'Women in Saudi Arabia: do they have the right to give their own consent for medical procedures?' (1985) 6 *Saudi medical journal* 74
[44] Population by Gender, Age Groups and Nationality 2018 available on www.stats.gov.sa accessed on 2 December 2018
[45] The Saudi 2030 Vision by Royal Decree 25 April 2016;'Transforming Saudi Arabia: National Transofrmation Program 2020 Approve' Shearman and Sterling, 14 June 2016; Banafea, et al 'Assessment of economic diversification in Saudi Arabia through nine development plan' (2018) 42 *OPECER* 42; Presley, et al. *A guide to the Saudi Arabian economy* (Springer 2017); Ramady *Saudi Aramco 2030: Post IPO challenges* (Springer 2017)
[46] Ahmad, *Privatisation Concepts and Experiences* (Markaz AlMajed 1998) [In Arabic]; Saati, 'Privatisation of public hospitals: future vision and proposed framework'. AlEqtisadiyah (Riyadh 2 December 2003) [in Arabic]; World Bank Annual Report 2003; Salhab, *A Critical Study of the Privatisation Project* (AlMawqif, 1999) [in Arabic]
[47] Lutfi, et al, 'Sadaqah-based crowdfunding model for healthcare' (National University of Malaysia 2016)
[48] ibid

to Islamic taxation (*Zakat*) to finance the healthcare system.[49] Some scholars have argued in favour of a more practical method of financing from within Sharia, joint guarantee (*Takaful*).[50] The later is implemented in Saudi Arabia to ensure foreign workers are granted access to healthcare and is known as the Cooperative Health Insurance System (CHIS).[51] The literature discussing and celebrating the CHIS presented by scholars such as AlMobarak and Barakah outlines that the system is similar to premiums and the contributions are based on income.[52] Understanding the differences between insurance and *Takaful* is essential to understand the Sharia stance against privatisation. These differences and similarities will be discussed in Chapter Four.[53]

Unfortunately, Sharia scholars did not discuss privatisation in healthcare or perform an assessment of its Sharia compliance. To enable this thesis to assess the Sharia compliance of healthcare privatisation models it was essential to understand what healthcare provision is according to Sharia. As Sharia does not consist of a written constitution, as do other legal systems, I analysed texts from the primary sources of Sharia and Islamic history literature to understand the Sharia healthcare provision obligations and requirements and form a checklist against which models of privatisation will be assessed. The main texts are those that discussed the obligation to seek healthcare on individuals and the

[49] Saleh, The role of Zakat in Financial and Social Development (AlBayan 2011) [In Arabic]
[50] Ismail, et al., *Essential Guide to Takaful (Islamic Insurance)* (CERT Publications 2008); Murtuza, *Insurance in Islam, Some Aspects of Islamic Insurance* (Islamic Economics Research and Bureau 1991); Siddiqi, M. *Insurance in an Islamic Economy* (The Islamic Foundation 1985)
[51] AlMobarak, 'Beneficiaries' Satisfaction with the Cooperative Health Insurance System (CHIS) in the Kingdom of Saudi Arabia: A Case Study of Riyadh City' (PhD Thesis, University of Hull 2010); Barakah, 'The Cooperative Insurance in Saudi Arabia: a Nucleus to Health Reform Policy' (2011) 21 *IPEDR 6*; Nadim, (2008) The effect of medical insurance on medical services: positive or Negative? Cooperative Health Insurance, No. 3
[52] ibid
[53] Chapter 4 Section 4.3

obligation on the government to ensure the greater benefit of the population and followed the Hanbali school of jurisprudence, which is primarily applied in Saudi Law.[54]

At the top of the hierarchy are the direct statements made by the prophet in the Hadeeth,[55] which have been collected by scholars in specialised books, such as *Kitab AlTeb* (The Book of Medicine). [56] These sacred statements are followed by Sharia literature discussing the importance of health and benefits such as AlGhazali.[57] The Sharia criteria of healthcare provision can be derived from the work of Sharia Medical Ethics pioneers AlRuhawi and AlTabari.[58]

Several scholars in Islamic history have also discussed the status of healthcare provision in Islam such as Ferngren, Kamali, and Nagamia. [59] These scholars set forward examples of the state of healthcare provided by the prophet and his successors earlier on in Islamic history. [60] According to the literature healthcare was free to all provided by the ruler who then delegated healthcare provision to skilful individuals.[61] Scholars such as AlAnsari, Lindsay, and Mehdi discussed how healthcare moved from the mosque to distinct establishments known as

[54] The Basic Law of Governance, Royal Decree No.A/90, 31/1/1992
[55] Sahih Bukhari 1:149
[56] AlKhayat, *Health: An Islamic Perspective* (WHO 1997); AlShohaib, et al. *Health and Well-being in Islamic Societies: A Background, Research and Applications* (Springer 2014); Deuraseh, 'Health and Medicine in the Islamic Tradition based on the Book of Medicine (Kitab AlTibb) of Sahih Bukhari' (2006) 5 *JISHIM* 2; Rahman, *Health and Medicine in the Islamic Tradition* (ABC 1998)
[57] Zayd , AlGhazali on Divine Predicates and their Properties (Ashraf 1970) [in Arabic]
[58] AlKhitamy et. al, 'Bioethics for Clinicians: Islamic Bioethics' (2001) 164 *CMAJ* 60; Levey, 'Medical Ethics of Medieval Islam with Special reference to AlRuhawi's Practical Ethics of the Physician' (1967) 57 *JTAPS* 3; Siddiqi, Paradise of Wisdom by alTabari, Berlin 1928
[59] Ferngren, *Medicine and Religion: A Historical Introduction* (JHUP 2014); Kamali, *Equity and Fairness in Islam* (ITS 2005); Kamali, *Right to Education, Work and Welfare in Islam* (ITS 2010); Nagamia, 'Islamic Medicine History and Current Practice' (2003) 2 *JISHIM* 19
[60] ibid
[61] ibid

Dar AlShifa.[62] The scholars demonstrated that the establishment of *Dar AlShifa* allowed citizens in rural areas to seek healthcare of quality without the need to travel far distances.[63] The literature discussing healthcare during early Islamic history such as that by Rodini, Nowsheravi and Gorini describes in detail how healthcare was of quality.[64] These scholars explain that these healthcare establishments focused on medical education and included new treatments.[65] Accordingly, the literature discussing healthcare provision in Islamic history and the Hadeeth collectively provide insight into the standard of healthcare, consequently denoting that Sharia requires healthcare to fulfil specific criteria. These criteria will be elucidated in Chapter Two,[66] and will serve as the benchmark when assessing healthcare provision for Sharia compliance.

1.7. Methodology

I will initially analyse the Sharia literature that discusses privatisation to gain a detailed understanding of Sharia scholars' objections to it and the reasons behind Sharia scholars' arguments. I will then consider the Sharia opinion in light of non-Sharia literature on privatisation to highlight similarities and differences between understandings of privatisation and its purposes. The textual analysis and comparison will form the foundation of this thesis and allow the arguments it advances to be developed.

---

[62] AlAnsari, Bimaristans and Waqf in Islam (PhD Thesis UOS 2013); Lindsay, Daily Life in the Medieval Islamic World (Greenwood 2005); Mehdi, et al. 'Medical care in Islamic tradition during the middle ages (historicl review)' (2013) 10 *LSJ*

[63] ibid

[64] Gorini, 'Bimaristans and Mental Health in Two Different Areas of the Medieval Islamic World'(2008) 7 *JISJIM* 16; Rodini, 'Medical care in Islamic Tradition During the Middle ages' (2012) 3 *WMC*; Nowsheravi, 'Muslim Hospitals in the Medieval Period' (1983) 22 *JIS* 51

[65] ibid

[66] Chapter Two Section 2.3

However, a major issue that I faced during this study was the lack of Sharia resources discussing privatisation in healthcare and a scarcity of discussions regarding privatisation in general. This became the inspiration for conducting this study as will be discussed later in this chapter. To overcome this obstacle and analyse this issue more closely, I will focus on the *Hanbali* school of thought that significantly utilises *Qiyas, Ijtihad* and Sharia Law Maxims. As I will rely on primary sources in this thesis, it is essential to use *Qiyas, Ijtihad* and Sharia Law Maxims to interpret the primary texts and deduce legal rulings and obligations from them. The *Hanbali* school offers the flexibility to determine the obligations in healthcare provision and reach valid conclusions regarding the Sharia opinion on the different models of privatisation in healthcare.

To determine whether the provision of healthcare is a government obligation, in addition to a textual analysis of Sharia literature discussing health and healthcare, I will adopt the traditional Sharia two-fold methodology that incorporates *Maslahah* (public benefit) and *Maqasid AlSharia* (purpose of Sharia). This established method is utilised in Sharia to determine the obligations of rulers or governments. Sharia scholars from all schools of jurisprudence agree on utilising the *Maqasidic* approach when identifying the obligations of the state, as all four schools of jurisprudence consider *Maqasid AlSharia* the basis for defining moral obligations in Sharia. As for *Maslahah,* the *Hanbali* school includes *Maslahah* when considering states' obligations. The

two-step methodology is of great significance to this thesis because the *Hanbali* school is the primary school of jurisprudence adopted in Saudi law.[67]

Utilising the traditional Sharia method to determine obligations of the government posed another problem during this research. I found the traditional method of *Maqasid* and *Maslahah* insufficient to determine healthcare requirements and obligations.[68] I have found that the traditional method identifies obligations on an individual micro-level rather than observing state obligations towards its citizens. Accordingly, by including the concept of *Huquq* (rights), this thesis will identify Sharia obligations on governments and what Sharia compliance means in the context of healthcare, which will serve as the foundation of the definition of Sharia compliance in healthcare. Furthermore, this three-step methodology that I have developed can be adopted to identify other Sharia obligations of governments in future research.

Subsequently, I adopt Sharia law's *Usul AlFiqh*, a methodology of legal reasoning and analogy in which legal rulings are deduced from Sharia primary and secondary sources, and Sharia law maxims may be employed.[69] This methodology was systemised by AlShafi'i over 1,200 years ago[70] and is widely used today to challenge old rulings by taking recourse to *Maqasid AlSharia* and

[67] The Basic Law of Governance, Royal Decree No. A/90, 31st of January 1992
[68] AbdulWajid, Utility in Classical Islamic Law: The concept of Maslahah in Usul Alfiqh (University Microfilms 1986); Attieh, Towards Activating The Role of Maqasid AlSharia (AlFikr 2001) [In Arabic]; Laluddin, et al, 'The Relationship between Islamic Human Rights and the Maqasidic Approach' (2012) 7 JSS 111
[69] Hallaq, A History of Islamic Legal Theories: An Introduction to Sunni Usul Alfiqh (CUP 1997); Hasan, The Principles of Islamic Jurisprudence: The Command of the Sharia and Juridical Norm (Adam 2005); Jereshah, Origins of Islamic Law, Content and Characteristics (Wahbah 1979); Kamali, Sharia Law: An Introduction (OneWorld 2008)
[70] Mumisa, Islamic Law: Theory and Interpretation (Amana 2002); Vogel, The Islamic School of Law: Evolution, Devolution and Progress (HUP 2005)

to deduce new rulings for matters that arise due to modernisation.[71] A major advantage of *Usul AlFiqh* is that it allows extensions of Sharia based on new requirements and includes specific matters of modern life, such as healthcare privatisation, while considering special circumstances like cost cutting. Accordingly, this methodology is particularly useful for two objectives of this thesis, namely, deducing healthcare provision requirements and challenging Sharia scholars' opinion against privatisation.

First, *Usul AlFiqh* is important to determining healthcare provision requirements, because even though the provision of healthcare may be a governmental obligation, its characteristics and what this obligation may entail remains unclear. Therefore, it is essential to deduce healthcare requirements by drawing on findings in Sharia primary sources and examples from Islamic history regarding health and healthcare. By adopting this methodology, I will establish the basis of healthcare provision requirements and the conduct required by Sharia-abiding governments in the healthcare context. Sharia healthcare provision requirements will serve as part of the benchmark when assessing the privatisation of healthcare for Sharia compliance.

Second, the significance of *Usul AlFiqh* to challenging Sharia scholars' opinion against privatisation is in the possibility of applying Sharia law maxims. Through *Usul AlFiqh*, Sharia scholars aim to find a balance between justice and

[71] Hosen, Modern Perspective on Islamic Law (Elgar 2013); Janin, Islamic Law: The Sharia from Muhammad's Time to the Present (McFarland 2007); Mottahedeh, Lessons in Islamic Jurisprudence (Oneworld 2014)

obligation.[72] The basis of this balance is what should be done because it is obligatory and what should not because it is unjust, remembering the ultimate goal of Sharia is to maintain *Maslahah* and protect *Maqasid AlSharia*.[73] Accordingly, it could be argued that, if an obligation in Sharia is found to contradict *Maslahah* or harm *Maqasid AlSharia*, it would be considered a state of need in this specific case and there would be the necessity to alleviate this harm and need.[74]

Therefore, applying the Law of Necessity would allow what would usually be unlawful to be considered lawful to remedy the situation at hand.[75] For example, the Law of Necessity could be applied if Sharia scholars recognised the high demand for healthcare, similar to the situation today in Saudi Arabia, as one of need. Hence, privatisation like the 2030VFH could be argued to be lawful if it is found to fulfil the basis of Sharia by protecting *Maqasid AlSharia* and establishing *Maslahah*.

Then, this thesis will draw upon non-Sharia literature discussing privatisation in healthcare. Through a textual analysis, this thesis will highlight the types of privatisation in healthcare and identify how these models can be grouped based on the purpose and extent of transfer. Establishing a typology for privatisation

[72] Hallaq, A History of Islamic Legal Theories: An Introduction to Sunni Usul Alfiqh (CUP 1997); Hasan, The Principles of Islamic Jurisprudence: The Command of the Sharia and Juridical Norm (Adam 2005); Jereshah, Origins of Islamic Law, Content and Characteristics (Wahbah 1979); Kamali, Sharia Law: An Introduction (OneWorld 2008)
[73] ibid
[74] Hosen, Modern Perspective on Islamic Law (Elgar 2013); Janin, Islamic Law: The Sharia from Muhammad's Time to the Present (McFarland 2007); Mottahedeh, Lessons in Islamic Jurisprudence (Oneworld 2014); Mumisa, Islamic Law: Theory and Interpretation (Amana 2002); Vogel, The Islamic School of Law: Evolution, Devolution and Progress (HUP 2005)
[75] ibid

in healthcare will allow this thesis to find which privatisation models are claimed to fulfil the objective of cost cutting.

Moreover, the textual analysis of non-Sharia literature discussing privatisation in healthcare will allow this thesis to highlight privatisation's effects on the provision of healthcare. The effects of privatisation in non-Sharia literature alongside Sharia healthcare provision requirements will serve as a benchmark when assessing Sharia compliance. Privatisation models enabling governments to fulfil Sharia healthcare provision requirements according to evidence of privatisation examples in non-Sharia literature could be considered compliant with Sharia. Meanwhile, if the literature presents examples of privatisation's negative effects on any Sharia healthcare provision requirement, the model will be considered not compliant with Sharia.

To understand the circumstances that led to the announcement of the 2030VFH, this research analyses literature discussing the 2030VFH, Saudi healthcare and Saudi healthcare privatisation. This thesis then assesses whether the privatisation of healthcare is compliant with Sharia in light of Saudi Arabia's circumstances. The thesis applies Sharia Law Maxims such as the Law of Necessity, which permits the consideration of specific circumstances, such as the need to cut costs and improve health services, when reaching a ruling. Accordingly, the privatisation models that are assessed and are not Sharia compliant may exceptionally be considered Sharia compliant if proven necessary to allow states to fulfil their Sharia obligations.

As part of my research, I approached Saudi hospital officials and the Saudi MOH personnel who appeared enthusiastic about my pursuit and research and greatly encouraged me. However, hospitals in Saudi Arabia were not cooperative when I asked them for data or information regarding their hospital and patient demographics. They were suspicious and afraid that I would expose them to the public and higher officials, as some have done with other governmental entities over the past years. As there was no data to back the arguments and deduce findings,[76] therefore I decided to overcome this obstacle by focusing on the evidence in the available literature discussing healthcare in Saudi Arabia. The literature was sufficient to identify the problems with the current state which could be further exaggerated when healthcare is privatised.

On my search for equitable healthcare and 'ideal' healthcare systems, I came across the privatised healthcare system in the state of Vermont, which surprisingly was established by Taiwanese experts, after the success of the Taiwanese National Healthcare Insurance System (NHIS).[77] The Taiwanese healthcare system was based on the Canadian system and according to the available literature and figures the Taiwanese NHIS has outperformed the Canadian system.[78] The celebrated success of the Taiwanese system drove me to travel to Taiwan and contact Taiwanese officials, who welcomed my plan to

[76] Ethical Approval was obtained from the University of Kent but has been omitted due to lack of data.
[77] AlMishaal, 'The Benefits of NHI in Taiwan' *Sehat AlSharqia* January 2008; AlMishael, 'The National Health Insurance Experience in Taiwan' *Sehat AlSharqia* January 2008; Chang, et al., 'Health care regulation and the operating efficiency of hospitals: Evidence from Taiwan' (2004) 23 *Journal of Accounting and Public Policy* 483; Cheng, et al. 'Hospital competition and patient-perceived quality of care: Evidence from a single-payer system in Taiwan' (2010) 1 *Health Policy* 65; David, et al. *Six Countries, Six Reform Models: The Healthcare Reform Experience Of Israel, The Netherlands, New Zealand, Singapore, Switzerland And Taiwan - Healthcare Reforms "Under The Radar Screen"* (World Scientific 2009); Papanicolas, et al. *Health System Performance Comparison: An Agenda for Policy, Information and Research* (Open University Press 2013)
[78] ibid

include Taiwan in my research.[79] However, the problem that arose was that, like the Saudis, the Taiwanese hospitals were not keen to share data. They too have had undercover reporters sharing private information with the public and media. Although I was fortunate enough to obtain data from the NHI and prominent healthcare lawyers sadly there was insufficient literature discussing the healthcare system of Taiwan in English, therefore my supervisors and I agreed that I omit Taiwan from this research.

1.8. Thesis Scope

In this thesis, the aim is not to find an ideal method of healthcare finance. Instead, the scope of this research is to assess whether privatised healthcare is Sharia compliant, because it is part of the Saudi government's agenda for change. Therefore, I do not discuss or recommend alternatives to privatisation, although these alternative methods of financing may be more efficient and ethical compared to privatisation. For example, I acknowledge that financing healthcare through taxation and *Zakat* may be more fruitful and ethical. Nonetheless, alternatives to privatisation remain out of the scope of this thesis. Accordingly, it is essential to note that the exclusion of other healthcare financing methods from the discussion does not signify single-mindedness and a bias towards privatisation but is due to the full concentration of this thesis on its scope.

[79] Ethical Approval was obtained from the University of Kent but has been omitted due to insufficient data.

Furthermore, it is crucial to note this thesis will not seek to justify privatisation, but aims to legally prove that healthcare finance can be transferred from governments while assuring Sharia healthcare requirements are maintained. Moreover, in this thesis, I do not claim that privatisation or any method to transfer financing is the panacea for the Saudi healthcare system's problems and economic agenda. Nonetheless, privatisation is the focal point of the 2030VFH; therefore, in this work, I assess the Sharia compliance of healthcare privatisation models. This assessment is fundamental due to the problematic clash between Sharia scholars' opinion against privatisation and the 2030VFH, considering the requirement for laws to be Sharia compliant according to the Basic Law of Governance of Saudi Arabia.

1.9. Thesis Motivation

This thesis's motivation is derived from four main inspirations. The first is the evident conflict between Sharia scholars' disapproval of privatisation and the planned implementation of privatisation policies in light of the obligation for all Saudi laws to be Sharia compliant. Second, the success of the *Takaful*-based Saudi Cooperative Health Insurance (CHI) which transferred healthcare costs from the government to the employers and ensured all foreigners in Saudi Arabia had access to healthcare. The success of the CHI is promising as a similar system can be implemented to ensure healthcare for all residents of Saudi Arabia. Moreover, the success of the CHI also encourages further research into how the Sharia friendly CHI differs from privatisation in healthcare. Furthermore, the success of CHI provides insight into how privatisation models

can be modified to adhere to Sharia requirements. Third, my medical and healthcare law background and personal interest in healthcare equity, human rights, Saudi healthcare, Sharia and Saudi law highlighted the need to evaluate how healthcare finance can be shifted while ensuring compliance with Sharia healthcare provision requirements. Finally, the current state of healthcare provision and lack of available healthcare of quality to all, the current situation would be at risk of further exacerbating when healthcare is privatised as planned.

Furthermore, my personal experiences have also played a huge role into the making of this thesis and my pursuit of Sharia compliant healthcare for all. While reading about the Saudi healthcare system, I became aware of how fortunate I was during my few years there, as I was not subjected to any of the injustices that this thesis highlights. Nonetheless, not all Saudis were as fortunate as myself. The main problem that shaped my interest in Saudi healthcare is travelling for medical care.

In the Saudi healthcare system patients are assigned to specific public hospitals. As patient records are not accessible across public hospitals, therefore patients cannot be admitted to other public hospitals even in the case of emergency. Due to this rule when my late grandmother fell ill, she was required to travel across Riyadh to go to her designated public hospital's A&E. Due to heavy traffic, she was delayed in reaching the hospital and as her situation had worsened she was directly admitted to the Intensive Care Unit upon arrival. However, it is only valid to ask the following: is traveling to receive urgent healthcare equitable?

With the plan to privatise, would access to healthcare become more difficult and compromised? My grandmother's story was not unique as it became apparent to me during my visits to her in hospital. Some patients travel from villages and other cities to seek medical help which was further emphasised in the literature discussing the state of healthcare in Saudi Arabia.

Furthermore, there is a newly emerging discussion about the possibility of healthcare inequity due to male guardianship in Saudi Arabia. While I personally have not been a victim of male guardianship, the stories of some Saudi women in the literature and newspapers show how they are dependent on the approval of their male guardian to access healthcare. I am a firm advocate for health equality and gender equity and I found these extremely lacking in these women's stories. Unfortunately, the literature discussing gender bias in healthcare is new and scarce; hence I will not be including it in my thesis. However, I will discuss how discrimination in healthcare affects the availability and accessibility of healthcare, and is against Sharia and Saudi law and may be exacerbated with the plan to privatise. Therefore, and as I believe academic participation plays a significant role in promoting change, I am determined to do my part through this thesis in calling for Saudi healthcare provision to be as it is required to be in Saudi law, Sharia, and international human rights treaties; free from discrimination. Furthermore, I will highlight the necessity of non-discrimination in healthcare provision, which will pave the way for further research to investigate the possible inequities and emphasise the need to tackle any factors causing discrimination.

The obstacles in data collection that I discussed above in the Methodology section were unfortunate, however they motivated me further. My main drive was to find a way to ensure healthcare equity as Sharia obliges when healthcare is privatised. Accordingly, I focused on the literatures which were sufficient, abundant, available and at the core of the research; Sharia, Saudi law, Saudi healthcare, healthcare in Sharia, privatisation in Sharia, and healthcare privatisation.

1.10. Thesis Context

1.10.1 Calls for Privatisation in Saudi Arabia

The opinion of some finance and healthcare scholars contrasts with the Sharia objection to privatisation.[80] Many finance and healthcare experts claim privatisation is essential to ensure the delivery of welfare services when states aim to cut costs.[81] For example, AlJazzaf asserted that, through privatisation, Malaysia lowered government expenses and allowed money to be spent where needed, which resulted in an overall improvement to services.[82]

Furthermore, healthcare experts emphasise the need for a separation of powers, which is possible through certain privatisation models.[83] According to

[80] AlObaidi, 'Privatisation between Islamic Economics and Positive Economics' (DAA 2011) [In Arabic]; Baltaji, Private Ownership in The Islamic Economical System (AlShabab 1988) [In Arabic]; Pomeranz, 'Privatisation and the Ethics of Islam' (1997) 14 AJISS 264

[81] AlHussain, 'Saudi Healthcare System: Where does improving the services and performance begin?' (RMA December 2004) [In Arabic]; Dossary, 'Health and Development in poor countries with particular reference to Saudi Arabia' (PhD Thesis, UA 1991); Mulla, et al. 'Privatisation of general hospitals and its applications in Saudi Arabia' (KFNL 2001)

[82] World Bank Annual Report 2003

[83] ibid; AlBorie et al 'A 'DIRE' needs orientation to Saudi health services leadership' (2013) 26 LHS; AlSharqi et al, "Diagnosing" Saudi health reforms: is NHIS the right "prescription"? (2013) 28 IJHPM 308;

the World Health Organization (WHO) and scholars such as AlMalki, an issue facing Saudi healthcare is the fact that the public healthcare system in Saudi Arabia is financed, operated, controlled, supervised and managed by the same body, the Ministry of Health (MOH).[84] They emphasise that there is no separation of powers and all authority is centralised in the MOH, which creates a bureaucracy, adds further pressure, and results in delays and unfulfilled tasks.[85] To understand these demands and arguments for privatisation it is essential to outline the development of Saudi healthcare. Identifying key providers and financiers of Saudi healthcare and understanding the arrangements to finance and provide healthcare services since the emergence of a Saudi healthcare system will enable this thesis to demonstrate models of privatisation existed in Saudi Arabia before the scholars calls for privatisation and the announcement of the 2030 Vision for Healthcare. Consequently, the Sharia compliance of some forms of privatisation arrangements can be anticipated.

The birth of Saudi public healthcare was in 1925 in Makkah, when the Public Health Department (PHD) was established by Royal Decree.[86] The purpose of the department was to monitor the health of the pilgrims and the larger population by establishing hospitals.[87] Unfortunately, the national income then

---

AlYousef, et al., 'Organization of the Saudi health system' (2002) 8 EMHJ 645; Mufti, The Saudi Healthcare System Issues and Opinions (Alamn 2002) [in Arabic]

[84] ibid; Almalki et al. 'The healthcare system in Saudi Arabia: An overview' (2011) 7 EMHJ 784; WHO, Country cooperation strategy for WHO and Saudi Arabia (WHO EM 2007)

[85] ibid; AlGhanim, 'Factors Influencing the Utilisation of Public and Private Primary Healthcare Services in Riyadh City' (2004) 19 JKAU 3; Alhowaish, "Healthcare spending and economic growth in Saudi Arabia: A Granger causality approach." (2014) 5 IJSER

[86] AlHussain, 'Saudi Healthcare System: Where does improving the services and performance begin?!' AlIdarah (Riyadh, December 2004); AlYousef, et al., 'Organization of the Saudi health system' (2002) 8 EMHJ 645; Khaliq A., 'The Saudi Healthcare System: A View from the Minaret' (2012) 13 WHP 52

[87] ibid; Milaat, "Public health in the saudi health system: A search for new guardian." (2014) 2 SJMMS 77

was insufficient to cater to all. Hence, most people continued to seek medical help from traditional medicine healers at their own expense.[88] With time, PHD proved extremely limited for the expanding kingdom and demanding population.[89] There was a need for a professional, specialised organisation to conduct health affairs on a large scale.[90] Finally, in 1950, the Ministry of Health was established by Royal Decree,[91] forming the foundation of the early vision of a modern national healthcare service becoming a reality. This huge interest in healthcare and its improvement continued in the modern-day Kingdom and was manifested in the Basic Law of Governance, which states, *'The State shall protect public health and provide healthcare to every citizen'*.[92]

Today Saudi public healthcare is primarily administered by the MOH and is free to the entire population. Alongside the MOH, some governmental agencies maintain hospitals for their employees and their families, such as the Ministry of Defence and Aviation, the Ministry of Interior and the Saudi Arabian National Guard. These agencies' hospitals constitute separate health systems from the main Saudi healthcare system, which is funded by the MOH.[93]

[88] ibid; AlSwailem, A. "Assessing healthcare delivery in Saudi Arabia", (1990) 10 ASM 63; Mufti, The Saudi Healthcare System Issues and Opinions (Alamn 2002) [in Arabic]; AlOsimy, 'Evaluation of primary healthcare in Riyadh, Saudi Arabia' (1994) 1 JFCM 45

[89] ibid; AlYousef, et al., 'Organization of the Saudi health system' (2002) 8 EMHJ 645; Colliers International, 'Kingdom Of Saudi Arabia Healthcare Overview' (2012) Q1

[90] ibid; Jannadi, et al. "Current structure and future challenges for the healthcare system in Saudi Arabia." (2008) 3 APJHM 43; Khaliq, 'The Saudi Healthcare System: A View from the Minaret' (2012) 13 WHP 52; Mahmoud, 'The Development of the National Health System in Saudi Arabia with Emphasis on the Armed Forces Hospital' (M.A. SSU 1985)

[91] Royal Decree no 8697/11/5

[92] The Basic Law of Governance Article 31

[93] AlYousef, et al., 'Organization of the Saudi health system' (2002) 8 EMHJ 645; Colliers International, 'Kingdom Of Saudi Arabia Healthcare Overview' (2012) Q1; Jannadi, et al. "Current structure and future challenges for the healthcare system in Saudi Arabia." (2008) 3 APJHM 43; Mahmoud, 'The Development of the National Health System in Saudi Arabia with Emphasis on the Armed Forces Hospital' (M.A. SSU 1985)

Based on the current literature, an all-governing body no longer serves its purpose and cannot cope with the growing population and its medical needs.[94] Consequently, healthcare provision problems are not readily overcome or addressed, and healthcare services are not provided to all in the different regions of Saudi Arabia as the Basic Law of Governance requires.[95] Hence, scholars like Mufti contend that separating powers through privatisation models would make the MOH more efficient.[96] Scholars have proposed that MOH should supervise hospitals and monitor the national distribution of healthcare, while hospitals manage the delivery of services.[97] Calls for a separation of powers in healthcare through forms of privatisation, such as corporatisation, contributed towards the announcement of 2030 Saudi Vision for Healthcare (2030VFH).

1.10.2 The 2030 Saudi Vision for Healthcare

The 2030VFH is one part of Saudi Vision 2030, which is a comprehensive plan to reduce Saudi Arabia's dependence on oil, diversify its economy and develop public services, including healthcare. One target of this plan is cost cutting through the private sector's greater participation in the economy. Therefore,

[94] ibid; Ali, et al., 'A study of patient satisfaction with primary healthcare services in Saudi Arabia' (1993) 18 JCH 49; Aljuaid, et al. "Quality of care in university hospitals in Saudi Arabia: a systematic review." (2016) 6 BMJ; Alkabba, et al. "The major medical ethical challenges facing the public and healthcare providers in Saudi Arabia." (2012) 19 JFCM; Almalki et al. 'The healthcare system in Saudi Arabia: An overview' (2011) 7 EMHJ 784; Almasabi, "An overview of health system in Saudi Arabia." (2013) 7 RJMS 70

[95] ibid

[96] ibid; AlBorie et al 'A 'DIRE' needs orientation to Saudi health services leadership' (2013) 26 LHS; AlSharqi et al, "Diagnosing" Saudi health reforms: is NHIS the right "prescription"? (2013) 28 IJHPM 308; AlYousef, et al., 'Organization of the Saudi health system' (2002) 8 EMHJ 645; Mufti, The Saudi Healthcare System Issues and Opinions (Alamn 2002) [in Arabic]

[97] AlHussain, 'Saudi Healthcare System: Where does improving the services and performance begin?!' AlIdarah (Riyadh, December 2004) [in Arabic]; AlShaikh, 'Saudi Healthcare Sector: Need for More Investment', Arab News (7 August 2006); Milaat, "Public health in the saudi health system: A search for new guardian." (2014) 2 SJMMS 77

part of the plan is a programme that aims to privatise different sectors in Saudi Arabia. The Saudi government emphasises it will use international best practices, transfer knowledge and achieve its goals in a balanced and scientific manner.[98]

The 2030VFH objectives are to improve healthcare services and the gross domestic product (GDP) to offer a fulfilling and healthy life and diversify the economy. To achieve the 2030VFH, the Saudi government has listed initiatives for authorities such as the MOH, the Saudi Food and Drug Authority, the Ministry of Education and the Saudi Arabia General Investment Authority.[99] These initiatives vary from ensuring a sufficient supply of basic medicines and increasing the capacity and quality of healthcare education to opportunities for foreign investors and increasing medical insurance. Therefore, privatisation is not the only initiative; it is part of the package. Accordingly, when assessing possible outcomes and practicality, it would be incorrect for privatisation alone to bear the burden of achieving all the 2030VFH objectives.

As mentioned, the 2030VFH is a two-step plan. It initially aims to provide healthcare through public corporations, like the UK, where hospitals are public trusts under the MOH, which is claimed to prepare the healthcare system for further privatisation.[100] The first step is the National Transformation Program (NTP). It aims to increase private healthcare spending to 35% from the current

[98] Jadwa, Saudi Vision 2030, May 2016; Reed, Saudi Vision 2030: Winners and Losers (Canergie 2016); Saudi Gazette, Full text of Saudi Arabia's Vision 2030, April 2016
[99] ibid
[100] Almashabi, et al., 'Saudi Arabia's Deputy Crown Prince Outlines Plans: Transcript.' *Bloomberg*, 4 April 2016; Transforming Saudi Arabia: National Transofrmation Program 2020 Approve' Shearman and Sterling, 14 June 2016; AlDakheel, 'An opinion on the 2030 Vision: A Critical Analytical Reading' (Riyadh 2016)

25% by 2020. This increase is argued to augment revenue generated by the private sector by 25% from USD 80Mn in 2016 to USD 1Bn by 2020.[101]

Furthermore, the NTP aims to increase mandatory health insurance, which is claimed to improve access to services and reduce waiting times for appointments with specialists. Currently, all private sector employees in Saudi Arabia have medical insurance, as opposed to only 35% in 2015.[102] Nevertheless, policyholders attain less than 40% of their appointments within four weeks in specialised medical facilities. The NTP aims to expand the medical insurance scheme and increase policyholders' appointments to 70% by 2020 and lessen waiting times.[103]

The second step is the total privatisation and implementation of a national health insurance system (NHI). In this form of privatisation, hospitals are privately owned companies, while the MOH focuses on its legislative, regulatory and supervisory roles. The MOH will privatise around 300 state-owned hospitals and 2,260 health centres by 2030.[104]

Since its announcement, the 2030VFH has been celebrated by many scholars, who argue that it is an essential step given the planned shift from oil in Saudi

[101] ibid; 'Transforming Saudi Arabia: National Transofrmation Program 2020 Approve' Shearman and Sterling, 14 June 2016; Almashabi, et al., 'Saudi Arabia's Deputy Crown Prince Outlines Plans: Transcript.' Bloomberg, 4 April 2016

[102] Alkhamis, A., and Miraj, S. "Association between demographic characteristics and health status of uninsured expatriate workers in Saudi Arabia." (2016) 9 *BBRC* 587; AlSheikhi, 'The Success of Health I.nsurance for Saudi Citizens: Hospital Privatisation in Saudi Arabia' (2016) 8 *European Journal of Business Management* 183

[103] ibid

[104] Almashabi, et al., 'Saudi Arabia's Deputy Crown Prince Outlines Plans: Transcript.' Bloomberg, 4 April 2016; Jadwa, Saudi Vision 2030, May 2016; Reed, Saudi Vision 2030: Winners and Losers (Canergie 2016); Saudi Gazette, Full text of Saudi Arabia's Vision 2030, April 2016

Arabia.[105] Despite these claims, it is imperative to examine privatisation models to adequately assess Saudi Sharia compliance to ensure that not only the aim of cost cutting is achieved but also that healthcare is provided to all with no discrimination as required in both Saudi law and Sharia.

1.10.3 Saudi Law

The Basic Law of Governance,[106] a constitution-like charter consisting of 83 articles, outlines the responsibilities and processes of governing institutions. The Basic Law of Saudi Arabia, adopted by Royal Decree in 1992, holds that the head of state must comply with Sharia. This is because the King, who is also the Prime Minister, combines legislative, executive and judicial functions. Saudi Arabia does not have a coded constitution; however, according to Article 1 of the Basic Law of Governance, the Quran and Hadeeth are the constitution of Saudi Arabia. Furthermore, Article 7 of the Basic Law of Governance states that the law is derived from Sharia, which has ultimate supremacy over manmade laws.[107]

Traditionally, laws in Saudi Arabia pass through a three-stage series of checks to ensure that they comply with Sharia, as required by the Basic Law of Governance. Initially, legal matters are studied by the Permanent Committee for Islamic Research and Issuing Fatwas, which was established by Royal Decree in

[105] AlKhamis, Privatisation of health services: a necessity or a luxury? AlEqtisadiah, 21 July 2015 [In Arabic]; Davis et al., Fiscal and Macroeconomic Impact of Privatisation, (IMF 2000); IMF, Health and Development (2004); Saati A., Privatisation of public hospitals: future vision and proposed framework. Al-Egtisadia Newspaper, 2 December 2003 [in Arabic].
[106] The Basic Law of Governance, Royal Decree No. A/90, 31st of January 1992
[107] Alluhaidan, Ijtihad of Judges in Sharia and its applications in Saudi Arabia (Master thesis, NAU 2004)[in Arabic]; AlZahm, The role of Experience, Islamic law and the Saudi regime (Master thesis, IUM 2011) [in Arabic]

1971. This is an Islamic organisation consisting of five senior scholars (muftis), including the Grand Mufti, who prepare research papers for the Council of Senior Scholars, who in turn advise the King on religious matters. The King appoints the committee's muftis from various Sharia schools of thought to reach a cohesive, thorough and accurate ruling (*fatwa*). The Grand Mufti is the head of the committee and the most senior religious authority in Saudi Arabia.[108]

Next, the decision is passed to the Council of Senior Scholars, whose 21 members are appointed by the King and is also headed by the Grand Mufti. The role of this council is to review research papers prepared by the Committee. If both the Committee and Council approve, the law is deemed to comply with Sharia.[109] Once a ruling is handed down, it is passed to the Council of Ministers, led by the Prime Minister, the King. The King also appoints the Council of Ministers, who are responsible for drafting and overseeing the implementation of internal, external, financial, economic, educational, healthcare and defence policies and general affairs of state. Legislation passes if the Council of Ministers approve it.[110]

However, the government can pass laws without the approval of appointed Sharia scholars and dismiss council and committee members for publicly disagreeing with governmental policy. Examples are the formation of a coalition with the US army during the Gulf War without prior Sharia scholar approval

[108] ibid
[109] ibid; AlAmri, 'The Saudi Policy System' (1982) 15 JEA 8; AlAtawneh, Wahhabi Islam Facing the Challenges of Modernity: Dar allfta in the Modern Saudi State (Brill 2010); Alghamedi, 'Lack of Diversification is a Challenge Facing Saudi Arabia' (2014) 8 JGBI 57
[110] ibid

and the dismissal of AlShithri after publicly opposing the lack of segregation between genders at KAUST University.[111] Furthermore, laws are occasionally passed by Royal Decree. Unlike the traditional route, a Royal Decree means the King directly makes laws without their passing through the three stages. In so doing, some laws have been proven to clearly contradict Sharia. For example, the Saudi Registered Real Estate Mortgage Law[112] was found to contradict Sharia after its passage by Royal Decree in 2008.[113] Therefore, not all laws in Saudi Arabia comply with Sharia, despite the Basic Law of Governance.[114] Accordingly, it is advisable to test the Sharia compliance of laws passed by Royal Decree, such as the agenda to privatise healthcare. Identifying contradictions to Sharia will allow laws to be adjusted accordingly and ensure the obligation for laws to be Sharia compliant is fulfilled.

1.10.4 Sharia Law

Sharia is a form of law derived primarily from the Quran and Hadeeth, the Prophet Mohammad's teachings and conduct. Within these two are the foundations of religious and moral prescriptions and legislation.[115] As defined by Schacht, Sharia is 'the epitome of Islamic thought, the most typical manifestation of the Islamic way of life, the core and kernel of Islam itself'.[116] Accordingly, Sharia is a comprehensive religious and moral system that

[111] Hoteit, 'Saudi Cleric sacked over co-ed university spat' AlArabiya News 4 October 2009
[112] Registered Real Estate Mortgage Law Royal Decree Number 49, dated 13/08/1433H.
[113] AlZeer The Registration of a Real Estate Mortgage (Masters thesis, IMSIU 1430H)[In Arabic]; Hamdan, The reasons for Terminating a Mortgage (MPhil thesis, IMSIU 1435H)[In Arabic]
[114] The Basic Law of Governance, Royal Decree No. A/90, 31 January 1992
[115] AlKhayat Health as a human right in Islam. (WHO 2004); Filiz, "Etiquette Of Life In Islam." NEU 7 (1997). 351 [Arabic Translation of Turkish Publication]
[116] Schacht, An Introduction to Islamic Law (Clarendon 1983); Schacht et al, The Encyclopaedia of Islam (Brill 1991)

combines the institutions in one jurisdiction, rather than dichotomising it as secular and spiritual.[117]

This section will highlight the sources of Sharia law, the different schools of thought within Sharia law, and the purpose of Sharia known as the Essence of Sharia. Understanding the sources, purpose, and different schools of thought of Sharia will enable this thesis to identify the requirements of healthcare provision in Sharia and readily detect what would be in accordance to Sharia and what would not. Consequently, this thesis will be able to recognise if models of privatisation in healthcare are in accordance to Sharia.

1.10.4.1 Sources of Sharia law

Sharia law is a religious law that is believed by followers of the Islamic faith to be dictated by the Creator. Unlike modern laws Sharia law does not consist of a written constitution. The following sections will outline the different sources of Sharia law namely the primary and secondary sources of Sharia law.

I. The Primary Sources of Sharia

The primary sources of Sharia, the Quran and Hadeeth, state various laws collectively known as *Mabad'i AlSharia,* the Sharia Principles,[118] and are considered Divine revelations. Therefore, adherence to them is considered adherence to the will of God.[119] Although most of the Quran's 6,235 verses are

[117] ibid; Madkour, Islamic Jurisprudence (Alqawmiyah 1384H)[in Arabic]
[118] Kamali, Sharia Law: An Introduction (OneWorld 2008); Ramadan, Understanding Islamic Law: From Classical to Contemporary (AlTamira 2006)
[119] ibid; Quran 5:48

concerned with moral and religious subjects, it contains 500 lengthy verses of detailed laws,[120] based on which the Hadeeth established its laws. [121]

Hadeeth enacts its judgements through three capacities: emphasising the Quran's laws, clarifying or justifying them, or making laws about matters on which the Quran was silent. In the latter case, the law originates purely from the Hadeeth, but remains within the realms of related Quran laws.[122] One example of this is the Constitution that Mohammed drafted based on laws of coexistence in the Quran. With these, he organised Arab and Jewish tribes in Medina, uniting them into one body politic during his time.[123]

Notably, many contemporary scholars, such as Schacht,[124] believe Hadeeth was fabricated later in Islamic history and some actions and narrations were falsely attributed to Mohammed. Therefore, it is essential to determine that Hadeeths are correct by examining the series of narrators and the authenticity of the content and historical timeline and ensuring the narrations can be attributed to Mohammed. Fortunately, Hadeeth criticism is an extensive body of studies and an established religious discipline conducted by knowledgeable scholars that relieves individuals and researchers from other disciplines of the in-depth individual analysis and evaluation of the Hadeeth's authenticity. Based on specialised scholars' in-depth examination, correct Hadeeths have been

[120] AlAasmi, Complete Collection of Legal verses of the Quran (SU 2009) [In Arabic]; Jereshah, Origins of Islamic Law, Content and Characteristics (Wahbah 1979)
[121] Hallaq, A History of Islamic Legal Theories: An Introduction to Sunni Usul Al-fiqh (CUP 1997); Kamali, Sharia Law: An Introduction (OneWorld 2008)
[122] Jereshah, Origins of Islamic Law, Content and Characteristics (Wahbah 1979)
[123] Hussain, Islam: Its Law and Society (Federation 2004); Janin, Islamic Law: The Sharia from Muhammad's Time to the Present (McFarland 2007); Maudoodi, The Islamic Law and Constitution (IP 1955)
[124] Schacht et al, The Origins of Muhammadan Jurisprudence (OUP 1950)

incorporated into collections of books, such as Sahih Bukhari and Sahih Muslim, both of which are verified authentic (*Sahih*) Hadeeths collected by Bukhari and Muslim scholars. This thesis refers only to correct Hadeeth collections.[125]

Despite the extensive laws of the Sharia primary sources, not all rulings can be found in them. Sharia law is an ancient law that has existed since over 1400 years, and as new issues and matters arose, the Quran and Hadeeth were found insufficient and lacking. Therefore, Sharia was in need for an evolution, which gave birth to the secondary sources of Sharia. The secondary sources of Sharia will be discussed in the following section.

II. Secondary Sharia Sources

Sharia secondary sources were developed to accommodate products of modernisation that were not directly considered in primary sources. These secondary sources are *Qiyas* (Analogy), *Ijtihad* (Mental Effort). and *Ijma'* (Consensus), all of which are rationalist doctrines that are dependent on related laws within primary sources and derive laws from them. In other words, these laws can be considered extensions of the existing primary sources' laws. [126]

These secondary sources are performed by Sharia scholars knowledgeable in primary sources' laws. This ensures they can reach a ruling, rendering it as

[125] Janin, Islamic Law: The Sharia from Muhammad's Time to the Present (McFarland 2007); Kamali, A Textbook of Hadeeth Studies: Authenticity, Compilation, Classification and Criticism of Hadeeth (IF 2005); Vogel, The Islamic School of Law: Evolution, Devolution and Progress (HUP 2005)

[126] Alama,'Ijtihad Jurisprudence and its Impact on the Multiplicity of Islamic Legal Schools' (2006) 41 AlRabetah 475 [In Arabic]; Fadel, 'Analogical Reasoning in Islamic Jurisprudence: A Study of the Juridical Principle of Qiyas' (2001) 15 JLR 359; Nyazee, Theories Of Islamic Law: The methodology of Ijtihad (IRIP 1994); Ramadan, Ijtihad and Maslaha: Foundations of Governance (Lexington 2006)

conclusive and certain as primary sources' laws. Notably, although *Qiyas*, *Ijtihad*, and *Ijma'* are also sources, Sharia sources are organised hierarchically. Primary place in the hierarchy is given the Quran, followed by the Hadeeth and, finally, *Qiyas*, *Ijtihad*, and *Ijma'*. In other words, secondary sources are utilised only in the absence of a clear ruling in primary sources.[127]

For example, the Sharia scholars' decision against privatisation is the result of the secondary source of Sharia law *Ijtihad* (mental effort).[128] This *Ijtihad* opinion is based on Sharia scholars' interpretation of privatisation while staying adherent to relevant Sharia laws, which are the laws of ownership and laws dictating state obligations to provide welfare services and to monitor and regulate the private sector.[129] However, it is important to note that Sharia rulings are subject to review and reconsideration, as Sharia is mindful of ever-changing circumstances.[130] Moreover, because the Sharia opinion against privatisation is derived from a secondary source, it has a higher probability of reconsideration.[131]

[127] ibid; Shahab Al Din, Rulings in Fatwas (Cairo 1983) [in Arabic]; Kamali, Principles of Islamic Jurisprudence (ITS 2002)

[128] Alama,'Ijtihad Jurisprudence and its Impact on the Multiplicity of Islamic Legal Schools' (2006) 41 AlRabetah 475 [In Arabic]; Nyazee, Theories Of Islamic Law: The methodology of Ijtihad (IRIP 1994); Ramadan, Ijtihad and Maslaha: Foundations of Governance (Lexington 2006)

[129] AlObaidi, Privatisation between Islamic Economics and Positive Economics (DAA 2011) [In Arabic]; Baltaji, Private Ownership in The Islamic Economical System (AlShabab 1988); Pomeranz, 'Privatisation and the Ethics of Islam' (1997) 14 AJISS 264

[130] Hussain, Islam: Its Law and Society (Federation 2004); Janin, Islamic Law: The Sharia from Muhammad's Time to the Present (McFarland 2007); Kamali, Shariah Law: An Introduction (OneWorld 2008); Maudoodi, The Islamic Law and Constitution (IP 1955); Ramadan, Understanding Islamic Law: From Classical to Contemporary (AlTamira 2006)

[131] ibid; The relevant Sharia laws and meaning and purpose of privatisation in Sharia scholarship will be discussed further Chapter Two. In addition, the differences between Sharia and non-Sharia interpretations and understandings of privatisation will be examined to efficiently assess the accuracy of the Sharia opinion against privatisation in Chapters Four and Five.

Although the hierarchy of the different sources of Sharia law is agreed upon amongst all followers of Sharia, the rulings reached may differ between scholars. These differences are due to the differences between the schools of thought within Sharia. The following section will outline the main schools of thought of Sharia.

1.10.4.2 Sharia Schools of Thought

There are four Sharia schools,[132] *Hanafi*, *Hanbali*, *Maliki* and *Shafii*.[133] They differ in three areas: their interpretation of the Quran, their acceptance and interpretation of Hadeeth and their rationalist doctrines. For example, the *Shafii* school depends on individual reasoning, rather than a consensus. The *Malki* and *Hanbali* schools added *Maslahah* (public benefit) and prohibit anything possibly leading to sin, *Sad Bab AlDhara'i*, in legal doctrines.[134]

A Muslim can join any school he or she wishes and change schools without formalities. In modern legislation, it is common for countries to use the divergent opinions of other schools and for a jurist to select or adopt various interpretations of Sharia deemed most suitable. Moreover, legal rules have been occasionally constructed by combining part of one school's doctrine with part of another's. This procedure is employed in most modern Sharia laws of Middle

[132] Alluhaidan, Ijtihad of Judges in Sharia and its applications in Saudi Arabia (Master thesis, NAU 2004)[in Arabic]; AlZahm, The role of Experience, Islamic law and the Saudi regime (Master thesis, IUM 2011) [in Arabic]

[133] Each school of Thought is named after the scholar who established it, and whose interpretations and opinions form the basis of the rulings of its followers.

[134] Hosen, Modern Perspective on Islamic Law (Elgar 2013); Janin, Islamic Law: The Sharia from Muhammad's Time to the Present (McFarland 2007); Mottahedeh, Lessons in Islamic Jurisprudence (Oneworld 2014); Mumisa, Islamic Law: Theory and Interpretation (Amana 2002); Vogel, The Islamic School of Law: Evolution, Devolution and Progress (HUP 2005)

Eastern countries, such as Saudi Arabia, and accommodates the needs and individual circumstances Islam requires.[135] However, the primary school adopted in Saudi Arabia is the *Hanbali* school.[136]

Despite the differences between the various schools of thought of Sharia, all schools are based on the same foundational principles. Furthermore, all rulings and judgements within the different Sharia schools of thought aim to maintain them. These foundational principles are known as the essence of Sharia and will be explained in the following section.

1.10.4.3 The Essence of Sharia

The basis of Sharia is to establish universal social benefits (*Maslahah*) and protect Sharia's Purposes (*Maqasid AlSharia*), namely, religion (*Deen*), life (*Nafs*), intellect (*Aql*), lineage (*Nasl*) and property (*Mal*). The preservation of *Maqasid* is considered essential to the existence of society and the continuation of human life.[137] Therefore, the protection of *Maqasid* is at the core of all Sharia legal obligations and prohibitions. Accordingly, each Sharia ruling protects one of the *Maqasid.* This rule explains all Sharia rulings, such as the prohibition of elective abortions and the obligation to perform abortions when it is the only

[135] AlHussayen, Man-made laws and Islamic Laws (1988) [In Arabic]; Coulson, A History of Islamic Law (EUP 1994)
[136] The Basic Law of Governance, Royal Decree No. A/90, 31st of January 1992
[137] Attieh, Towards Activating The Role of Maqasid AlSharia (AlFikr 2001) [In Arabic]; Crane, 'Human Rights in Traditionalist Islam: Legal, Political, Economic, and Spiritual Perspectives' (2007) 25 AJISS 82; Laluddin, et al, 'The Relationship between Islamic Human Rights and the Maqasidic Approach' (2012) 7 JSS 111

option to save the mother's life.[138]

Due to their importance, the violation of these five *Maqasid AlSharia* constitutes a great crime in Sharia, with their punishments explicitly stated in detail in Sharia primary sources. These punishments are known as *Hadd*, or 'fixed punishment'. These extreme penalties are intended and designed to serve as warnings and eliminate the possibility of these crimes being committed and *Maqasid* being violated.[139]

Furthermore, the specification of *Maqasid AlSharia* emphasises the need to take positive measures that would lead to the establishment of the rights related to these objectives. For example, lineage and life are not only preserved through forbidding abortion[140] and murder,[141] and stating extreme punishments, but also by encouraging marriage[142] and childbearing.[143] Sharia considers these rights as granted by the Divine to all humankind, rather than being granted by rulers or legislation. Thus, humankind was created free and self-governing, and these rights protect and ensure this state. Accordingly, no legislative body can deny an individual these rights. On the contrary, Sharia obliges legislative

[138] AbdulHussain, 'Ensoulment & The Prohibiton of Abortion in Islam' (2005) 16 ICMR 103; Asman, 'Abortion in Islamic Countries- Legal and religious Aspects' (2004) 23 JML 73; Rogers, 'The Islamic Ethics of Abortion in The Traditional Islamic Sources' (1999) 89 JMW 122
[139] ibid
[140] AbdulHussain, 'Ensoulment & The Prohibiton of Abortion in Islam' (2005) 16 ICMR 103; Asman, 'Abortion in Islamic Countries- Legal and religious Aspects' (2004) 23 Med Law 73; Maqasid AlSharia, Ijtihad and Civilization Renewal (IIIT 2012); Ramadan, Understanding Islamic Law: From Classical to Contemporary (AlTamira 2006); Rogers, 'The Islamic Ethics of Abortion in The Traditional Islamic Sources' (1999) 89 MW 122
[141] Quran 5:32
[142] Tirmidhi 3096
[143] AbuDawood 5128

bodies to create conditions that allow these rights to be protected and ensured.[144]

For example, to protect the mind, Sharia calls for pursuing education and knowledge, as stated in the Hadeeth *'The seeking of knowledge is obligatory for every Muslim'.*[145] Consequently, Sharia obliges states to establish conditions to ensure this right where every individual can fulfil this obligation, as this thesis will demonstrate. Likewise, regarding the remainder of *Maqasid*, the state must establish conditions that ensure these are protected and the related rights are delivered.[146] The rights and obligations related to the protection of life, intellect and lineage are connected to healthcare and will be discussed in Chapter Two.

1.10.5 Sharia Obligations for Governments

To determine governments' obligations, Sharia scholars adopt distinct approaches, depending on their school of thought. *Malki* and *Shafi'i* schools consider anything that protects more than one of *Maqasid AlSharia* an obligation on the state.[147] This is known as the *Maqasidic* approach and is essential when identifying states' duties, as all schools of jurisprudence consider *Maqasid AlSharia* the basis for defining moral Sharia obligations as mentioned in the previous section.[148] Therefore, states must ensure *Maqasid*

[144] Maudoodi, Human Rights in Islam (IF 1976)
[145] Tirmidhi 74
[146] Attieh, Towards Activating The Role of Maqasid AlSharia (AlFikr 2001) [In Arabic]; Kamali, Maqasid AlSharia Made Simple (IIIT 2008)
[147] Auda, Maqasid AlSharia as Philosophy of Islamic Law: A Systems Approach (IIIT 2008); Ibn Ashur Islamic Maqasid AlSharia (AlSalam 2005); Duderija, Maqasid AlSharia and Contemporary Reformist Muslim Thought (Springer 2014)
[148] ibid; Attieh, Towards Activating The Role of Maqasid AlSharia (AlFikr 2001) [In Arabic]; Auda, Maqasid AlSharia as Philosophy of Islamic Law: A Systems Approach (IIIT 2008); Howard, 'Muslim Legal Approaches to Modern Problems.' (2001) 8 Islam 21; Kamali, Sharia Law: An Introduction (OneWorld

AlSharia are protected.[149] When adopting the *Maqasidic* approach, health and healthcare from a Sharia perspective are analysed by both primary and secondary Sharia sources in light of *Maqasid AlSharia*.

The second approach is the *Maslahah* approach. As mentioned, Sharia scholars declare *Maslahah* one of the secondary Sharia sources by which rulings can be justified based on the public benefit. *Maslahah* in Sharia is divided into three categories: *Maslahah Mu'tabarah* (expressed in either the Quran or Hadeeth), *Maslahah Mursalah* (not found within Sharia primary sources) and *Maslahah Mulghah* (rejected in Sharia primary sources).

The *Maslahah* approach is fundamental when assessing and identifying states' responsibilities, specifically for those who follow the *Hanbali* school of jurisprudence. The *Hanbali* school requires adopting both the *Maqasidic* and *Maslahah* approaches combined, as it recognises the public interest that is *Maslahah Mu'tabarah* and the protection of *Maqasid AlSharia* as obligations on states.[150] The combination is based in the belief that the delivery of *Maslahahs* specified in Sharia primary sources fulfils God's orders.[151] For Sharia scholars

---

2008); Jereshah, Origins of Islamic Law, Content and Characteristics] (Wahbah 1979) [In Arabic]

[149] Abou ElFadl, Reasoning with God: Reclaiming Sharia in the Modern Age. (Littlefield 2014); Bowering, Islamic Political Thought: An Introduction (PUP 2015); Duderija, Maqasid AlSharia and Contemporary Reformist Muslim Thought (Springer 2014); Ghazali, Development and Islamic Perspective. Malaysia: (Pelanduk 1990); Kamali, Maqasid AlSharia Made Simple (IIIT 2008); Laluddin, The concept of Maslahah with special reference to Imam AlGhazali (IIUM 1998)

[150] AbdulWajid, Utility in Classical Islamic Law: The concept of Maslahah in Usul Alfiqh (University Microfilms 1986); AlMatroudi, The Hanbali School of Law and Ibn Taymiyyah (TF 2006); Laluddin, The concept of Maslahah with special reference to Imam AlGhazali (IIUM 1998); Mouline, The Clerics of Islam: Religiois Authority and Political Power in Saudi Arabia (YUP 2014); Vogel, Islamic Law and the Legal System of Saudi Arabia (BRILL 2000)

[151] Abou ElFadl, Reasoning with God: Reclaiming Sharī'a in the Modern Age. (Littlefield 2014); Barnet, Does Human Rights need God? (Eerdmans 2005); Bielefeldt, '"Western" versus "Islamic" Human Rights Conceptions: A Critique of Cultural Essentialism in the Discussion on Human Rights' (2002) 28 JPT 90; Crane, 'Human Rights in Traditionalist Islam: Legal, Political, Economic, and Spiritual Perspectives' (2007) 25 AJISS 82; Kamali, Fundamental Rights of the Individual: An Analysis of Haqq in Islamic Law, (IIIT 1993)

following the *Hanbali* school, such as in Saudi Arabia, the link between healthcare and Sharia is essential to emphasise its importance and declare its provision an obligation on the state.[152] Therefore, Government Sharia healthcare obligations will be assessed in Chapter Two.

1.10.6 Sharia Law Maxims

Sharia changes with circumstances, societal evolution and alterations in customs and needs.[153] However, this only applies to Sunni schools and a few Shiite scholars who apply Sharia law maxims, which allow the law to accommodate necessity and circumstances. Together with *Dawabit* (rules controlling specific themes), Sharia law maxims consolidate the vast *corpus juris* of Sharia.[154] Sharia law maxims are derived from the extensive and detailed reading of Sharia rules, which jurists have reduced into abstract statements of principles.

Sharia Law Maxims can be divided into two types: leading maxims, that reiterate a text from the Quran or Hadeeth, and subsidiary maxims, whose texts have been formulated by the jurists themselves but remain based on Sharia primary sources' laws.[155] The five leading Sharia law maxims are: *'Hardship is to*

[152] AlMatroudi, The Hanbali Scool of Law and Ibn Taymiyyah (TF 2006); Bearman, et al., The Law Applied: Contextualizing the Islamic Sharia (Tauris 2008); Kareemi, Islamic Law and the State, (LLM Thesis UT 2011); Laluddin, The concept of Maslahah with special reference to Imam AlGhazali (IIUM 1998); Mayer, Islam and Human Rights: Tradition and Politics (Westview 1991); Mumisa, Islamic Law: Theory and Interpretation (Amana 2002); Sattam, Sharia and the Concept of Benefit: The Use and Function of Maslaha in Islamic Jurisprudence (Tauris 2015)
[153] Shahab AlDin, Rulings in Fatwas (Cairo 1983) [in Arabic]
[154] Hasan, The Principles of Islamic Jurisprudence: The Command of the Sharia and Juridical Norm (Adam 2005); Kamali, Sharia Law: An Introduction (OneWorld 2008); Otto, Sharia Incorporated: A Comparative Overview of the Legal Systems of Twelve Muslim Countries in Past and Present (AUP 2010)
[155] ibid; Kamali, Equity and Fairness in Islam (ITS 2005); Kamali, Sharia Law: An Introduction (OneWorld 2008); Mottahedeh, Lessons in Islamic Jurisprudence (Oneworld 2014)

be alleviated',[156] *'Actions are judged by intentions'*,[157] *'Certainty is not overruled by doubt'*,[158] *'Hardship begets facility'*[159] and *'Custom is the basis of judgment'*.[160] These leading maxims are also referred to as: the Law of Removal of Harm, Law of Maslahah, Law of Certainty, Law of Necessity and Law of *Urf* (Custom), respectively. All subsidiary maxims can be encompassed by these five leading maxims.[161] Sharia law maxims have been collected into books such as *Kitab AlAshbah* by AlSuyuti, which was published in 1899, and the *Mejelle*, which was compiled by the Ottomans, completed in 1876 and is still used as a standard reference in some countries today whose laws are partially based on Sharia, such as Kuwait and Jordan.[162]The most common and widely used maxims are *Maslahah*, *Removal of Harm* and *Darurah* (Necessity).

Sharia law maxims rejuvenate Sharia, by accommodating life changes as they appear, rather than solely adhering to sacred, yet ancient, scriptures.[163] As described by Fishman,[164] *'Islamic law is a system of jurisprudence of continuous reform and renewal due to the turbulence and challenges of modern daily life and*

[156] Mejelle Art 20
[157] Mejelle Art 2
[158] Mejelle Art 4
[159] Mejelle Art 17
[160] Mejelle Art 36
[161] For example, the subsidiary maxims *'A greater harm is eliminated by tolerating a lesser one'*, *'Harm may not be eliminated by its equivalent'* and *'Harm is to be eliminated within reasonable bounds'* are derived from the leading maxims: *'Hardship is to be alleviated'* (Mejelle Art 20) and *'Hardship begets facility'* (Mejelle Art 17). In turn, these two leading maxims were derived from the Quranic verses *'God intends ease for you, and He does not intend to put you in hardship'* (Quran 2:185) and *'God does not intend to inflict hardship on you'* (Quran 5:6)
[162] Hasan, The Principles of Islamic Jurisprudence: The Command of the Sharia and Juridical Norm (Adam 2005); Kamali, Sharia Law: An Introduction (OneWorld 2008); Otto, Sharia Incorporated: A Comparative Overview of the Legal Systems of Twelve Muslim Countries in Past and Present (AUP 2010)
[163] ibid; Bearmen, The Islamic School of Law: Evolution, Devolution and Progress (HUP 2005); Jereshah, Origins of Islamic Law, Content and Characteristics (Wahbah 1979); Khan, Foundations of Islamic Law (Pentagon 2007); Rehman et al, 'How islamic are Islamic countries?' (2010) 10 GEJ 2
[164] Fisherman et al, 'Islamic Sunni Mainstream Opinions on Compensation to Unrelated Live Organ Donors' (2011) 2 RMMJ 1

its scientific and medical developments'. Furthermore, the fact that Sharia is derived from more than one source – the Quran, Hadeeth, *Ijma'*, *Maslahah* and *Qiyas*, in AlKhitamy's opinion[165] – permits the flexibility to adapt and include new matters and issues as they arise. Analogy, public interest and necessity are also useful when facing new situations, such as those related to healthcare and healthcare provision laws, as in this thesis.[166] Understanding that Sharia laws are not absolute but modifiable and considerate of ever-changing circumstances allows this thesis to review Sharia scholars' disapproval of privatisation. Importantly, Sharia scholars' opinions, if proven valid, can only be reviewed if a state of need arises in healthcare, with the necessity to improve services.

1.10.7 Sharia Compliance

Sharia compliance is the adherence to all relevant Sharia requirements.[167] All matters not explicitly mentioned in Sharia sources would need to undergo a Sharia compliance test to ensure adherence to Sharia requirements.[168] When testing Sharia compliance, Sharia requirements are check-listed, as evident in research concerning Sharia compliance in finance, such as that by Azmat[169] and Ibrahim.[170] In this thesis, Sharia compliance is relevant because healthcare

[165] AlKhitamy et. al, 'Bioethics for Clinicians: Islamic Bioethics' (2001) 164 CMAJ 60
[166] Imam, 'Islamic health care services in the contemporary world' (1995) 39 IQ 234; Shomali, 'Islamic Bioethics: A General Scheme' (2008) 1 JMEHM
[167] Azmat et al., 'The Sharia Compliance Challenge in Islamic Bond Markets' (2014) 28 PBFJ 47; Ibrahim, 'Issues in Islamic banning and finance: Islamic banks, Sharia compliant investment and sukuk' (2015) 34 PBFJ 185; Sharia compliance is popularly known to describe financing schemes that are within Sharia requirements; Islamic finance is an area that is widely researched, unlike other fields of Sharia. This may lead to the common misconception that Sharia compliance is a term specific to Islamic finance.
[168] AlalSheikh, Fatwas between Sharia Compliance and Following Desire (Jareer 2013) [In Arabic]; AlMaududi, On the Application of Sharia in the Present Era (AlRushd 2012) [In Arabic]; Esposito, What Everyone Needs to Know about Islam (OUP 2002);
[169] Azmat, et. al, 'The Sharia Compliance Challenge in Islamic Bond Markets' (2014) 28 PBFJ 47
[170] Ibrahim, 'Issues in Islamic banning and finance: Islamic banks, Sharia compliant investment and sukuk' (2015) 34 PBFJ 185

privatisation is a modern concept and is not mentioned in Sharia sources; nor has it, based on the available literature, been researched from a Sharia perspective. To understand the Sharia stance on healthcare privatisation, we must compare what Sharia says about healthcare provision to what healthcare privatisation entails. This assessment will allow privatisation models not affecting Sharia healthcare provision requirements to be deemed Sharia compliant.[171] Sharia compliance is extremely important when considering laws in countries that follow Sharia like Saudi Arabia.[172]

1.10.8 Privatisation

Different privatisation models have been highlighted and discussed in non-Sharia literature. The oldest were examples of a privatisation model known as contracting out, which date to ancient Greece and Rome.[173] In those ancient time, some states contracted out work to individuals while it maintained ownership of land, forests and mines to lower costs and improve production,[174] or to reduce bureaucracy and improve efficiency.[175] In modern times, privatisation enthusiasts argue that privatisation was a solution to problems that arose due to nationalisation.[176] The same arguments are presented today

[171] AlalSheikh, Fatwas between Sharia Compliance and Following Desire (Jareer 2013) [In Arabic]; AlMaududi, On the Application of Sharia in the Present Era (AlRushd 2012) [In Arabic]; Esposito, What Everyone Needs to Know about Islam (OUP 2002); Mustafa, 'Islam and the four principles of medical ethics' (2014) 40 JME 479
[172] ibid
[173] Cowan, "A global overview of privatisation." in Hanke, Privatisation and Developmemt (ICS, 1987); Drakeford, et al. Privatisation and Social Policy (Longman 2000)
[174] Pitelis, The Political Economy of Privatisation (Routledge 1993); Starr, "The meaning of privatisation," (1988) 6 YLPR 1101
[175] Fariborz, et al. Privatisation for Development: Strategies and Techniques (ILI 1987); Hatim, Global Experience in Privatisation (Cairo 1994) [in Arabic]; Kahn, et al., Privatisation and the welfare state (PUP 2014)
[176] Hemming, et al. Privatisation and Public Enterprises (IMF 1988); Kemp, Privatisation: The Provision of Public services by the Private Sector (McFarland 2007); Saal, et al. International Handbook on

by scholars who call for Saudi healthcare privatisation, as will be discussed in Chapter Three.[177]

An analysis of non-Sharia literature highlights that privatisation is an umbrella term applied to a variety of arrangements. These include the transfer of ownership, financing, management or provision to the private sector. These arrangements may be a total transfer or a joint ownership and operation between private and public sectors.[178] Privatisation has primarily come to mean two things: the shift of activity or functions from public to private or the shift of the production of goods or services from public to private.[179] Nonetheless, all arrangements of privatisation can be adopted in different fields of the public sector, such as education and healthcare. [180]

Privatisation advocates such as Kemp and Saal argue that each arrangement of privatisation has a specific aim which may be to improve services or cut costs, depending on the model of privatisation implemented. [181] However, some scholars such as Jones argue that some governments may resort to privatisation

---

Privatisation (Elgar 2003); AlRabeie, Privatisation and its effect on development in developing countries (Madbouli 2004) [In Arabic]; Alsaqa, The Experience of Privatisation in the U.K (KU 1997) [in Arabic]

[177] Colliers, 'Kingdom Of Saudi Arabia Healthcare Overview' (2012) Q1; Ismail, "What Derives Public Health Expenditures in Saudi Arabia? Macro-Econometric Analysis." (2016) 6 IJSR 623; Jannadi, et al. "Current structure and future challenges for the healthcare system in Saudi Arabia." (2008) 3 APJHM 43; Jone, et al. 'Challenge to Saudi Arabian Hospitals?' (1984) 5 SMJ 1

[178] Saal, International Handbook on Privatisation, (Elgar 2003); Sappington, et al. 'Privatisation, information and incentives' (1987) 6 JPAM 567; Sheshinski, et al., 'Privatisation and its benefits: theory and evidence' (2003) 49 ES 429; Starr, "The meaning of privatisation," (1988) 6 YLPR 1101

[179] Jones, et al, Share issue privatisations as financial means to political ends, (1999) 53 JFE 217; Kettle, Sharing Power: Public Governance and Private Markets. (Brookings 1993); Laffont, 'Privatisation and incentives' in A theory of incentives in procurement and regulation (MIT 1993)

[180] Kremic, et al. 'Outsourcing decision support: a survey of benefits, risks, and decision factors' (2006) 11 *Supply Chain Management: An International Journal* 6; Roerich, et al, 'Delivering European healthcare infrastructure through public-private partnerships: the theory and practice of contracting and bundling' in *Research in Strategic Alliances* (Information Age Publishing 2013); Rohrer J. Performance contracting for public health: the potential and the implications. (2004) 10 *J Public Health Manage Pract* 23

[181] Hemming, et al. *Privatisation and Public Enterprises* (International Monetary Fund 1988); Kemp, *Privatisation: The Provision of Public services by the Private Sector* (McFarland & Co 2007); Saal, et al. International Handbook on Privatisation (Elgar 2003)

to seek additional political support.[182] These claims are debatable due to the high number of evidence against privatisation.[183] In this thesis the focus is privatisation in healthcare with the aim of cost cutting, as stated in the 2030 Vision for Healthcare.[184] Therefore, only models of privatisation in healthcare that are claimed to fulfil this aim will be assessed for Sharia compliance in Chapter Five.

Sharia scholars define privatisation as *'Naql Kamil LilMulkiyah Min AlQita' AlA'am Ela AlMulkiyah AlFardiyah'.*[185] This definition can be translated as: a total transfer of ownership from the public sector to personal private possession. Based on this definition, Sharia scholars like Eissa argue that the transfer to personal private possession would result in public deprivation, which is against Sharia and would obstruct the public benefit (*Maslahah*) and the purpose of Sharia law (*Maqasid AlSharia*).[186] The Sharia scholars' opinion against privatisation gave rise to the recommendation of alternative economic systems from within Sharia such as *Takaful* (Islamic Joint Financial Guarantee).[187]

---

[182] Jones, et al, Share issue privatisations as financial means to political ends, (1999) 53 *JFE* 217; Mulla, et al. 'Privatisation of general hospitals and its applications in Saudi Arabia' (King Fahad National Library 2001) [in Arabic]; Perotti. et al. "Machiavellian Privatisation." (2002) 92 *AER* 240-258; Saal, *International Handbook on Privatisation*, (Elgar 2003)

[183] Karlaftis, "Privatisation, regulation and competition: A thirty-year retrospective on transit efficiency." (2008) ITF Round Tables 67; Price, 'The consequences of health service privatisation for equality and equity in health care in South Africa' (1988) 27 Soc Sci Med 703; Terzi, et al 'Privatisation of health care facilities in Istanbul' (2011) 19 European Planning Studies 1117

[184] 'Operating Costs' *The Economist* (London 30 April 2016) 30; Aboudah, "Dealing with Economic Sustainability Challenges Evolving from Declining Oil Production in Saudi Arabia" (MS Thesis, MTU 2015); Akoum, "Privatisation in Saudi Arabia: is slow beautiful?." *TIBR* 51.5 (2009): 427; Al-Darwish, et al. *Saudi Arabia: Tackling Emerging Economic Challenges to Sustain Growth*. (International Monetary Fund 2015)

[185] Ali, Privatisation (AlAhram 1996) [in Arabic]; AlShabani, *Privatisation from an Islamic Perspective: Selling the Public Sector to Individuals* (AlBayan 1995) [In Arabic]; Eissa, *Privatisation and a Diversified Economy* (AlMuntalaq 1996) [In Arabic]

[186] ibid; Eissa, Privatisation and a Diversified Economy (AlMuntalaq 1996) [In Arabic]; Saba, Privatisation and a Weak and Absent Public Sector (AlMawqif 1994) [In Arabic]

[187] Ahmad, Privatisation Concepts and Experiences (AlMajed 1998) [In Arabic]; Saati, 'Privatisation of public hospitals: future vision and proposed framework'. AlEqtisadiyah (Riyadh 2 December 2003) [in

1.10.9 *Takaful*

Takaful[188] is a pact of mutual guarantee and protection of its members against loss or damage.[189] It is funded from small, regular donations agreed upon beforehand, similar to premiums. Implementing such a system would relieve the government of its financial burden. However, the questions that arise are: can *Takaful* be implemented in healthcare, and will it be Saudi Sharia compliant?

Takaful has been practised since AD 622 during the time of Mohammed between the Muslims of Makkah and Medinah.[190] This laid the foundation for insurance in Islam. Despite the resemblance to *Takaful*, many scholars consider conventional insurance forbidden, as it has elements of interest (*Riba*), uncertainty (*Gharar*) and chancing (*Qimar*), which are all categorically unlawful in Sharia.[191] Nonetheless, the aim of this thesis is to discuss the practicality and legality of economic systems from within Sharia and the Sharia compliance of non-Sharia systems to finance the provision of healthcare. Furthermore, Sharia compliant insurance is relevant to this thesis as the second phase of the 2030VFH includes the establishment of an NHI as mentioned earlier in this chapter.[192]

Arabic]; World Bank Annual Report 2003; Salhab, A Critical Study of the Privatisation Project (AlMawqif, 1999) [in Arabic]

[188] *Takaful* is defined according to Section 2 Malaysian Takaful Act 1984 as 'a scheme based on brotherhood, solidarity, and mutual assistance which provides for mutual financial aid and assistance to the participants in case of need whereby the participants mutually agree to contribute for that purpose'.

[189] Ali, (2006). Basis And Models of Takaful: The need for Ijtihad. ICMIF Takaful

[190] Fisher, et al. Prospects for Evolution of Takaful in the 21st century, 2000

[191] Ismail, et al., Essential Guide to Takaful (CERT 2008); Murtuza, Insurance in Islam, Some Aspects of Islamic Insurance (IERB 1991); Siddiqi, Insurance in an Islamic Economy (IF 1985)

[192] Section 1.10.2

The question that arises is: how does conventional insurance, which some consider unlawful, differ from *Takaful*? The distinction between conventional insurance and Islamic-accepted insurance (*Takaful*) is that conventional insurance is where a party offers and sells protection and the other party accepts and buys the service at a certain cost.[193] Hence, there is an arguable risk of loss and exploitation according to some schools of thought in Sharia as will be outlined in Chapter Two. However, as explained earlier in this chapter,[194] Sharia forbids harming *Maqasid AlSharia* and exploiting individuals in any way, including financially, which Sharia scholars argue to be a possibility in conventional insurance.[195] The understanding of *Takaful* and its protection of *Maqasid AlSharia* highlights the basis of Sharia scholars' disapproval of privatisation.[196]

There are four types of *Takaful*, the most famous being *Mudaraba*-based *Takaful*, which is based on profit sharing.[197] In *Mudaraba*-based *Takaful*, the operator manages the *Takaful* business and gains returns from investing funds in Sharia-compliant ways in accordance with a ratio agreed upon by the operator and policyholders.[198] Any expenses of the investment are charged to

[193] Hargaves, et al., 'The Contribution of Insurance Coverage and Community Resources to Reducing Racial/Ethnic Disparities in Access to Care' (2003) 38 *Health Services Research* 809; Ma, 'Optimal Health Insurance and Provider Payment' (1997) *American Economic Review* Sept 685; Newhouse, J. *Free for all? Lessons from the Rand health insurance experiment* (Harvard University Press 1993)
[194] Section 1.10.4.3
[195] AlFadhil, 'Healthcare Insurance in Shariah and Law' (Masters Thesis, Islamic University of Madinah 2012) [In Arabic]; Ali, 'Principles and Practices of Insurance under The Islamic Framework' (1989) Insurance Journal 29; Siddiqi, M. *Insurance in an Islamic Economy* (The Islamic Foundation 1985)
[196] ibid
[197] Ismail, et al., *Essential Guide to Takaful (Islamic Insurance)* (CERT Publications 2008); Jaffer. *Islamic Insurance: Trends, Opportunities and the Future of Takaful* (Euro money Institutional Investment Plc. 2007); Maysami, 'An analysis of Islamic Takaful Insurance: A Cooperative Insurance Mechanism' (1999) 18 Journal of Insurance Regulation 109
[198] ibid

the shareholders' fund. All other charges, including administrative fees, are charged to the policyholders' fund. In the case of a surplus, policyholders receive the full amount. This form of *Takaful* is highly utilised in forms of bank investments today in Saudi Arabia, where *Sukuk* bonds are bought by individuals at a fixed price for banks to invest, with a set annual return on top of the surplus.[199]

Takaful is not restricted to loans and investments; it can also be applied to health insurance,[200] in the form of a long-term *Mudaraba* contract.[201] All individuals pay a set amount, which is divided between funds and investments based on the individual's risk level,[202] in a form that saves individuals from loss and exploitation.[203] The understanding of the implementation of *Takaful* will allow this thesis to assess Saudi and Sharia compliance to its implementation in the healthcare sector as an alternative to privatisation.

[199] ibid; Abdullah, et al. "Risk in Funding Infrastructure Projects through Sukuk or Islamic Bonds."(2014) 3 *International Review of Management and Business Research* 915; Ibrahim, 'Issues in Islamic banning and finance: Islamic banks, Sharia compliant investment and sukuk' (2015) 34 Pacific-Basin Finance Journal 185; Nienhaus *Takaful Islamic Insurance: Concepts and Regulatory Issues* (John Wiley & Sons 2009)

[200] Abdullah, 'Risk Management via Takaful from a Perspective of Maqasid Sharia' (2012) 65 SBS 535; INCEIF, Takaful Realities and Challenges (Pearson 2012); Islamic Economics, Risk Management in Islam Takaful (IRW 2003)

[201] The premium paid is divided into two separate funds: the policyholder's fund, which will be invested, and the policyholder's special fund, which is considered a donation and has an unfixed amount. This amount is calculated by considering the risk level of the policyholder, which is determined by a few criteria: age, gender, duration and health.

[202] Abdul Aziz, 'Fulfillment of Maqasid al-Shari'ah via Takaful' (2013) 1 *International Policy Review*; Abdul Rahman, Takaful: Potential Demand and Growth, (2009) 22 *J.KAU: Islamic Economics* 55; Ismail, et al., *Essential Guide to Takaful (Islamic Insurance)* (CERT Publications 2008); Jaffer. *Islamic Insurance: Trends, Opportunities and the Future of Takaful* (Euro money Institutional Investment Plc. 2007); Syahida, 'Risk Management via Takaful from a perspective of Maqasid AlSharia' (2012) 65 *Social and Behavioral Sciences* 535

[203] If the policyholder is considered a high risk, for example is elderly and suffers from certain illnesses, more money would be put into the special fund, and less would be invested. Accordingly, those most likely to file a claim knowingly donate; thus, they are not subject to losses The reverse would occur if the policyholder were low risk, for example young fit individuals. Therefore, those less likely to file a claim knowingly contribute to the investment, thus, they are not subject to exploitation.

One example of healthcare *Takaful* is the Cooperative Health Insurance System for foreigners in Saudi Arabia (CHIS) established in 2005. According to article 13 of the Saudi Health Law, the state will provide healthcare services to foreigners through the CHIS rather than through the state budget.[204] According to the Cooperative Health Insurance Act, employers must pay premiums and relieve MOH of the financial burden while not depriving foreigners of their right to healthcare.[205] An understanding of the implementation of *Takaful* in healthcare will allow this thesis to assess the compliance of finance transfers regarding healthcare with Sharia and Saudi law.

1.11. Chapter Outline

This thesis is arranged in six chapters:

Chapter One: introduces the topic, its significance, methodology, terminology, and research questions. The chapter links the different topics discussed in this thesis to provide the reader with an overview of the following chapters and an understanding of how these topics relate: Sharia government duties, privatisation in healthcare, Saudi healthcare, *Takaful*, the 2030 Vision for healthcare, Sharia law, Saudi law (and the meaning of Royal Decree and lack of Sharia verification) and healthcare equity in Sharia law. Chapter One presents the main literature which this thesis engaged with and contributed to the

[204] The Saudi Health Law, Royal Decree No. M/11, 4 June 2002

[205] AlMobarak, 'Beneficiaries' Satisfaction with the Cooperative Health Insurance System (CHIS) in the Kingdom of Saudi Arabia: A Case Study of Riyadh City' (PhD Thesis, UH 2010); Alosaimi, et al. The equity in access to health services in cooperative health insurance system, Jeddah, 2008-2009. (ABCM 2009); Barakah, et al. 'The Cooperative Insurance in Saudi Arabia: a Nucleus to Health Reform Policy' (2011) 21 IPEDR 6; Implementing Regulations of the Cooperative Health Insurance Law in the Kingdom of Saudi Arabia (Amended) Cooperative Council for Health Insurance, Session 73 Ministerial Decision DH/1/30/6131 (2009); Rules of Implementation of Cooperative Health Insurance System & Cooperative Health Policy, Ministry of Health Resolution 460/23/DH (2002); The Cooperative Health Insurance Act, Royal Decree M/10 August (1999)

arguments it presented. This chapter also presents the motivations that led to this thesis, its main objectives, and the arguments that it sets forward.

Chapter Two: The main argument presented in this chapter is that healthcare is required to be provided by the government to all citizens according to Sharia, which appears contrary to the state of privatised healthcare. Therefore, privatisation may be considered unlawful in Sharia, and Sharia scholars could be justified in their opinion against privatisation. The chapter demonstrates that healthcare provision is an obligation on the state by initially demonstrating how obligations are deduced, and then identifying the criteria of this obligation to provide healthcare. Chapter Two also critiques the existing method of determining government obligations and presents the argument that the current methodology adopted is insufficient to declare services obligations on the state. The healthcare obligations, requirements, and criteria derived from the analysis of Sharia literature will serve as part of the benchmark when assessing models of privatisation for Sharia compliance.

Chapter Three: discusses Saudi healthcare laws and the state of Saudi healthcare provision, and indicates how these differ from Sharia healthcare provision requirements, arguing that Saudi healthcare is not currently compliant with Sharia. The chapter highlights gaps in Saudi laws which it argues may allow certain privatisation models to be implemented. Chapter Three reviews literature discussing calls for healthcare privatisation in Saudi Arabia, the 2030 Vision for healthcare and outlines the laws for privatising healthcare which bypassed requirements for Sharia verification. This chapter

will highlight how these new laws differ from what Sharia dictates and how this contradicts the Basic Law of Governance which states laws must be compliant with Sharia in Saudi Arabia.

Chapter three also presents the argument that the state of healthcare in Saudi Arabia constitutes a state of necessity and need which allows the Sharia scholar ruling to be exceptionally reconsidered. In this chapter I analyse the literature discussing the economy, gender inequity, and the high demand on the Saudi healthcare system and investigate if these circumstances can be considered need and necessity, which will justify adopting Sharia law maxims when assessing Sharia compliance. Accordingly, some models of privatisation in healthcare may be considered compliant if they relieve and remedy the state of need and necessity.

Chapter Four: discusses different meanings, purposes and arrangements of healthcare privatisation in general then focuses on privatisation in healthcare. These meanings will be compared to the meaning and purpose of privatisation in Sharia literature to identify the shortcomings of Sharia scholarship. Accordingly, the chapter will demonstrate that the Sharia opinion is specific to one arrangement of privatisation rather than against privatisation in general. In this chapter I argue that the meaning and purpose of privatisation in Sharia literature is limited and precise, identifying just one model while privatisation is an umbrella term in non-Sharia literature. Therefore, I argue that the Sharia opinion is specific to just one single model, and not necessarily to others.

Chapter Four engages with Sharia literature discussing *Takaful* and critiques alternatives that Sharia scholars propose to finance healthcare. In this chapter I concur with the opinion of some Sharia scholars and argue that healthcare may be financed by specific economic systems from within Sharia, while other systems fail to reach the potential they advocate. Moreover, Chapter Four takes a closer look at *Takaful* in healthcare as envisaged in the Saudi Cooperative Health Insurance for Foreign Workers. The understanding of the implementation of *Takaful* allows us to anticipate the Sharia compliance of some models of privatisation, such as financial privatisation, and the NHI.

Furthermore, in Chapter Four, I develop a typology that groups healthcare privatisation models according to their main objective. The typology allows ease in identifying models of privatisation that allow cost cutting to readily assess their Sharia compliance.

Chapter Five: The main argument in this chapter is that some models of privatisation in healthcare can be considered Sharia compliant as they do not affect the ability to provide healthcare adherent to Sharia healthcare provision requirements. In this chapter I identify healthcare finance privatisation models by using the developed typology. The chapter combines the evidence from non-Sharia bodies of literature discussing the problems with privatisation in healthcare and the Sharia requirements for healthcare provision and accordingly assesses their Sharia compliance. Moreover, chapter five highlights arrangements of privatisation adopted in Islamic history. Consequently, this

chapter will identify which models of privatisation in healthcare can be considered compliant with Sharia.

Chapter Six: draws a conclusion based on the findings of the thesis thus far and identifies the limitations of this research and directions for possible future research. The main argument this chapter presents is that with monitoring and regulation by the government and independent bodies, healthcare finance and provision can be transferred from the government through privatisation and *Takaful* while healthcare provision remains compliant with Sharia and Saudi law. The compliant methods of privatisation include those specified in the 2030 Vision for healthcare which bypassed Sharia verification when it was passed by Royal Decree in 2016. This chapter emphasizes that the burden of their continued compliance lies upon the government which is obliged in Sharia and Saudi law to monitor public services including healthcare.

Furthermore, Chapter Six acknowledges that the Saudi healthcare provision requires monitoring and regulation by governmental and independent bodies to ensure existing problems are not exacerbated with the plan to privatise.

Chapter Two Sharia, the State and Privatisation

2.1 Introduction

In order to challenge the Sharia opinion that privatisation prevents states from fulfilling their Sharia obligations, in this chapter I will define Sharia compliance in the context of healthcare provision, and I will critique the Sharia scholar analysis of privatisation. To define healthcare provision compliance, I will determine whether healthcare provision is an obligation on the state through the adoption of the *Maslahah* and *Maqasidic* approaches that were discussed in Chapter One and are widely utilised by Sharia scholars.[206] According to the majority of schools of jurisprudence, adopting either approach would be sufficient to identify obligations of the state.[207] However, I argue that either approach in isolation is insufficient to declare the provision of a particular service an obligation on the state, and I have adopted a three-fold approach: the *Maslahah, Maqasidic* and *Huquq* approaches, combined. I will determine what the healthcare obligation on the state entails. Based on these findings, I will assess the Sharia compliance of healthcare according to the model of privatisation, as identified in Sharia's precise definition.

I argue that, due to laws of ownership,[208] the terminology of the Sharia scholars' definition of privatisation has led them to argue that privatisation prevents the

[206] Chapter One Section 1.10.5
[207] AbdulWajid, Utility in Classical Islamic Law: The concept of Maslahah in Usul Alfiqh (University Microfilms 1986); Attieh, *Towards Activating The Role of Maqasid AlShariah* (AlFikr 2001) [In Arabic]; Jackson, Islamic Law and The State (BRILL 1996)
[208] Behdad, "Property Rights in Contemporary Islamic Economic Thought: A Critical Perspective" (1989) 2 *RSE* 185; Taleqani, *Islam and Ownership* (Lexington 1983)

state from fulfilling its obligations to regulate the private sector, to sustain the economy and to provide basic services.[209] Nonetheless, I argue that, due to the Sharia definition's specific terminology, the Sharia analysis is fixated on one arrangement.[210] Accordingly, in this chapter, I demonstrate the shortcomings of both the Sharia definition of privatisation and the analysis based on it.[211] The next section will identify Sharia healthcare obligations.

2.2 Sharia Obligations on the State in the Context of Healthcare Provision

In order for this thesis to challenge Sharia scholars' opinions against privatisation the following section will determine whether healthcare is an obligation on the government by adopting the *Maqasidic* and *Maslahah* approaches that were explained in Chapter One.

2.2.1. Healthcare provision through the *Maqasidic* approach

The *Maqasidic* approach was derived by the Sharia jurist AlGhazali, who identified, through the in-depth analysis of Hadeeth and Quran legal texts, that the protection of *Maqasid AlSharia* is essential to individuals.[212] As rule of

[209] Kholwadia, et al, 'Wilayah (authority and governance) and its implications: A Sunni perspective' (2013) 34 *JTMB* 95; Qasmi, *Islamic Government* (Gyan 2008); Souaiaia, *Islamic Law and Government*. (WCP 2002)
[210] ibid; Kemp, Privatisation: The Provision of Public services by the Private Sector (McFarland & Co 2007); Saltman, 'Melting public-private boundaries in European health system' (2003) 13 our J Public Health 24-29
[211] Baderin, *Islamic Legal Theory* (Routledge 2017); Dusuki, et al. 'Maqasid AlShariah, Maslahah and Social Responsibility' (2007) 24 *AJISS* 25; Howard, 'Muslim Legal Approaches to Modern Problems.' (2001) 8 *Islam* 21, 2–3; Kamali, 'siyasah Shariyah or the Policies of Islamic Government' (1989) 6 *AJISS* 59; Mumisa, *Islamic Law: Theory and Interpretation* (Amana 2002); Saeed, Islamic Thought: An Introduction (Routeldge 2006); Vogel, The Islamic School of Law: Evolution, Devolution and Progress (HUP 2005)
[212] Abou El Fadl, Reasoning with God: Reclaiming Shar ia in the Modern Age. (Rowman & Littlefield 2014); Bowering, *Islamic Political Thought: An Introduction* (PUP 2015); Duderija, Maqasid AlShariah and Contemporary Reformist Muslim Thought (Springer 2014); Ghazali, *Development and Islamic Perspective*. Malaysia: (Pelanduk 1990); Kamali, Maqasid AlShariah Made Simple (IIIT 2008); Laluddin, *The concept of Maslahah with special reference to Imam AlGhazali* (IIUM 1998)

thumb, what preserves *Maqasid AlSharia* is considered an obligation in Sharia, and what harms them is considered prohibited.[213] Three of the five *Maqasid* cannot be safeguarded without the preservation of health, namely life, progeny and mind, and the protection of these three *Maqasid AlSharia* forms the basis of all Sharia healthcare laws.[214] Accordingly, what preserves health, and consequently life, progeny and mind, is an obligation, and what harms health, and consequently life, progeny and mind, is prohibited. Thus, as the protection of health is an obligation in Sharia, with this obligation comes the obligation on individuals to seek cure when ill, which is reiterated in Sharia primary sources.

The obligation to preserve health is highlighted in Sharia primary sources and in the Hadeeth specifically, which states, 'Second to faith, no one has ever been given a greater blessing than good health'.[215] Moreover, the Sharia obligation to protect health is further emphasised by directly declaring the protection of the body and health to be a right in the Hadeeth, with the words, 'Your body has a right upon you'.[216] Furthermore, individuals adhering to Sharia law are ordered as part of the obligation to preserve health and life to 'Seek cure as God has created no disease without creating a cure for it, except old age'[217].

---

[213] ibid; Attieh, Towards Activating The Role of Maqasid AlShariah (AlFikr 2001) [In Arabic]; Auda, Maqasid AlShariah as Philosophy of Islamic Law: A Systems Approach (IIIT 2008); Howard, 'Muslim Legal Approaches to Modern Problems.' (2001) 8 *Islam* 21, 2–3; Kamali, Shariah Law: An Introduction (OneWorld 2008); Jereshah, Origins of Islamic Law, Content and Characteristics] (Wahbah 1979) [In Arabic]

[214] Deuraseh, 'Health and Medicine in the Islamic Tradition based on the Book of Medicine (Kitab AlTibb) of Sahih Bukhari' (2006) 5 *JISHIM* 2; Mustafa, 'Islam and the four principles of Medical Ethics', (2014) 40 *JME* 479

[215] AlAlbani, The Life of The Prophet (Damascus 2001) [In Arabic]; Deuraseh, 'Health and Medicine in the Islamic Tradition based on the Book of Medicine (Kitab AlTibb) of Sahih Bukhari' (2006) 5 *JISHIM* 2; ElKadi, 'Health and Healing in the Quran', (1985) 2 *AJISS* 291; Ernst, *Following Muhammad: Rethinking Islam in the Contemporary World* (UNCP 2004); AlAlbani 1:94; Ramadan, *In the footsteps of the prophet: lessons from the life of Mohammed* (OUP 2009)

[216] Sahih Bukhari 5199

[217] Sahih Bukhari 1:149

Various statements in the Hadeeth focus on the obligation of individuals to seek cure and the importance of medication and remedies, such as cupping and other medicinal practices, including fasting, to maintain health and cure sicknesses.[218] To further emphasise the importance of maintaining health in Sharia, the obligations of maintaining health and seeking cure have been extended to include medications that contain products that would normally be considered forbidden.[219] This decision has been reached by utilising the Sharia Law Maxims of Necessity and Harm, which state: 'No harm or counter-harming', 'Harm must be removed', 'Necessity renders the prohibited permissible', 'Need, whether private or public, is treated as a necessity', and 'That which is legalised due to necessity shall only be recognised to the extent of the necessity'.[220] Accordingly, a situation must consist of harm to *Maqasid AlSharia* in order for it to be recognised as a need, and only then will a ruling be reconsidered for that specific situation. For example, medications containing pork products such as heart valves from pigs, which are traditionally prohibited, are acceptable in Sharia if they are necessary to relieve the harm.[221] Accordingly, it could be said that in cases of absolute necessity in which Sharia-accepted alternatives do not exist, Islamic teaching allows for Sharia law to be suspended temporarily to

[218] AlShohaib, et al. *Health and Well-being in Islamic Societies: A Background, Research and Applications* (Springer 2014); Deuraseh, 'Health and Medicine in the Islamic Tradition based on the Book of Medicine (Kitab AlTibb) of Sahih Bukhari' (2006) 5 *JISHIM* 2; Rahman, *Health and Medicine in the Islamic Tradition* (ABC 1998)

[219] ibid; Clukey R., (2007), Islamic Medical Ethics, Concordia College; ElKadi, 'Health and Healing in the Quran', (1985) 2 *American Journal of Islamic Social sciences* 291; Farhad, *Islam and the everyday World: Public Policy Dilemmas,* (Routledge 2006)

[220] Badar, 'Islamic Law (Sharia) and the Jurisdiction of the international criminal court' (2011) 24 *LJIL* 411; Biu, et al. 'The relevance of Islamic Legal Maxims in determining some contemporary legal issues' (2016) 24 IIUMLJU 415; Mohammed, 'The Islamic Law Maxims' (2005) 44 *JSTOR* 191; Pakeeza, 'Role of Islamic Legal Maxims in Ijtihad' (2014) 5 *PI* 39

[221] AlKhayat, Health: An Islamic Perspective (WHO 1997); AlKhayat, 'Health as a Human Right in Islam' in *The Right Path to Health: Health Education through Religion* (WHO Regional Office, Cairo, 2004); AlShohaib, et al. *Health and Well-being in Islamic Societies: A Background, Research and Applications* (Springer 2014); Carson, et al. *Handbook of Religion and Health* (OUP 2012); Rahman, Health and Medicine in the Islamic Tradition (ABC 1998); Ott et al., 'Preventing Ethical Dilemmas: Understanding Islamic Health care Practices' (2003) 29 *JPN*

protect *Maqasid AlSharia*.[222] Consequently, I argue that this demonstrates that the obligations to protect life and maintain health have supremacy and precedence over other Sharia obligations. This precedence allows us to understand, as will be outlined in Chapters Five and Six, how it could be argued that models of privatisation are compliant with Sharia if they are proven necessary to ensure that the Sharia obligations to protect *Maqasid AlSharia* and maintain *Maslahah* are fulfilled.

As mentioned in Chapter One,[223] according to the *Malki* and *Shafi'i* schools, adopting the *Maqasidic* approach alone as outlined above would be sufficient to deem healthcare provision an obligation on the state, as healthcare provides more protection than one *Maqasid AlSharia.* However, and more specific to this thesis, adopting the *Maqasidic* approach alone would not be sufficient to declare healthcare provision an obligation on the state in countries that adhere to the *Hanbali* school, such as Saudi Arabia.[224]

2.2.2. Healthcare provision through the *Maslahah* approach

As mentioned in Chapter One,[225] Sharia scholars consider *Maslahah* as one of the secondary sources of Sharia in which rulings can be justified based on their public benefit. Traditionally, to identify and justify *Maslahah*, public benefit is

[222] ibid
[223] Chapter One Section 1.10.5
[224] AlMatroudi, *The Hanbali Scool of Law and Ibn Taymiyyah* (Taylor and Francis 2006); Howard, 'Muslim Legal Approaches to Modern Problems.' (2001) 8 *Islam* 21, 2–3; Kamali, 'siyasah Shariyah or the Policies of Islamic Government' (1989) 6 *AJISS* 59; Siddiqi, Modern Reformist Thought in the Muslim World (IRI 1982); Vogel, *Islamic Law and the Legal System of Saudi Arabia* (BRILL 2000)
[225] Chapter One Section 1.10.4.1 II

linked to one *Maqasid AlSharia*.[226] As concluded in the previous section, health is essential for the protection of three *Maqasid AlSharia.* Nonetheless, in Sharia, rights do not emerge from social relationships in Sharia as they do in non-Sharia laws;[227] rather, they are conferred directly by God and stem from the moral status of human actions ascribed by God in the Quran or Hadeeth.[228] Accordingly, for a right to be identified in Sharia, it would need to be explicitly declared in either the Quran or Hadeeth as a *Maslahah* that God intends to preserve by declaring it an obligation on the state.[229] The rights specified in Sharia primary sources are considered obligations, and the delivery of these rights fulfils God's orders.[230] Therefore, for Sharia scholars who follow the *Hanbali* school to accept healthcare provision as a state obligation, the obligation would need to be expressed in the Quran or the Hadeeth.

In Sharia, the importance of healthcare stems from the importance of health, which is recognised, as addressed in the Hadeeth and Quran, as part of Sharia.[231] Good health is essential in Sharia, and its primary sources contain

---

[226] ibid; Laluddin, *The concept of Maslahah with special reference to Imam AlGhazali* (IIUM 1998); Ramadan, *Ijtihad and Maslahah: The Foundations of Governance* in *Islamic Democratic Discourse: Theory, Debates and Philosophies* (Lexington 2006); Sattam, *Sharia and the Concept of Benefit: The Use and Function of Maslaha in Islamic Jurisprudence* (Tauris 2015); Zarqa, *An Approach to Human Welfare* in Ghazali, et al., *Readings in the Concept and Methodology of Islamic economics.* (Pelanduk 1989)

[227] AlDosari, *Human Rights in Islam* (PhD Thesis UCL 2010); Ali, *Human Rights in Islam* (Aziz Publishers 1980); Barnet, *Does Human Rights need God?* (Wm B Eerdmans 2005); Bielefeldt, '"Western" versus "Islamic" Human Rights Conceptions?: A Critique of Cultural Essentialism in the Discussion on Human Rights' (2002) 28 *Political Theory* 90

[228] Hallaq, *Shariah: Theory, practice, transofrmations.* (CUP 2009); Janin, *Islamic Law: The Sharia from Muhammad's Time to the Present* (McFarland 2007); Jereshah, *Origins of Islamic Law, Content and Characteristics* (Wahbah 1979) [in Arabic]; Kamali, *Maqasid AlShariah, Ijtihad and Civilization Renewal* (International Institute of Islamic Thought 2012)

[229] ibid

[230] Abou El Fadl, *Reasoning with God: Reclaiming Shar̄ı'a in the Modern Age*. (Rowman & Littlefield 2014); Barnet, Does Human Rights need God? (Eerdmans 2005); Bielefeldt, '"Western" versus "Islamic" Human Rights Conceptions: A Critique of Cultural Essentialism in the Discussion on Human Rights' (2002) 28 *JPT* 90; Crane, 'Human Rights in Traditionalist Islam: Legal, Political, Economic, and Spiritual Perspectives' (2007) 25 *AJISS* 82; Kamali, *Fundamental Rights of the Individual: An Analysis of Haqq in Islamic Law*, (IIIT 1993)

[231] Sahih Bukhari 1:149; Tirmidhi 3698; Quran 5:32

texts that declare the *Maslahah* of the protection of health and life as essential and obligatory among individuals. These texts range from Hadeeths that order the seeking of cures to scripts from the Quran that discuss the obligation to protect life.[232] These health-related Sharia obligations and orders in *Kitab AlTeb*, [233] as mentioned in Chapter One,[234] narrate the Prophet's actions, discussing how he attended to the ill and ordered the establishment of institutions where the ill could be treated.[235] Collectively, this demonstrates that healthcare is considered *Maslahah Mu'tabarah*.

Although healthcare is considered *Maslahah Mu'tabarah,* as concluded above, I argue that this fact remains insufficient in determining whether healthcare provision is an obligation on the state, as not all actions narrated in the Hadeeth that are *Maslahah* are considered obligations of the state. For example, oral hygiene is a *Maslahah* that protects health, which is connected to *Maqasid AlSharia* and is expressed in Sharia primary sources; thus, it is a *Maslahah Mu'tabarah.*[236] However, the method thusfar does not introduce any obligations on the state. For example it can not be concluded that the state would be obliged to provide free toothbrushes and oral hygiene products which are essential but nonetheless separate from the obligation on the state to provide dental care. Therefore, oral hygiene is not an obligation on the state; rather, it is

[232] Sahih Bukhari 1:149; Quran 5:32
[233] AlKhayat, *Health: An Islamic Perspective* (WHO 1997); AlShohaib, et al. *Health and Well-being in Islamic Societies: A Background, Research and Applications* (Springer 2014); Deuraseh, 'Health and Medicine in the Islamic Tradition based on the Book of Medicine (Kitab AlTibb) of Sahih Bukhari' (2006) 5 *JISHIM* 2; Rahman, *Health and Medicine in the Islamic Tradition* (ABC 1998)
[234] Chapter One Section 1.6
[235] ibid; AlAli, The Prophet's state in Madinahh: A study of its establishment and organization (AlMatbu'at 2001)[in Arabic]; Nagamia, 'Islamic Medicine History and Current Practice' (2003) 2 *JISHIM* 19; Nagamia, 'Medicine in Islam' (2008) *EHSTMNWC* 1541; Rahman, 'The Development of the Health Sciences and Related Institutions during the First Six Centuries of Islam' (2000) 44 *IQ* 601
[236] Filiz, "Etiquette Of Life In Islam." 7.7 (1997). *NEUIFD* 351 [Arabic Translation]; Lapidus, *A History of Islamic Societies* (CUP 2014); Lindsay, *Daily Life in the Medieval Islamic World* (Greenwood 2005)

encouraged to be performed by individuals. Accordingly, I argue that Sharia clearly differentiates between *Maslahah* regarding the responsibilities of individuals and the communal obligations of states, and considers these rights of humankind (*Huquq AlIbad*) and rights of God or obligations owed towards God (*Huqaq Allah*), respectively. Therefore, to determine whether healthcare provision is an obligation on the state, I argue that it is essential to determine whether it is an obligation rulers owe to God by adopting the *Huquq* approach.

2.2.3. Healthcare provision through the *Huquq* approach

In Sharia, *Huquq AlIbad* include human beings' obligations and responsibilities towards themselves and others. These rights are confined to the individual and micro levels and are related to private and individual interests. Thus, *Huquq AlIbad* do not place obligations on the state. Examples of *Huquq AlIbad* are the rights of neighbours and the right to ownership.[237] Accordingly, in the context of healthcare, *Huquq AlIbad* include interpersonal obligations between physicians and patients, including the obligation to maintain confidentiality and respect privacy.[238]

Huquq Allah in Sharia are the rights of God, and are better explained as the duties humans owe to God. Sharia scholars divide *Huquq Allah* into two main

[237] Auda, Maqasid AlShariah as Philosophy of Islamic Law: A Systems Approach (IIIT 2008); Emon, 'Huquq Allah and Huquq AlIbad: A Legal Heuristic for a Natural rights regime' (2006) 13 *JILS* 325; Fadel, "The True, the Good, and the Reasonable: The Theological and Ethical Roots of Public Reason in Islamic Law."(2008) *CJLJ* 21; Kamali, *Fundamental Rights of the Individual: An Analysis of Haqq in Islamic Law*, (IIIT 1993)

[238] Levey, 'Medical Ethics of Medieval Islam with Special reference to AlRuhawi's Practical Ethics of the Physician' (1967) 57 *Transactions of the American Philiosophical Society* 3; Miles, *The Hippocratic Oath and the Ethics of Medicine* (Oxford University Press 2005); Mustafa, 'Islam and the four principles of medical ethics' (2014) 40 *Journal of Medical Ethics* 479; Oh, *The Rights of God: Islam, Human Rights, and Comparative Ethics* (Georgetown University Press 2007)

groups: devotional obligations, such as daily prayers, and the obligations of a *Maslahah*, which are beneficial to the society as a whole. Sharia scholars consider the latter obligations that rulers owe to God.[239] This obligation is in accordance with the following direct order by the Prophet in the Hadeeth: 'The ruler is a guardian and responsible for his subjects'. The Prophet reiterated this order through his actions during his time as ruler.[240] Similarly, according to the Sharia scholar Abdo, 'the government has the right of allegiance by its citizens, and citizens have the right to justice and *Maslahah* by their government'.[241] Accordingly, establishing *Maslahah* by building infrastructure, nourishing the economy through investments and ensuring the safety of citizens is beneficial to society at large, and therefore, rulers are obliged to fulfil *Huquq Allah*.

In the case of healthcare, it is evident that healthcare provision is beneficial to society as a whole and secures interests beyond the individual micro level; thus, it cannot be considered part of *Huquq AlIbad.* I argue that healthcare provision is of a greater interest to society as a whole and is considered a universal public benefit when services are provided to all inhabitants under the governance of the state. Accordingly, I conclude that healthcare provision is one *Huquq Allah* that states owe towards God, according to Sharia.

---

[239] ibid; Ajijola, *The Islamic Concept of Social Justice* (IPL 1977); Gerber, *State, Society, and Law in Islam* (SUNY1994); Gummi, *The Islamic Welfare State: The Basic Imperatives Toward a Better Society* (SSRN 2013); Hussain, Islam: Its Law and Society (Federation 2004); Rahmani, 'Siasah Shariah: A Mean to Ensure Justice in the Society' (2011) 26 *AlAdwa* 9; Ramadan, *Ijtihad and Maslaha: Foundations of Governance* (Lexington 2006); Young et al, *Guidance for Good Governance: Explorations in Qur'anic, Scientific and Cross-cultural Approaches* (IIUM Press 2008);

[240] AlAli, The Prophet's state in Medinah: A study of its establishment and organization (AlMatbu'at 2001) [in Arabic]; AlKatani, The Prophetic Government: Administrative Formalities (Dar AlArqam 2008) [In Arabic]; Black, The History of Islamic Political Thought: From the Prophet to the Present (EPU 2011); Coulson, *The State and the Individual in Islamic Law*, (CUP 1957); Sahih Bukhari 67:122; Sahih AlAlbani 9:51; Siegman, 'The State and Individual in Sunni Islam.' (1964) *JMW* 54

[241] ibid; Emon, 'Huquq Allah and Huquq AlIbad: A Legal Heuristic for a Natural rights regime' (2006) 13 *JILS* 325; Hussain, Islam: Its Law and Society (Federation 2004); Ghannouchi, 'The State and Religion in the Fundamentals of Islam and Contemporary Interpretation' (2013) 6 *JCAA* 164; Ibn Taymiyyah, *Shariah Politics in improving the ruler and the ruled* (AlArabiyyah 1961) [In Arabic]

As healthcare provision is *Maslahah Mutabarah,* protects three of *Maqasid AlSharia,* and is one of the *Huquq Allah,* I conclude that it is a Sharia obligation on the state. Nonetheless, declaring healthcare provision a Sharia obligation on the state is not in itself sufficient to assess whether privatisation would prevent states from fulfilling the obligation, as argued by Sharia scholars. It is essential to specify the details of this obligation placed upon the state to provide healthcare, according to Sharia. The next section will discuss this further.

2.3 Healthcare Provision Requirements in Sharia

Sharia healthcare provision requirements can be identified through the Sharia methodology of *Usul AlFiqh*. These requirements are based on the obligation on the state to ensure *Maslahah* in light of the two obligations on individuals: to maintain health and to seek a cure when ill.[242] Based on this, I argue that states are obliged to create conditions in which citizens are able to fulfil the obligations placed upon them. Understanding these requirements, supported by examples from Islamic history demonstrating rulers' fulfilment of them, will demonstrate what healthcare provision means from a Sharia perspective and thus what is required of Sharia-adhering states today regarding healthcare provision.[243]

[242] Fadel, "The True, the Good, and the Reasonable: The Theological and Ethical Roots of Public Reason in Islamic Law."(2008) *CJLJ* 21; Hallaq, The Origins and Evolution of Islamic Law (CUP 2005); Maudoodi, The Islamic Law and Constitution (IPL 1955); Mayer, Islam and Human Rights: Tradition and Politics (Westview 1991); Rahman, 'The Quran And Fundamental Human Rights' (1978) 1 *JHI* 71; Siegman, 'The State and Individual in Sunni Islam.' (1964) *JMW* 54

[243] AlKhayat, 'Health as a Human Right in Islam' in The Right Path to Health: Health Education through Religion (WHO Regional Office, Cairo, 2004); Barnet, Does Human Rights need God? (Eerdmans 2005); Crane, 'Human Rights in Traditionalist Islam: Legal, Political, Economic, and Spiritual Perspectives' (2007) 25 *AJISS* 82; Deuraseh, 'Health and Medicine In the Islamic Tradition Based on The Book of Medicine (Kitab

2.3.1 Healthcare Provision in the Hadeeth and Early Islamic History

Maintaining *Maslahah* is part of the Sharia obligation of *Imarat* (building and attending)[244] on the government.[245] *Maslahah*, in the context of healthcare, can be defined as society's ability to maintain its health, which can only be achieved by ensuring that it has access to healthcare when needed.[246] Society's ability to maintain its health is a more rational and achievable *Maslahah* than its ability to be free of diseases, as some diseases are chronic and can only be controlled instead of cured. I argue that this *Maslahah* is the basis for all healthcare provision requirements in Sharia. Upon analysis of Sharia healthcare literature, I argue that these requirements can be better identified by dividing Sharia texts into two groups: texts that discuss the obligation to protect health and texts that discuss the obligation to seek cures.

Healthcare provision requirements related to the obligation of individuals to protect health are outlined in the Hadeeth. One example is when the Prophet calls for quarantine of those with contagious diseases, such as leprosy and plague, to protect the health of the remainder of the population and maintain *Maslahah*.[247] By ordering the segregation of those with contagious diseases, the

---

AlTibb) of Sahih Bukhari' (2006) 5 *JISHIM* 2; ElKadi, 'Health and Healing in the Quran', (1985) 2 *AJISS* 291; Mustafa (n 61); Oh, The Rights of God: Islam, Human Rights, and Comparative Ethics (GUP 2007)

[244] *Imarat* will be explained further in Section 2.5.1.1 A of this chapter

[245] Asad, *The Principles of State and Government in Islam,* (Berkeley 1961); Chapra, *The Islamic welfare state and its role in the economy*. (The Islamic Foundation 1979); Coulson, *The State and the Individual in Islamic Law*, (CUP 1957); Gerber, *State, Society, and Law in Islam* (SUNY Press 1994)

[246] Imam, 'Islamic health care services in the contemporary world' (1995) 39 *Islamic Quarterly* 234; O'Connell et al, 'What does Universal Healthcare Coverage mean?' (2014) 383 Lancet 277; Ott, et al. 'Preventing ethical dilemmas: understanding Islamic health care practices' (2003) 9 *Pediatric Nursing* 227; Padela, 'Social Responsibility and the State's Duty to provide Healthcare: An Islamic Ethico-Legal Perspective' (2016) *Developing World Bioeth*

[247] Adam, *Medicine in the Quran and Sunnah: An intellectual reappraisal of the legacy and future of Islamic medicine and its represent* (IIIT 2002); Bulmus, Plague, Quarantines and Geopolitics in the Ottoman Empire

Prophet safeguarded the health of unaffected citizens, and thus, their *Maqasid AlSharia* were protected.[248] Accordingly, *Maslahah* was ensured as opposed to if the ill were allowed to mix with the remainder of society.[249] Based on this analogy, it can be concluded that it is an obligation on the state to protect citizens within its borders from contagious diseases through every possible means. These means can be through quarantine, as the Prophet called for, or through modern forms of health protection, such as vaccinations.

Furthermore, I argue that the obligation on the state to protect the health of citizens within its borders extends to provision of healthcare services that are essential to protecting citizens' lives. Accordingly, it can be deduced that this obligation does not include the provision of aesthetic or cosmetic treatments, as these do not contribute to the protection of health or *Maqasid AlSharia*. Nonetheless, it is essential to note that there may be some scenarios in which cosmetic treatments could be considered essential for the protection of the *Maqasid AlSharia* of *Aql* (mind).[250] However, these cases are exceptions to the main rule and would be considered essential treatments due to their direct link to *Aql*.[251] To reach this ruling, Sharia Law Maxims of Harm and Necessity, such as '*That which is legalised due to necessity shall only be recognised to the extent of necessity*',[252] would be applied. Accordingly, I argue that providing essential

(EUP 2012); Dusuki, et al. 'Maqasid AlShariah, Maslahah and Social Responsibility' (2007) 24 *AJISS* 25; Imam, 'Islamic health care services in the contemporary world' (1995) 39 *IQ* 234; Rahman, *Health and Medicine in the Islamic Tradition* (ABC 1998); Sachedina, 'In Search of Principles of Healthcare Ethics in Islam' in *Islamic Biomedical Ethics Principles and Applications* (OUP 2009)

[248] ibid

[249] ibid

[250] ibid

[251] ibid

[252] Badar, 'Islamic Law (Sharia) and the Jurisdiction of the international criminal court' (2011) 24 *LJIL* 411; Biu, et al. 'The relevance of Islamic Legal Maxims in determining some contemporary legal issues' (2016)

services would allow individuals to fulfil the Sharia obligations placed upon them to protect health, and therefore ensure *Maslahah* and protect *Maqasid AlSharia*.

As for the obligation of individuals to seek cure, various narrations in the Hadeeth demonstrate how the Prophet attended to the ill and established a *Dar AlShifa* (House of Healing) where the ill within the territory were treated for free without discrimination.[253] Thus, I argue that a lack of inequality is essential to ensuring that the obligations of protecting *Maqasid AlSharia* and therefore establishing *Maslahah* in society can be truly fulfilled. As mentioned, healthcare provision is one of the *Huquq Allah* due to its benefit to society as a whole.[254] Accordingly, it can be concluded that when limited services are available, or when healthcare is not provided to all individuals, *Maslahah* is at risk. Therefore, to ensure *Maslahah* and protect *Maqasid AlSharia,* I argue that it is essential to provide healthcare to all people within the state's borders and allow them to seek cures when needed. In non-Sharia literature, this is known as the availability and affordability of healthcare. [255] Availability is a sufficient quantity of functioning public health and healthcare facilities, services and programmes. [256] Thus, a sufficient number of hospitals and physicians to

24 IIUMLJU 415; Mohammed, 'The Islamic Law Maxims' (2005) 44 *JSTOR* 191; Pakeeza, 'Role of Islamic Legal Maxims in Ijtihad' (2014) 5 *PI* 39

[253] Bsoul, 'An Arab Muslim Scientific Heritage: Islamic Medicine' (2016) 21 *IOSRJHSS* 29; Edriss, et al. ' Islamic Medicine in the Middle Ages' (2017) *AJMS* 18; Horden, "The Earliest Hospitals in Byzantium, Western Europe, and Islam". (2005) 35 *JIH* 361; Rahman, 'The Development of the Health Sciences and Related Institutions during the First Six Centuries of Islam' (2000) 44 *IQ* 601

[254] AlKhayat, 'Health as a Human Right in Islam' in The Right Path to Health: Health Education through Religion (WHO Regional Office, Cairo, 2004); Crone, God's Rule: Government and Islam, (CUP 2005); Rahman, *Health and Medicine in the Islamic Tradition* (ABC 1998); Sachedina, 'In Search of Principles of Healthcare Ethics in Islam' in *Islamic Biomedical Ethics Principles and Applications* (OUP 2009)

[255] O'Connell et al, 'What does Universal Healthcare Coverage mean?' (2014) 383 *Lancet* 277; WHO 'Health Systems Financing: The Path to Universal Health Coverage' (2010); WHO. (2013). Research for universal health coverage; WHO 'Universal Healthcare Coverage (UHC)' Factsheet updated December 2016

[256] ibid

provide health services to citizens must exist in order for healthcare to be considered available. [257]

Accordingly, I argue that it is an obligation on the state to ensure that society is able to protect its health, which can only be achieved by ensuring that healthcare services are available to all without discrimination. This obligation of nondiscrminiation can be comprehended by understanding that the *Maslahah* is for all individuals in the community to have access to healthcare and be able to protect their *Maqasid AlSharia* in order to effectively avoid the spread of disease in the community. Moreover, the obligation of non-discrimination can also be understood by reflecting on early Islamic history. The time of the Prophet was a time of coexistence in Madinah, and the society under his ruling consisted of individuals from different demographics, origins, ages, financial abilities and Abrahamic religions. [258] Therefore, to effectively protect *Maqasid AlSharia* within the territory of the state and maintain *Maslahah* within the whole society, I argue that all individuals within the territory would have to be able to protect their health and seek cure when ill, which logically can only be achieved if *Dar AlShifa* is open to all and the ill are attended to regardless of their faith, gender, age and financial ability.[259] The Hadeeth includes several stories of the Prophet's actions to ensure the safeguarding of the health of the different

[257] ibid
[258] AlGhanoushi, Rights of Non-Muslims in the Islamic Society (IIIT 1993) [In Arabic]; Lambton, *State and Government in Medieval Islam: An Introduction to the study of Islamic Political Theory* (Psych 1981); Saeed, 'Rethinking citizenship rights of non-Muslims in an Islamic state' (1999) 10 *JICMR* 307; Yildirim, 'Peace and Conflict Resolution in the Medina Charter' (2006) 18 *PR* 109; Watt, *Muhammad at Medina* (OUP 1956); White, 'Madina Charter and Pluralism' (2010) 76 *TF*
[259] This argument is in accordance to the Hanbali school of thought of Sharia law which is applied in Saudi Arabia as mentioned in chapter one. Some other schools of thought in Islam are of the opinion that the state is obliged to provide public services to muslims only, and this is due to the misinterpretation and misuse of religion by their scholars and Imams. Therefore, it is essential to note that there are differences in laws within Sharia, and that the incorrect and inhumane practices of individuals do not represent the law but rather are a respresentation of the individuals themselves.

demographics of the society including visitors from Makkah who at the time were polytheistic.[260]

Other examples of the non-discrimination in healthcare provision include the fact that the first *Dar AlShifa* was established by the Prophet in the courtyard of his mosque in Madinah, where he personally attended to the ill,[261] some of which were not residents but were passing by in their travels out of maintenance of *Maslahah*.[262] By attending to different demographics and establishing *Dar AlShifa*, the prophet created conditions in which the Sharia obligation of individuals to seek a cure when ill was fulfilled and, accordingly, their health was protected and *Maslahah* of the society was established. Thus, the state fulfilled the obligation to protect *Maqasid AlSharia* and maintain *Maslahah*.[263]

In doing so, the Prophet demonstrated that governments must ensure that healthcare services are provided to all within the borders of the community without discrimination. A lack of discrimination in healthcare provision is further emphasised in Hadeeth texts where, in his statements, the Prophet emphasises and refers to *'the ill'* without specifying faith, race, gender or age. For example, he ordered the ill to seek a cure,[264] and he ordered the community

[260] Sahih Bukhari 1290; Sahih Bukhari 2156; Sahih Bukhari 3671
[261] AlAli, The Prophet's state in Madinahh: A study of its establishment and organization (AlMatbu'at 2001)[in Arabic]; Deuraseh, 'Health and Medicine in the Islamic Tradition based on the Book of Medicine (Kitab AlTibb) of Sahih Bukhari' (2006) 5 *JISHIM* 2
[262] AlShohaib, et al. *Health and Well-being in Islamic Societies: A Background, Research and Applications* (Springer 2014); Rahman, 'The Development of the Health Sciences and Related Institutions during the First Six Centuries of Islam' (2000) 44 *IQ* 601
[263] ibid; Ferngren, *Medicine and Religion: A Historical Introduction* (JHUP 2014); Kamali, *Equity and Fairness in Islam* (ITS 2005); Kamali, *Right to Education, Work and Welfare in Islam* (ITS 2010); Nagamia, 'Islamic Medicine History and Current Practice' (2003) 2 *JISHIM* 19
[264] Abu Dawood, 3376; Tirmidhi, 2038

to visit the ill amongst them and ensure that their needs are met; thus, the ill were comforted which was deemed a right of the ill upon the community. These orders were also applied to the wider community and included different demographics of society.[265] Accordingly, I argue that Sharia requires healthcare to be available to all without discrimination. This requirement has been further emphasised in the modern era by renowned scholars and Sharia Medical Ethics pioneers AlRuhawi and AlTabari, who noted that all individuals – kings and nomads, rich men and poor men – should be able to maintain their health and have equal access to healthcare with no discrimination at all.[266]

One of the most valuable manuscripts in Sharia Medical Ethics is the Medical Letter of Advice written by Ahwazi, which is more comprehensive than the Hippocratic Oath and includes specific details regarding the moral code and behaviour of physicians that are derived from Sharia law sources including the above mentioned practices of the Prophet. The Muslim Physician Oath which is based on laws and teachings in the Quran and Hadeeth obliges all physicians to 'protect human life in all stages and under all circumstances, doing one's utmost to rescue it from death, malady, pain and anxiety, and extend medical care to near and far, virtuous and sinner, and friend and enemy'.[267] However, it is important to note that in Hadeeths that include religious practices such as *Ruqyah* (Healing with Religious Recitations), the Prophet is specific and refers

[265] Abu Dawood, 3098; AlAlbani, The Life of The Prophet (Damascus 2001) [In Arabic]; AlShayaa, The Concise Life story of The Prophet (AlRayyan 2003) [In Arabic]; Maudoodi, Human Rights in Islam (IF 1976); Nasr, *The Heart of Islam : Enduring Values for Humanity* (Harper 2002); Sahih Ahmed, 976; Sahih Ahmed, 12813; Sahih AlAlbani, 2504; Sahih Bukhari, 522; Sahih Bukhari, 515; Sahih Muslim 3:92; Sahih Muslim 7:110; Tirmidhi, 2008; Tirmidhi, 983

[266] AlKhitamy et. al, 'Bioethics for Clinicians: Islamic Bioethics' (2001) 164 *CMAJ* 60; Levey, 'Medical Ethics of Medieval Islam with Special reference to AlRuhawi's Practical Ethics of the Physician' (1967) 57 *JTAPS* 3; Siddiqi, Paradise of Wisdom by alTabari, Berlin 1928

[267] WHO, 'Islamic Code of Medical and Health Ethics' (2005) EM/RC52/7

to 'ill Muslims', rather than 'the ill' in general as he does in Hadeeths that discuss healthcare and non-religious healing practices.[268] I argue that in doing so, the Prophet demonstrates that the rights of the ill, including the right to healthcare, are applied to all individuals within the territory except with regard to religious practices that are specific to the Islamic faith, such as spiritual healings which include recitations from the Quran. This exception is so that religious healings are not imposed on non-Muslim individuals and is part of the preservation of *Maqasid AlSharia* of *Deen* (faith) of the individuals following other Abrahamic religions.[269]

Moreover, the financial ability of individuals to seek healthcare is vital to protecting health and curing illness, and is also expressed in Sharia sources.[270] Healthcare services during the time of the Prophet were provided at his own expense in *Dar AlShifa* and also to individuals he came across during his travels. For example, he encountered wounded soldiers and ordered them to be treated at his expense.[271] As territory expanded, it was essential to state in the documents of *Dar AlShifa* establishments that these establishments were *Waqf* (financed by endowments) and that no one was to be turned away untreated or charged for treatment regardless of race, religion, citizenship, gender or age.

[268] Sahih Ahmed, 13859; Sahih Ahmed, 23139; Sahih Muslim, 14:189; Tirmidhi, 2083
[269] Hamarneh Health Sciences in Early Islam (Zahra 1984); Kamali, *Fundamental Rights of the Individual: An Analysis of Haqq in Islamic Law*, (IIIT 1993); Nagamia, *Medicine in Islam* (Kluwer 2008); Sahih Bukhari, 1356; Lapidus, A History of Islamic Societies (CUP 2014); Nasr, *Science and Civilization in Islam* (UHP 1968); Tahir, 'A true vision of human rights in Islam'(2013)40*AlAdwa* 7
[270] Ellis, et al., 'Optimal payment systems for health services' (1990) 9 *JHE* 375; Schieber, *Innovations in Health Care Financing,* (World Bank Disc. Paper n. 365. 1997); Schreyögg, et al., 'Costs and Quality of Hospitals in Different Health Care Systems: a Multilevel Approach with Propensity Score Matching' (2010) 20 *JHE* 85; WHO 'Health Systems Financing: The Path to Universal Health Coverage' (2010)
[271] AlAli, The Prophet's state in Madinahh: A study of its establishment and organization (AlMatbu'at 2001)[in Arabic]; Deuraseh, 'Health and Medicine in the Islamic Tradition based on the Book of Medicine (Kitab AlTibb) of Sahih Bukhari' (2006) 5 *JISHIM* 2; Rahman, 'The Development of the Health Sciences and Related Institutions during the First Six Centuries of Islam' (2000) 44 *IQ* 601

Similarly, there are examples within Islamic history of healthcare services being provided at no cost. [272]

For example, during the reign of Alwalid, a specialised hospital was built in Damascus for patients with leprosy to be treated for free.[273] The first hospital in a modern sense was established by Harun AlRashid in Baghdad, and was followed by others in Egypt and Damascus with their staff allocated and paid for directly by the government rather, while no costs were incurred by the ill.[274] Furthermore, *Dar AlShifa*, built by the Umayyad sultan Nur AlDin in Damascus, was reported by the historian AlMaqrizi to have operated solely on revenue generated by the sultan, and its library books were also donated directly by him.[275] Moreover, *Dar AlShifa* was reported in Islamic history texts to have provided clothes for all patients for free and allowance money for poor patients upon their discharge.[276]

Therefore, it can be concluded that in order to fulfil the Sharia obligation to ensure *Maslahah* and protect health, the state must ensure that healthcare services provided within the territory are affordable. According to Victora and colleagues, a health system is considered inequitable when it provides more and higher quality services to the rich and financially able in comparison to the

[272] AlAnsari, Bimaristans and Waqf in Islam (PhD Thesis UOS 2013); Baer, 'The Waqf as a prop for the social system (16th-20th Centuries), (1997) 4 *JILS* 264; Leeuwen, Waqfs and Urban structures: The Case of Ottoman Damascus (BRILL 1999); Lindsay, Daily Life in the Medieval Islamic World (Greenwood 2005); Mehdi, et al. 'Medical care in Islamic tradition during the middle ages (historicl review)' (2013) 10 *LSJ*
[273] ibid; Rahman, 'The Development of the Health Sciences and Related Institutions during the First Six Centuries of Islam' (2000) 44 *IQ* 601
[274] ibid; Campbell, Arabian Medicine and its influence on the Middle Ages (Routledge 2013) pp. 2–20; Rodini, 'Medical care in Islamic Tradition During the Middle ages' (2012) 3 *WMC*
[275] ibid; Gorini, 'Bimaristans and Mental Health in Two Different Areas of the Medieval Islamic World'(2008) 7 *JISJIM* 16; Nowsheravi, 'Muslim Hospitals in the Medieval Period' (1983) 22 *JIS* 51
[276] ibid; AlKhalili, Pathfinders the Golden Age of Arabic Science (Penguin 2010)

poor, who may need them more but are unable to obtain them.[277] Mooney describes this as the 'inverse care law', where the poor in countries that do not ensure the affordability of their healthcare services are unhealthy, forgotten and unfortunate.[278] This law was first described in 1971,[279] and is the opposite of the definition of health service equity, which dictates that the access to services should correlate with the need for them. This could be considered the essence of *Maslahah* in the context of healthcare. Therefore, I argue that the obligation on the state to ensure that society is able to maintain its health can only be achieved by ensuring that healthcare services are affordable for those in need.

It is important to note, however, that although the Prophet was said to have treated the ill at his own expense, no explicit narration in the Hadeeth states that it is obligatory for states to provide free healthcare services. On the contrary, there are narratives within Islamic history that imply healthcare services were paid for. For example, the physician Asad ibn Jani was told that his medical business was expected to flourish during the plague year, which denotes that he provided services at an expense.[280] However, it is unclear whether these expenses were Asad's salary paid for by the state, whether patients paid him directly for his services, or whether his prices were based on each patient's ability to pay. Therefore, it can be concluded that Sharia does not

[277] Victora et al, Making Health Systems more equitable (2004) 364 Lancet 1273
[278] Mooney, 'The Health of Nations: Toward a New Political Economy' (Zed Books 2012)
[279] Hart, The inverse care law (1971) 1 *Lancet* 405
[280] Adam, *Medicine in the Quran and Sunnah: An intellectual reappraisal of the legacy and future of Islamic medicine and its represent* (IIIT 2002); AlKalai, "Arabian Medicine in the Middle Ages"(1984) 77 *JRSM* 60; Mehdi, et al. 'Medical care in Islamic tradition during the middle ages (historicl review)' (2013) 10 *LSJ*; Ragab, The Medieval Islamic Hospital: Medicine, Religion and Charity (CUP 2015); Rahman, *Health and Medicine in the Islamic Tradition* (ABC 1998)

oblige states to ensure services are free, however it is essential for these services to be affordable to ensure *Maslahah* and protection of *Maqasid AlSharia*.[281]

Accordingly, I argue that implementing a method of healthcare finance that includes premiums based on the individual's ability to pay while excluding the less wealthy could allow for the fulfilment of the Sharia obligations to protect health and seek treatment when ill. However, if healthcare services are priced in such a way that some cannot afford to pay, this would affect those services' fulfilment of these obligations. This issue will be discussed further in Chapters Five and Six. Furthermore, I argue that the fact that there is no explicit obligation on states to provide healthcare for free explains why Saudi healthcare law specifies that the government provides healthcare to citizens according to their financial abilities. The specifics of Saudi healthcare laws will be discussed in Chapter Three.

The availability of healthcare also includes its geographical and physical availability, which can be understood from Hadeeth narrations. The location of *Dar AlShifa* in the courtyard of the Prophet's mosque is of great importance, as traditionally, mosques were located in a central position in town. This central location was intentionally planned to ensure that worshippers were able to attend the five daily prayers easily. Furthermore, the courtyards of mosques

[281] ibid; Abdullah, 'Maqasid AlShariah, Maslahah and corporate social responsibility' (2007) 24 *The American Journal of Islamic Social Sciences* 25; Attieh, *Towards Activating The Role of Maqasid AlShariah* (Dar AlFikr 2001) [In Arabic]; Auda, *Maqasid Al-Shariah as Philosophy of Islamic Law: A Systems Approach* (The International Institute of Islamic Thought 2008); Dusuki, et al. 'Maqasid AlShariah, Maslahah and Corporate Social Responsibility' (2007) 24 *The American Journal of Islamic Social Science* 25

were spacious and accommodated large numbers, allowing more individuals to seek cure at any given time.[282] As healthcare services were in central locations and in the courtyards of mosques, all individuals were able to fulfil their obligations to seek treatment. Accordingly, I argue that the central location of *Dar Alshifa* efficiently portrays the healthcare provision requirement of the geographical availability of healthcare in order to allow individuals to seek cure, as outlined in Sharia.

In the condition that an individual was unable to go to *Dar AlShifa*, the Prophet attended to their medical needs in their homes.[283] Similarly, travelling *Dar AlShifa* were established to accompany groups travelling, in order for the ill amongst them to be treated during their travels and to allow healthcare to be accessed when and where it was needed.[284] Another example of geographical availability is when the Prophet ordered a tent to be assembled for wounded soldiers to be treated where they were.[285] Furthermore, as the territory under his reign expanded, the Prophet ordered the establishment of *Dar AlShifa* in these new territories to ensure that healthcare was available locally.[286]

[282] Adam, *Medicine in the Quran and Sunnah: An intellectual reappraisal of the legacy and future of Islamic medicine and its represent* (IIIT 2002); Horden, "The Earliest Hospitals in Byzantium, Western Europe, and Islam". (2005) 35 *JIH* 361; Nagamia, 'Islamic Medicine History and Current Practice' (2003) 2 *JISHIM* 19
[283] AlAli, The Prophet's state in Madinahh: A study of its establishment and organization (AlMatbu'at 2001)[in Arabic]; Deuraseh, 'Health and Medicine in the Islamic Tradition based on the Book of Medicine (Kitab AlTibb) of Sahih Bukhari' (2006) 5 *JISHIM* 2
[284] ibid; AlShohaib, et al. *Health and Well-being in Islamic Societies: A Background, Research and Applications* (Springer 2014); Rahman, 'The Development of the Health Sciences and Related Institutions during the First Six Centuries of Islam' (2000) 44 *IQ* 601
[285] ibid
[286] Edriss, et al. ' Islamic Medicine in the Middle Ages' (2017) *AJMS* 18; Nasr, Science and Civilization in Islam (UHP 1968); Rahman, 'The Development of the Health Sciences and Related Institutions during the First Six Centuries of Islam' (2000) 44 *IQ* 601; Saunders, A History of Medieval Islam (Routeledge 1978)

I argue that in these examples, the Prophet fulfilled the Sharia obligation to ensure *Maslahah* and protect *Maqasid AlSharia* by creating conditions in which all individuals within the territory were able to seek cure regardless of geographical barriers. In non-Sharia literature, this is known as the accessibility of healthcare. Accessibility occurs when healthcare services are physically and economically accessible with no discrimination. Accordingly, healthcare is accessible when there are short waiting times for appointments, when physicians are available and when opening hours are convenient for patients.[287] Therefore, I argue the obligation on the state to ensure society is able to maintain its health can only be achieved by ensuring that access to healthcare is available when needed.

Finally, the type of healthcare provided also affects its ability to protect health and cure illnesses. In non-Sharia literature, this is known as the quality of healthcare, which is when services are not drastically outdated and are in accordance with medical developments, human rights, the medical code, the country's law, international treaties and the core principles of medical ethics.[288] Quality of patient care is a central concern for health systems, especially during financial challenges and rising demand, as currently experienced in Saudi Arabia,[289] which will be discussed in Chapter Three.[290]

---

[287] Waters, Measuring Equity in Access to Health Care, (2000) 51 *JSSM* 599; WHO 'Health Systems Financing: The Path to Universal Health Coverage' (2010); WHO. (2013). Research for universal health coverage; WHO 'Universal Healthcare Coverage (UHC)' Factsheet updated December 2016

[288] Eddy, et al. "Healthcare quality measurement." U.S. Patent No. 8,538,773. 17 Sep. 2013; Kelley, et al. "Health care quality indicators project." *OECD Health Working Papers*, No. 23 (OECD 2006); O'Connell et al, 'What does Universal Healthcare Coverage mean?' (2014) 383 *Lancet* 277; WHO 'Health Systems Financing: The Path to Universal Health Coverage' (2010)

[289] Albejaidi, "Healthcare system in Saudi Arabia: An analysis of structure, total quality management and future challenges." (2010) 2 *JAPSS* 794; Aljuaid, et al. "Quality of care in university hospitals in Saudi Arabia: a systematic review." (2016) 6 *BMJ open*; Almasabi, "Factors influence and impact of the implementation of quality of care in Saudi Arabia." (2013) 4 *JMMS* 92

According to the literature, the Prophet allocated skilful individuals to attend to the ill and supervised the services they provided.[291] For example, he instructed Rufaidah to attend to the needs of the ill in *Dar AlShifa* after she had proven to be knowledgeable and skilful.[292] Similarly, the Prophet allocated skilful individuals to attend to the needs of the ill when the individuals were unable to attend *Dar AlShifa,* were travelling to *Dar AlShifa,* or were in new territories.[293] The skills and standards of the treatments provided were based on *Urf* (the commonly known standard). As medicine advanced, the *Urf* developed, and more treatments were included, some replacing old practices.[294] For example, Greek and Indian medicine and music were incorporated into the treatments provided in *Dar AlShifa* after they were proven to be beneficial.[295]

To further emphasise the importance of skill, *Dar AlShifa* included lecture halls and developed establishments of medical learning and research, indicating that treatment was required to be up-to-date and of common standards.[296] Rulers after the Prophet expanded *Dar AlShifa* to include lecture halls, libraries, a mosque and chapels for other Abrahamic faiths to ensure that the staff's needs

---

[290] Chapter Three Section 3.3.1
[291] Adam Medicine in the Quran and Sunnah: An intellectual reappraisal of the legacy and future of Islamic medicine and its represent (IIIT 2002); Ahmed, 22645; Deuraseh, 'Health and Medicine In the Islamic Tradition Based on The Book of Medicine (Kitab AlTibb) of Sahih Bukhari' (2006) 5 *JISHIM* 2; Muslim, 2207
[292] ibid
[293] ibid
[294] AlKalai, "Arabian Medicine in the Middle Ages"(1984) 77 *JRSM* 60; Ferngren, Medicine and Religion: A Historical Introduction (JHUP 2014); Majeed, How Islam Changed Medicine, (2005) 331 *BMJ* 1486; Rahman, Health and Medicine in the Islamic Tradition (ABC 1998); Reider et al, 'Urf: Islamic Biomedical Ethics in Rural Mali' (Springer 2008)
[295] ibid
[296] Edriss, et al, ' Islamic Medicine in the Middle Ages' (2017) *AJMS* 18; Horden, "The Earliest Hospitals in Byzantium, Western Europe, and Islam". (2005) 35 *JIH* 361; Miller, 'Jundi-Shapur, bimaristans, and the rise of academic medical centres' (2006) 99 *JRSM* 615; Ragab, The Medieval Islamic Hospital: Medicine, Religion and Charity (CUP 2015)

were met and to ensure the quality of their skills and services. This expansion included the shift from the ruler attending to the ill himself, as the Prophet did, to establishing hospitals with staff, as well as specialised hospitals during the Umayyad era, which concentrated on researching and treating specific diseases.[297]

I argue that the importance of skills and knowledge are at the core of the state's obligation to provide healthcare, as it is only when services are beneficial that health is protected and the obligation to maintain *Maslahah* is fulfilled. This is further emphasised in the Hadeeth, which states that 'a person who practices the art of healing when he is not acquainted with medicine will be responsible for his actions'.[298] Accordingly, in Sharia, providing professional services of poor quality is considered a crime, and the provider is held accountable. The obligation to ensure the presence of knowledge has also been stressed in Sharia Medical Ethics texts. According to Zikria and Levey, in Sharia, a physician is required to update his knowledge and 'must acquire information from anywhere or anything which may prove beneficial to the recovery of the patient'.[299] It is extremely important to maintain professional knowledge in Sharia ethics. To illustrate this, some scholars, such as Zikria, have stated that it is unwise for physicians to be involved in trade and business alongside their medical profession, as this holds them back from maintaining their medical

[297] ibid; Nasr, *Science and Civilization in Islam* (UHP 1968); Pormann, Islamic medical and scientific tradition: Critical concepts in Islamic studies (Routledge 2011)
[298] AlGhazal, 'Medical Ethics in Islamic History at a glance' (2004) 3 *JISHIM* 12; Mustafa, 'Islam and the four principles of Medical Ethics', (2014) 40 *JME* 479; Padela, 'Social Responsibility and the State's Duty to provide Healthcare: An Islamic Ethico-Legal Perspective' (2016) *JDWB*; Rahman, *Health and Medicine in the Islamic Tradition* (ABC 1998)
[299] Levey, 'Medical Ethics of Medieval Islam with Special reference to AlRuhawi's Practical Ethics of the Physician' (1967) 57 *JTAPS* 3; Zikria, Doctor Ethics (1981) 13 *JIMA* 79

knowledge efficiently and hence affects their skills and the quality of services they provide.[300]

2.4 Assessment of Healthcare Provision Requirements in Privatisation

It is important to note that the above healthcare requirements are mandatory and that failure to ensure one of these requirements could compromise the availability, quality, accessibility or affordability of healthcare and, accordingly, its Sharia compliance. Examples can be seen today in countries that claim to adhere to Sharia as demonstrated by Reider, Naghavi and Chew.[301] These countries focus on affordability of healthcare and provide healthcare that is either free or at reduced prices.[302] However, the affordability of healthcare alone is not sufficient to declare healthcare Sharia-compliant, as there are other requirements that must be taken into account.[303]

2.4.1 Essential Services

Since providing essential services is a Sharia healthcare provision requirement, I argue that what affects the delivery of these services will also affect the fulfilment of the Sharia requirement and, consequently, Sharia compliance. For example, if health insurance schemes or governments exclude certain essential

[300] Guinn, Handbook of Bioethics and Religion (OUP 2006); Levey, 'Medical Ethics of Medieval Islam with Special reference to AlRuhawi's Practical Ethics of the Physician' (1967) 57 *JTAPS* 3; Sachedina, 'In Search of Principles of Healthcare Ethics in Islam' in Islamic Biomedical Ethics Principles and Applications (OUP 2009); Zikria, Doctor Ethics (1981) 13 *JIMA* 79

[301] Chew et al, 'A Nationwaide survey on the expectation of public healthcare providers' (2014) 4 *BMJ*; Naghavi et al, The utilization of healthcare services in Islamic Republic of Iran, Ministry of Health, Tehran 2002; Rehman et al, 'How islamic are Islamic countries?' (2010) 10 *GEJ* 2; Reider et al, 'Urf: Islamic Biomedical Ethics in Rural Mali' (Springer 2008)

[302] ibid

[303] ibid

treatments, this would be in contradiction to Sharia requirements and therefore not Sharia-compliant. This can be seen in the U.S., where essential treatments are under the various insurance schemes and are not equally provided to all citizens in different states.[304] On a larger scale, in India, rural areas are lacking in healthcare facilities and are often unable to provide essential services.[305] Based on these facts, I argue that models of privatisation that compromise the delivery of essential healthcare services are not Sharia-compliant.

2.4.2 Availability and Accessibility

Similarly, because the availability and accessibility of healthcare are Sharia healthcare provision requirements, I argue that what affects either of these will also affect the fulfilment of the Sharia healthcare provision requirements and, consequently, Sharia compliance. For example, if healthcare, once it is privatised, is only provided to certain demographics of society, such as those in large cities in which more paying patients are available versus smaller towns that are neglected, this would be in contradiction to Sharia requirements and therefore not Sharia-compliant. This can be seen in India and China, where services are not readily available to all demographics, resulting in deprivation and the formation of urban migration.[306] Based on these facts, I argue that

[304] Angell, 'Privatizing health care is not the answer: lessons from the United States' (2008) 179 *CMAJ* 916; Johns, et al., 'Selective contracting in California: Experience in the second year' (1985) 22 *Inquiry* 335; Rowland, et al., 'Medicaid: Moving to managed care' (1996) 15 *JHA* 150; Starr, *The Social transformation of American Medicine,* (Basic 1982)

[305] Alankar, et al., 'Health system in India: opportunities and challenges for improvements' (2006) 20. *JHOM* 560; Kumari, 'Migration and access to maternal healthcare: determinants of adequate antenatal care and institutional delivery among socio-economically disadvantaged migrants in Delhi, India' (2013) 18 *JTMIH* 1202; Mahal, et al., *The Poor and Health Service Use in India* (World Bank 2001); Maharaj, et al., 'Healthcare for the poor and dispossessed: from AlmaAta to the Millennium Development Goals' (2011) 60 *WIMJ* 493

[306] Bachman, "China and 'privatization," Paper presented at the Privatization Working Conference (Princeton 1988); Datar, et al. "Health infrastructure & immunization coverage in rural India." (2007) 125 *IJMR* 31; De Costa, et al. "'Where is the public health sector?': Public and private sector healthcare

models of privatisation that compromise the availability or accessibility of healthcare are not Sharia-compliant.

2.4.3 Affordability

As the affordability of healthcare is a Sharia healthcare provision requirement, I argue that what affects the affordability of healthcare will also affect the fulfilment of the Sharia healthcare provision requirement and, consequently, Sharia compliance. For example, if privatised hospitals price their services to maximise their financial returns and consequently deprive individuals of the services due to these expensive prices, as can be seen in the U.S. and developing countries, this would be in contradiction to Sharia requirements and therefore not Sharia-compliant.[307] Based on this, I argue that models of privatisation that compromise the affordability of healthcare are not Sharia-compliant.

2.4.4 Quality

Finally, as the quality of healthcare is a Sharia healthcare provision requirement, I argue that what affects the quality of healthcare will also affect the fulfilment of the Sharia healthcare provision requirement and, consequently, Sharia compliance. For example, if privatised hospitals aim to cut costs by employing less competent staff who provide lower quality services, as

---

provision in Madhya Pradesh, India." (2007) 84 *JHP* 269; Dethier, *Governance, decentralization and reform in China, India and Russia* (Kluwer 2000); Jian, et al., 'China's rural-urban care gap shrank for chronic disease patients, but inequities persist' (2010) 29 *JHA* 2189

[307] Bartley, 'Health costs of social injustice: there is such a thing as society' (1994) 309 *BMJ* 1177; Belli, et al., 'Out-of-pocket Payments in the Health Sector: evidence from Georgia' (2004) 70 *JHP* 109; Gertler, et al., *Pricing public health services: Lessons from a social experiment in Indonesia (*RAND 1990); Iglehart, 'Cutting the costs of health care for the poor in California: A two-year follow-up' (1984) 311 *NEJM* 745; Ma, et al., 'Optimal Health Insurance and Provider Payment' (1997) *AER* 685; Russell, *Medicare's New Hospital Payment System: Is It Working?* (Brookings 1989)

is evident in the U.K.'s National Health System (NHS) scandals, this would be in contradiction to Sharia requirements and therefore not Sharia-complaint.[308] Based on this, I argue that models of privatisation that affect the quality of healthcare are not Sharia-compliant. If the quality of healthcare is compromised, this model of privatisation would be in contradiction to the Sharia healthcare requirement of quality and therefore would not be Sharia-compliant. Accordingly, it can be concluded that in order to fulfil the Sharia obligation to establish *Maslahah* and protect health, the state must ensure that healthcare services provided within the territory are of high quality by allocating skilful staff and supervising the services provided.[309]

As privatisation is not discussed in the Quran or the Hadeeth, the primary sources of Sharia law, Sharia scholars have relied on a secondary source of law called the *Ijtihad* (mental effort). As mentioned in Chapter One, *Ijtihad* is a methodology that includes a thorough analysis of the different circumstances that affect a situation at hand.[310] Nonetheless, the Sharia-based opinion contrasts with that of finance and healthcare scholars,[311] who claim that privatisation is essential to ensuring the delivery of welfare services when the

[308] Dyer, 'Government responds to Stafford inquiry with new "whistleblower in chief" to rate hospitals' (2013) 346 *BMJ* f2030; Footman, et al., 'Quality check: does it matter for quality how you organise and pay for health care? A review of the international evidence' (2014) 44 *IJHS* 479; Francis, Robert Francis inquiry report into MidStaffordshire NHS Foundation Trust (Stationery Office 2010); *Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 -1995 Command Paper CM 5207(2001);* O'Dowd, 'NHS regulator plans to make it easier for doctors to raise concerns and break "mafia" code of silence' (2013) 347 *BMJ* f6428

[309] Reinhart, "Islamic Law as Islamic Ethics."(1983) 11 *JRE* 186–203

[310] Alama,'Ijtihad Jurisprudence and its Impact on the Multiplicity of Islamic Legal Schools' (2006) 41 AlRabetah 475 [In Arabic]; Nyazee, *Theories Of Islamic Law: The methodology of Ijtihad* (IRIP 1994); Ramadan, *Ijtihad and Maslaha: Foundations of Governance* (Lexington 2006)

[311] AlObaidi, 'Privatisation between Islamic Economics and Positive Economics' (DAA 2011) [In Arabic]; Baltaji, Private Ownership in The Islamic Economical System (AlShabab 1988) [In Arabic]; Pomeranz, 'Privatisation and the Ethics of Islam' (1997) 14 AJISS 264

state is not financially able. [312] This will be discussed in Chapter Three.[313] The next section will critique the Sharia analysis of privatisation in order to allow this thesis to challenge Sharia scholars' opinions against privatisation.

2.5 A Critique of Sharia Scholars' Analyses of Privatisation

As mentioned in Chapter One,[314] Sharia scholars define privatisation as *'Naql Kamil LilMulkiyah Min AlQita' AlA'am Ela AlMulkiyah AlFardiyah'*[315] (the total transfer of ownership from the public sector to personal private possession). Through an examination of available Sharia literature that discusses privatisation, I have identified problems with the Sharia analysis. These problems can be divided into two groups: problems due to the terminology of the definition and shortcomings of the analysis itself. In the following sections, I will outline these problems and discuss how they affect the validity of the Sharia-based opinion.

2.5.1 The effect of the Sharia definition's terminology

I argue that the root of the problem with Sharia literature and opinion is the specification of *AlMulkiyah AlFardiyah* (personal private possession) in the definition. *AlMulkiyah AlFardiyah* is a term unique to Sharia literature, as non-

[312] AlHussain, 'Saudi Healthcare System: Where does improving the services and performance begin?' (RMA December 2004) [In Arabic]; Dossary, 'Health and Development in poor countries with particular reference to Saudi Arabia' (PhD Thesis, UA 1991); Mulla, et al. 'Privatization of general hospitals and its applications in Saudi Arabia' (KFNL 2001)
[313] Chapter Three Section 3.4.1
[314] Chapter One Section 1.10.8
[315] AlHussain, 'Saudi Healthcare System: Where does improving the services and performance begin?' (RMA December 2004) [In Arabic]; Dossary, 'Health and Development in poor countries with particular reference to Saudi Arabia' (PhD Thesis, UA 1991); Mulla, et al. 'Privatization of general hospitals and its applications in Saudi Arabia' (KFNL 2001)

Sharia literature that discusses privatisation specifies the private sector,[316] which is discussed in Chapter Four.[317] The specification of *AlMulkiyah AlFardiyah* is problematic because different laws apply to the three distinctive ownerships recognised in Sharia: *A'am* (public), *Khas* (private) and *Fardiyah* (personal).[318] Some scholars have also included a fourth type specific to the charity sector; however, I follow the school of thought that includes it as part of the public sector because of the direct link in Sharia law between charities and government supervision and distribution and because charitable institutions are not obliged to pay *Zakat* taxes like the private sector.[319] The next section will outline the differences between these ownerships and the accompanying laws and discuss how the specification of *AlMulkiyah AlFardiyah* in the Sharia scholar definition is problematic.

2.5.1.1 Types of Ownership in Sharia

A. *AlQita' AlA'am* (The Public Sector)

The sharia constitution, found in the Quran and the Hadeeth, orders rulers to 'focus on *Imarat* (building and attending to) the land rather than reaping benefits, as those can only be obtained by *Imarat*. Whoever seeks the benefits (of power) without *Imarat* will destroy the land and decimate the

[316] Johaet al., 'Public-private partnerships, outsourcing or shared service centres: Motives and intents for selecting sourcing configurations' (2010) 4 *JTG* 232; Kettle *Sharing Power: Public Governance and Private Markets.* (Brookings 1993); Palmer, 'The use of private-sector contracts for primary health care: theory, evidence and lessons for low-income and middle-income countries' (2000) 78 *Bulletin WHO* 821; Rundall, et al., 'The private management of public hospitals' (1984) 19 *HSR* 519

[317] Chapter Four Section 4.2.1

[318] AlMaamiry *Private Personal Ownership and its limitations in Islam* (Lancer 1987); Bhalla, *The institution of property: Legally, Historically and Philosophically Regarded* (EBC 1984); Messick, "Property and the Private in a Sharia System." (2003) *JSR* 711; Taleqani, *Islam and Ownership* (Lexington 1983) Gulaid, *Ownership in Islam* (IDI 1991)

[319] ibid

population'.[320] In Sharia, the land and its resources are owned by the public and form *AlQita' AlA'am*.[321] According to Sharia scholars, *AlQita' AlA'am* is required to establish three main objectives: to maintain natural resources as public wealth, to invest these resources, and to establish *Maslahah*, which includes ensuring the protection of *Maqasid AlSharia*, the basis of Sharia, as outlined in Chapter One.[322] Therefore, Sharia-abiding governments are obliged to establish means of protecting *Maqasid AlSharia* as part of their endorsement and establishment of Sharia law. This obligation also applies to *Imarat* and includes investing resources of *AlQita' AlA'am* to protect the population's *Maqasid AlSharia*.[323]

As part of establishing *Maslahah*, according to AlDuri, governments are obliged to nourish the economy and oversee the sectors that affect it, which include the private sector.[324] Accordingly, governments are required to invest resources in order to generate income and establish infrastructure, security systems and other establishments essential to protecting *Maqasid AlSharia* and establishing *Maslahah*. This is commonly known as a welfare state; different services are part of *AlQita' AlA'am* and are provided by the government. Several examples can be found of the Islamic welfare state in the Hadeeth and in Islamic

[320] AbulFazl, *Sayings of the Prophet Muhammad* (APH 1980); Ibn Taymiyyah, *Shariah Politics in improving the ruler and the ruled* (AlArabiyyah 1961) [In Arabic]
[321] AfzalurRahman, *Economic Doctrines of Islam Vol III*, (IP 1980); Ajijola, *The Islamic Concept of Social Justice* (IP 1977); AlDuri, Islamic Systems (AlHikmah 1988) [In Arabic]; AlMaamiry, *Economics in Islam* (Lancer 1987); Kamali, 'The limits of power in an Islamic state', (1989) 28 *ISQ* 104; Siddiqi, *Some Aspects of the Islamic Economy,* (IP 1978)
[322] Chapter One Section 1.10.4.3
[323] Ahmad,"Role of Finance in Achieving Maqasid alShariah." (2011) 19 *IES* 1; Attieh, Towards Activating The Role of Maqasid AlShariah (AlFikr 2001) [In Arabic]; Chapra, *The Islamic Vision of Development in the Light of the Maqasid AlShari`ah* (IDB 2008); Ibn Ashur, *Islamic Maqasid AlShariah* (AlSalam 2005) [In Arabic]
[324] ibid; ElKaleh, 'The Ethics of Islamic Leadership' (2013) 2 *JAC* 188; The General Presidency of Scholalry research and Ifta, The Obligations of the Ruler (1994) Fatwa 38 page 222; Samier, *Fairness, Equity and Social Cooperation: A Moderate Islamic Social Justice Leadership Model* (Macmillan 2016)

history.[325] However, the obligation on governments does not end with the establishment of these systems and institutions; it includes their continuing regulation to ensure that they are operating efficiently and contributing to the protection of *Maqasid AlSharia*.[326] According to the Hadeeth, 'Whosoever of you sees an evil action must change it with his hand. If he is not able to do so, then with his tongue',[327] denoting that the whole of society is obliged to take part in this supervision and aid the government in fulfilling the obligation of *Imarat*.[328] If an individual is in a position of authority, he must make changes within his ability to overcome this evil. However, if he is not, then he must make changes through his 'tongue' by notifying those in power so that they may make the necessary changes, continue to seek *Imarat* and maintain *Maslahah*, as obliged by Sharia.[329]

With regard to healthcare, numerous Hadeeths describe how the healthcare sector was attended to during the time of the Prophet to protect the *Maqasid AlSharia* of mind, soul and progeny and to establish *Maslahah*.[330] The Prophet

[325] ibid; Madkur, *Features of Islamic Countries* (AlFalah 1983) [In Arabic]; Rizvi, *The Ideal Islamic Government: As expounded by the Leader of the Faithful Ali Ibn Abi Talib,* (BMMT 1990); Siegman, 'The State and Individual in Sunni Islam.' (1964) *JTMW* 54; Soldatos, "A Critical Overview of Islamic Economics from a Welfare State Perspective" (MPRA, UM 2016); Young et al, *Guidance for Good Governance: Explorations in Qur'anic, Scientific and Cross-cultural Approaches* (IIUM 2008)
[326] ibid; Attia, *Towards Realization of the Higher Intents of Islamic Law* (IIIT 2007); Auda, *Maqasid AlShariah as Philosophy of Islamic Law: A Systems Approach* (IIIT 2008); Duderija, *Maqasid AlShariah and Contemporary Reformist Muslim Thought* (Springer 2014); Ghannouchi, 'The State and Religion in the Fundamentals of Islam and Contemporary Interpretation' (2013) 6 *JCAA* 164
[327] Sahih Muslim 49/78
[328] Crane, 'Human Rights in Traditionalist Islam: Legal, Political, Economic, and Spiritual Perspectives' (2007) 25 *AJISS* 82; Gerber, *State, Society, and Law in Islam* (SUNY 1994); Hussain, Islam: Its Law and Society (Federation 2004); Ibn Taymiyyah, *Shariah Politics in improving the ruler and the ruled* (AlArabiyyah 1961) [In Arabic]; Samier, *Fairness, Equity and Social Cooperation: A Moderate Islamic Social Justice Leadership Model* (Macmillan 2016)
[329] ibid
[330] AlAli, The Prophet's state in Medinah: A study of its establishment and organization (AlMatbu'at 2001) [In Arabic]; AlDaghistani, 'Semiotics of Islamic Law, Maslahah, and Islamic Economic Thought' (2016) 29 *IJSL* 389; Dusuki, et al. 'Maqasid AlShariah, Maslahah and Social Responsibility' (2007) 24 *AJISS* 25; Gummi, "The Islamic Welfare State: The Basic Imperatives Toward a Better Society." (SSRN 2013); Rahmani, 'Siasah Shariah: A Mean to Ensure Justice in the Society' (2011) 26 *AlAdwa* 9 [In Arabic]; Siegman, 'The State and Individual in Sunni Islam.' (1964) *JMW* 54

was also narrated in the Hadeeth to supervise services provided by others as part of the obligation of *Imarat* to ensure that they were capable of protecting *Maqasid AlSharia.*[331] His actions as a ruler were considered in Sharia to be obligations of the state and were a code of conduct and protocol to be adhered to by the Sharia-abiding rulers who followed him, which will be discussed later in this chapter. In addition to the great emphasis and detail within Sharia on the importance of providing services and the investment of public resources for the population's *Maslahah*, Sharia also encourages personal ownership and the formation of *AlQita' AlKhas*.[332]

B. *AlQita' AlKhas* (The Private Sector)

AlQita' AlKhas in Sharia remains secondary to *AlQita' AlA'am* and is subject to its supervision as part of the obligation of *Imarat* because by definition, *AlQita' AlKhas* is an institution of a socio-economic structure that contributes to the national economy.[333] As the government is obliged to protect *Maqasid AlSharia* and seek *Imarat*,[334] by association it is therefore also obliged to ensure that these are protected from negative outside influences, such as the diverse effects of the economy. Accordingly, I argue that it is obligatory for the government to supervise the economy and the sectors that affect it, which include *AlQita' AlKhas*.

[331] ibid
[332] ibid
[333] ibid; Ahmad, 'Role of finance in achieving Maqasid alShariah' (2011) 19 *JIES* 1; Naqvi, *Islam, Economics, and Society.* (Kegan Paul 1994); Sirry, Islamic Economic Principles, Characteristics, and Objectives (AlIskandariya 1988) [In Arabic]
[334] ibid; Abdullah, 'Maqasid AlShariah, Maslahah and corporate social responsibility' (2007) 24 *AJISS* 25; Dusuki, et al. 'Maqasid AlShariah, Maslahah and Social Responsibility' (2007) 24 *AJISS* 25; Ramadan, *Ijtihad and Maslaha: Foundations of Governance* (Lexington 2006)

This obligation to regulate does not imply that the government may interfere with owners' decisions.[335] On the contrary, private businesses are encouraged; however, if these businesses include services to the public, these services will also be supervised, as they affect *Maqasid AlSharia*, which the government is obliged to protect.[336] Accordingly, if a privately owned establishment is found to provide poor quality services, the government would be able to close it and take legal action on behalf of those affected to protect *Maqasid AlSharia* and the establishment of *Imarat*.[337] Transfers from *AlQita' AlA'am* to *AlKhas* are those specified in non-Sharia literature that discuss privatisation, as will be discussed in Chapter Four.[338] According to Sharia law, transfers to *AlQita' AlKhas* would be subject to state regulation, which allows for the anticipation of their Sharia compliance, which will be assessed in Chapter Five.[339] Some scholars in non-Sharia literature have argued that privatisations with state regulation can be successful, lower costs and improve efficiency,[340] however, this varies greatly from transfers to *AlMulkiyah AlFardiyah*, as specified by the Sharia definition, which is not subject to state regulation according to Sharia ownership laws.[341]

[335] AlMaamiry *Private Personal Ownership and its limitations in Islam* (Lancer Books 1987); AlObaidi, *The Three Ownerships: A study about Private public ownership, Private personal ownership, and Governmental public ownership in the Islamic Economical System* (Islamic Affairs 2009); Taleqani, *Islam and Ownership* (Lexington 1983)
[336] ibid; Gerber, *State, Society, and Law in Islam* (SUNY 1994); Hussain, Islam: Its Law and Society (Federation 2004); Ibn Taymiyyah, *Shariah Politics in improving the ruler and the ruled* (AlArabiyyah 1961) [In Arabic]
[337] ibid
[338] Chapter Four Section 4.2
[339] Chapter Five Section 5.3
[340] Chapter One, Section 1.7 Literature
[341] Ali, Privatization (AlAhram 1996) [In Arabic]; AlShabani, Privatization from an Islamic Perspective: Selling the Public Sector to Individuals (AlBayan 1995) [In Arabic]; Hussain, *Privatisation and its social affects on people of the Gulf* (Ghabbash 1996) [In Arabic]; Kamil, *Privatisation and Singularity in the Market* (TA 1997) [In Arabic]

C. *AlMulkiyah AlFardiyah* (Private Personal Possession)

AlMulkiyah AlFardiyah is a form of private ownership; however, it is not subject to governmental supervision in Sharia because unlike *AlQita' AlKhas,* it does not contribute to the economy or provide services to the population.[342] For example, an individual's house, car, land and all personal items do not contribute to the wider population and are forms of *AlMulkiyah AlFardiyah*. In Sharia law, an individual is granted free disposal of *AlMulkiyah AlFardiyah* items, which includes selling, buying, investing, donating and granting.[343] This granted free will is what differentiates between ownership of *AlQita' AlKhas* (private sector) and *AlMulkiyah AlFardiyah* in Sharia.[344]

Accordingly, transfers to *AlMulkiyah AlFardiyah* as specified in Sharia scholars' definition of privatisation would not be subject to state regulation. This arrangement is known as a deregulation and is not considered a form of privatisation in non-Sharia literature,[345] and the new owner would be granted free disposal of his possession. Therefore, the owner would be able to deprive the population of the services provided. Consequently, Sharia scholars argue that privatisation, based on their definition, would prevent governments from

[342] AlMaamiry *Private Personal Ownership and its limitations in Islam* (Lancer 1987); Baltaji, Private Ownership in The Islamic Economical System(AlShabab 1988) [In Arabic]; Behdad, *Property Rights and Islamic Economic Approaches* in Jomo, *Islamic Economic Alternative. Critical Perspectives and New Directions* (Macmillan 1992); Messick, "Property and the Private in a Sharia System." (2003) *JSR* 711; Siddiqi, *Islam's Approach to right of property,* (IP 1978)

[343] ibid

[344] Behdad, "Property Rights in Contemporary Islamic Economic Thought: A Critical Perspective" (1989) 2 *RSE* 185; Crane, 'Human Rights in Traditionalist Islam: Legal, Political, Economic, and Spiritual Perspectives' (2007) 25 *AJISS* 82; Gulaid, *Ownership in Islam* (IDI 1991); Taleqani, *Islam and Ownership* (Lexington 1983)

[345] Karlaftis, 'Privatisation, regulation and competition: A thirty-year retrospective on transit efficiency' (2008) *ITF* 67; Kemp, *Privatisation: The Provision of Public services by the Private Sector* (McFarland 2007); Kettle *Sharing Power: Public Governance and Private Markets.* (Brookings 1993); Kikeri, *Privatisation: trends and recent developments* (WBP 2005)

fulfilling their obligations.[346] For example, scholars such as Saba portrayed privatisation as a way for corrupt governments to abandon obligations, leaving citizens deprived of their rights.[347] Hence, Sharia scholars argue that possession of anything that is a public benefit is only permitted by either *AlQita' AlA'am* or *AlKhas*, which the government is obliged to regulate.[348]

Accordingly, I argue that transferring healthcare to *AlMulkiyah AlFardiyah* as the Sharia definition specifies would not allow for the supervision of the healthcare services provided; therefore, this may risk the quality of the services, which is a healthcare provision requirement in Sharia. Consequently, I argue that Sharia scholars are justified in their opinion against privatisation as they define it. Nonetheless, it is essential to analyse non-Sharia literature that discusses privatisation to determine whether Sharia scholars' opinion is specific to the definition on which it is based or whether their opinion can be applied to privatisation as a whole. An analysis of the meaning and arrangements of privatisation in non-Sharia literature will be discussed in Chapter Four.[349]

Furthermore, it can be argued that if Sharia scholars were to specify the transfer to *AlQita' AlA'am* in the same way that non-Sharia bodies of literature do, it would be possible for them to reach a different opinion about privatisation, as *AlQita' AlA'am,* unlike *AlMulkiyah AlFardiyah,* is subject to state

[346] Ali, Education and Privatisation (AlAhram 1996) [In Arabic]; AlShabani, Privatization from an Islamic Perspective: Selling the Public Sector to Individuals (AlBayan 1995) [In Arabic]; Saba, Privatisation and a Weak and Absent Public Sector (AlMawqif 1994) [In Arabic]; Salhab, 'A Critical Study of the Privatisation Project (AlMawqif, 1999) 143 [In Arabic]
[347] ibid
[348] Ali, Privatization (AlAhram 1996) [In Arabic]; Eissa, Privatisation and a Diversified Economy (AlMuntalaq 1996) [In Arabic]; Kamil, *Privatisation and Singularity in the Market* (TA 1997) [In Arabic]; Rasool, *State responsibility and privatization* (AlAmwal 1998) [In Arabic]; Sabri, *Privatisation: Transfering Public Ownership in Light of Islamic Shariah* (Awanj 2000) [In Arabic]
[349] Chapter Four Section 4.2

regulation, which has been proven in non-Sharia literature to be essential for privatisation to be successful. Understanding the different forms of ownership in Sharia and their different laws supports the argument set forth by this chapter that the Sharia scholar's definition is problematic due to laws specific to possessions of *AlMulkiyah AlFardiyah*, namely free disposal granted to the owner and the lack of governmental regulation of possessions.[350]

2.5.2.2 Shortcomings of the Sharia Scholar Analysis

Due to the specification of the transfer of *AlMulkiyah* (ownership) in the Sharia definition, the Sharia analysis of privatisation focuses only on transfers of ownership.[351] Furthermore, an examination of the literature demonstrated that Sharia scholars fixate their analyses on improving efficiency through the total transfer of ownership. Accordingly, Sharia scholars argue that quality and efficiency could be achieved through more basic measures – for example, administrative reform and regulation. Sharia scholars emphasise that resorting to privatisation rather than administrative reform is 'like a patient resorting to amputating a limb before taking medication to cure his illness'.[352]

However, contrary to Sharia scholar opinion, reality demonstrates that reform is insufficient to increasing efficiency. One example of this is the Saudi Ministry

[350] Behdad, "Property Rights in Contemporary Islamic Economic Thought: A Critical Perspective" (1989) 2 *RSE* 185; Crane, 'Human Rights in Traditionalist Islam: Legal, Political, Economic, and Spiritual Perspectives' (2007) 25 *AJISS* 82; Gulaid, *Ownership in Islam* (IDI 1991); Taleqani, *Islam and Ownership* (Lexington 1983)

[351] Ali, Privatization (AlAhram 1996) [In Arabic]; Eissa, Privatisation and a Diversified Economy (AlMuntalaq 1996) [In Arabic]; Kamil, *Privatisation and Singularity in the Market* (TA 1997) [In Arabic]; Rasool, *State responsibility and privatization* (AlAmwal 1998) [In Arabic]; Sabri, *Privatisation: Transfering Public Ownership in Light of Islamic Shariah* (Awanj 2000) [In Arabic]

[352] AlHarthi, Privatisation of Services (Arak 2012) [In Arabic]; Pitelis, *The Political Economy of Privatization* (Routledge 1993); Mills, 'To contract or not to contract? Issues for low and middle-income countries' (1998) 13 *JHPP* 32; Vickers, et al., 'Economic perspectives on privatization' (1991) 5 *JEP* 111

of Health, which is notorious for its administrative reform; it has had ten different ministers over the past three years alone.[353] These changes did not serve the purpose of improving efficiency or relieving the financial burden as scholars proposed; on the contrary, the financial situation escalated to the significant deficit in funding.[354] Due to the financial situation in Saudi Arabia, which will be discussed in Chapter Three,[355] it could be argued that it is highly unlikely that continuing with administrative reform would lead to different results. Therefore, it is essential to consider an alternative policy, such as privatisation, if proven to be Sharia-compliant.[356]

Nonetheless, Sharia scholars did not consider the possibility that privatisation may in fact extend beyond efficiency improvement. The decision to privatise can be made for financial purposes, as some scholars in non-Sharia literature argue, rather than for what administrative reform can fix.[357] Furthermore, Sharia scholars have disregarded that Sharia obligations, including the obligation on the state to deliver welfare services, are emphasised in Sharia primary sources to be within their ability,[358] as the Quran clearly states, 'God

[353] https://www.boe.gov.sa
[354] Alkhamis et al,. 'Financing healthcare in Gulf Cooperation Council countries: a focus on Saudi Arabia' (2014) 29 *IJHPM* e64; AlHussain, 'Saudi Healthcare System: Where does improving the services and performance begin? (RMA December 2004) [in Arabic]; Noland, et al. "Arab economies at a tipping point." (2008) 15 *JMEP* 60; Ramady, 'The Saudi Arabian economy: Policies, achievements, and challenges' (Springer 2010)
[355] Chapter Three Section 3.3.1
[356] I have explained in Chapter One why I am only considering privatisation in this thesis although other policies are more ethical and could be more successful.
[357] Lahn, et al., *Burning Oil to Keep Cool. The Hidden Energy Crisis in Saudi Arabia.* (Chatham House 2011); McKinsey Global Institute, *Saudi Arabia Beyond Oil. The Investment and Productivity Transformation*. (2015); Thielges, et al., *Sustainable energy in the G20: prospects for a global energy transition* (IASS 2016)
[358] AbdulRauf, *Defining Islamic Statehood: Measuring and Indexing Contemporary Muslim States,* (Springer 2015); Ahmad, 'Islamic Law, Adaptability and Financial Development' (2006) 13 *JIES* 79; AlRaysuni, *Theory of the Higher Objectives and Intents of Islamic Law* (IIIT 2005); AlMaududi, *On the Application of Shariah in the Present Era* (AlRushd 2012) [In Arabic]; Chapra, *Islam and the Economic Challenge* (IIIT 1992); Kamali, 'Policies of Islamic Government' (1989) 6 *AJISS* 59; Mayer, *Islam and Human Rights: Tradition and Politics* (Hachette 2012); Souaiaia, *Islamic Law and Government*. (WCP 2002); Vikor, *Between*

does not place a burden on a soul greater than it can bear', which includes both devotional and non-devotional Sharia obligations.[359] It could be said that the beauty of Sharia obligations is this individualistic scenario-based approach, which takes into consideration reality and ever-changing circumstances and allows a more rational approach rather than if these were absolute obligations unaffected by ability or circumstances, as Sharia scholars have portrayed in their analyses. Nonetheless, Sharia scholars failed to acknowledge that governments may require alternative methods of financing to fulfil Sharia obligations and ensure *Maslahah*.

Additionally, it appears that Sharia scholars have disregarded the obligation on the state to nourish the economy like the Prophet had when he invested in land to provide for his people.[360] It is essential for the government to be able to generate revenue to fulfil its obligations towards its citizens, as Sharia calls not for full ownership and dictatorship of the government but for economic growth, and it encourages matters that serve *Maslahah*.[361] Accordingly, I argue that Sharia scholars may have misunderstood what privatisation entails, as Sharia encourages investments in the benefit of the society and obliges the state to regulate private investments, which I argue can be achieved through models of

---

God and the Sultan: A History of Islamic law (OUP 2005); Zarqa, *An Approach to Human Welfare* in Ghazali, et al., *Readings in the Concept and Methodology of Islamic economics.* (Pelanduk 1989)

[359] Quran 2:286

[360] Ahmad, 'Role of finance in achieving Maqasid alShariah' (2011) 19 *JIES* 1; AlKatani, The Prophetic Government: Administrative Formalities (AlArqam 2008) [In Arabic]; Chapra, *The Islamic Vision of Development in the Light of the Maqasid AlShari`ah* (IDB 2008); ElKaleh, 'The Ethics of Islamic Leadership' (2013) 2 *JAC* 188; Ghazali, *Development and Islamic Perspective*. Malaysia: (Pelanduk 1990); Ghannouchi, 'The State and Religion in the Fundamentals of Islam and Contemporary Interpretation' (2013) 6 *JCAA* 164; Mahmood, *The Reference of The Arab Islamic Civilisation* (AlSalasil 1984) [In Arabic]

[361] *The Islamic Conception of Justice* (JHUP 1984); Naqvi, *Perspectives on Morality and Human Well-Being: A Contribution to Islamic Economics* (IF 2003); Ramadan, *Ijtihad and Maslahah: The Foundations of Governance* in *Islamic Democratic Discourse: Theory, Debates and Philosophies* (Lexington 2006); Mannan, *Islamic economics: Theory and practice* (Ashraf 1970); Ozcan, 'Is Islam an Obstacle to Development? Evidence to the Contrary and Some Methodological Consideration'. (1995) 2 *JID* 1; Sadeq, *Economic Development in Islam* (Pelanduk 1990)

privatisation. For example, these benefits may be achieved through outsourcing, as some scholars and authorities in non-Sharia literature claim,[362] which will be discussed further in Chapter Four.[363]

The lack of consideration given to the need for new methods of finance in Sharia literature that discusses privatisation may be because the time at which Sharia scholars discussed privatisation was a time of prosperity in Arab countries such as Saudi Arabia, according to Ministry of Finance figures.[364] During that time, the Saudi government provided all welfare services for free to all residents.[365] Therefore, it could be argued that there was no need to consider other means of financing or to view privatisation through the lens of cost cutting. Furthermore, this financial status may explain why Sharia scholars did not consider economic systems to macro-finance service provision from within Sharia, such as *Takaful* in their discussions of privatisation, and only provided proposals of microfinancing through *Sadaqah* and *Zakat,*[366] as I will discuss in Chapter Four. [367] Finally, despite the similarities between *Takaful* and financial privatisation, as I will argue in Chapter Five,[368] these similarities have not been investigated.

---

[362] Chalkley, et al., 'Contracts for the National Health Service' (1996) 106 *EJ* 1691; Loevinsohn, *Checklist for contracting of health services* (World Bank 2000); Palmer, 'The use of private-sector contracts for primary health care: theory, evidence and lessons for low-income and middle-income countries' (2000) 78 *Bulletin WHO* 821; Taylor, 'Contracting for Health Services' in *Private Participation in Health Handbook* (World Bank 2000)

[363] Chapter Four Section 4.2

[364] Saudi Ministry of Finance website Document Library www.mof.gov.sa

[365] AlBejaidi, 'Healthcare system in Saudi Arabia: An analysis of structure, total quality management and future challenges' (2010) 2 *JAPSS* 794; Alshahrani, et al. Economic growth and government spending in Saudi Arabia: An empirical investigation. (IMF 2014); Benchea, "Rebuilding the Arab Economies: New Regional and Global Strategies." (2015) 7 *EJIS* 29; Garba, 'Managing urban growth and development in the Riyadh metropolitan area, Saudi Arabia' (2004) 28 *Habitat* 593; Malik. et al. The political economy of Saudi Arabia (Routledge 2007)

[366] Ayub, Understanding Islamic Finance (Wiley 2008); INCEIF, *Takaful Realities and Challenges* (Pearson 2012); Ismail, et al, *Essential Guide to Takaful (Islamic Insurance)* (CERT 2008); Syahida, 'Risk Management via Takaful from a perspective of Maqasid Alshariah' (2012) 65 *JSBS* 535

[367] Chapter Four Section 4.3

[368] Chapter Five Sections 5.4 and 5.5

2.6 Conclusion

Since the basis of the Sharia argument against privatisation is that it prevents the state from fulfilling obligations, it is essential to define the government's Sharia obligations in the context of healthcare. I conclude that although the *Maqasidic* and *Maslahah* approaches remain important in Sharia and are widely applied, the obligations of the state in the context of healthcare by adopting either of these approaches alone remain unclear, and the arguments are subject to debate. As the approaches are insufficient, it was essential to adopt a three-fold approach. It was concluded that healthcare provision is an obligation on the state according to the *Hanbali* school, which is primarily adopted in Saudi Arabia, as it is *Maslahah Mu'tabarah* and one of the *Huquq Allah,* and it protects the *Maqasid AlSharia* of life, progeny and mind.

Based on the findings of this chapter, Sharia obliges states to ensure *Maslahah,* protect *Maqasid AlSharia* and establish *Imarat*. In the context of healthcare, this can only be fulfilled by states that provide healthcare to all within their borders and ensure that the healthcare provided is essential, available, accessible, affordable and of high quality. These healthcare requirements are crucial to ensuring that the aim of protecting the *Maqasid AlSharia* of mind, soul and progeny is achieved. Collectively, these obligations and requirements of healthcare provision determine what Sharia compliance means in the context of healthcare provision, and will serve as a benchmark when assessing models of

privatisation in Chapter Five.[369] Furthermore, it is essential to note that supervision of the services provided can only be achieved if these healthcare services are part of either the public or private sectors, as concluded previously in this chapter. Accordingly, I argue that transferring healthcare to *AlMulkiyah AlFardiyah*, as the Sharia definition specifies, would not allow for the supervision of healthcare services provided, and may compromise the quality of the services.

Consequently, I conclude that due to Sharia laws related to *AlMulkiyah AlFardiyah*, Sharia scholars were justified in their opinion against the arrangement identified in their definition, which is known in non-Sharia literature as deregulation. However, the Sharia scholar opinion against privatisation is specific to the model identified in their definition, and therefore cannot be considered applicable to privatisation in general, as claimed in Sharia literature. Accordingly, the analysis of privatisation in Sharia scholarship would have been more accurate and all-encompassing if Sharia scholars had chosen the term *AlQita' AlKhas* in their definition rather than *AlMulkiyah AlFardiyah* and included partial transfers and transfers of management and provision, as non-Sharia literature discussing privatisation has done. Subsequently, I argue that a different decision could have been reached regarding privatisation; thus, more models of privatisation would have been included in the analysis. This will be discussed further in the following chapters.

[369] Chapter Five Section 5.3

In the next chapter I will discuss the state of healthcare provision in Saudi Arabia and assess its compliance with Sharia based on the findings of this chapter. Furthermore, I will outline Saudi healthcare laws and identify how they differ from Sharia healthcare obligations and requirements. Identifying the gaps in Saudi healthcare laws will allow this thesis to identify whether Saudi healthcare allows for different methods for the financing and provision of healthcare that can be argued in order for models of privatisation to be adopted.

Chapter Three Saudi Healthcare and Sharia Compliance

3.1 Introduction

The Basic Law of Governance obliges all laws in Saudi Arabia to comply with Sharia, including healthcare provision laws.[370] This Sharia adherence is problematic considering the Sharia scholars' opinion against privatisation and the enforcement of 2030VFH.[371] As mentioned in Chapter One,[372] 2030VFH calls for the privatisation of the healthcare sector, however, based on the findings of Chapter Two, I concluded that Sharia scholars were justified in their opinion against their definition of privatisation. In this chapter, I focus on Saudi healthcare laws, and assess if they differ from the Sharia healthcare obligations identified in Chapter Two.[373]

In this chapter I will identify gaps in Saudi healthcare laws, which arguably allow the government to implement models of privatisation. For example, if Saudi law does not oblige the government to provide or finance healthcare services, accordingly, this would allow the adaptation of privatisation of finance and provision of healthcare services. Accordingly, it would be concluded that these arrangements of privatisation are compliant if they fulfil the Sharia healthcare provision requirements.

[370] The Basic Law of Governance, Royal Decree No.A/90, 31st January 1992
[371] Ali, *Privatisation* (AlAhram 1996) [In Arabic]; Almashabi, et al., 'Saudi Arabia's Deputy Crown Prince Outlines Plans: Transcript.' *Bloomberg*, 4 April 2016; Salhab, 'A Critical Study of the Privatisation Project' (AlMawqif, 1999) [in Arabic]; Smith, G. In U-Turn, Saudis Choose Higher Prices Over Free Oil Markets. – *Bloomberg*, 29 September 2016
[372] Chapter One Section 1.10.2
[373] Chapter Two Section 2.2

In addition, I will assess if modern Saudi healthcare is adherent to Sharia healthcare provision requirements. The first section of this chapter will assess if the present condition of the Saudi healthcare provision can be considered Sharia compliant, as the Basic Law of Governance obliges. The next section will assess if the current circumstances facing the Saudi healthcare system, based on the scholarship and figures by the Saudi government and Ministry of Health, can be considered circumstances of need and necessity. Need and necessity are exceptional circumstances allowing Sharia law Maxims to be applied, as demonstrated in Chapter One.[374] The application of Sharia law Maxims allows for what is traditionally against Sharia to be considered compliant in light of the circumstances of need and necessity.[375] Adopting this methodology is essential to correctly and effectively assessing if the privatisation of healthcare can be considered Sharia compliant, given the current circumstances in Saudi Arabia, which will be discussed in this chapter.

Finally, I will consider literature discussing healthcare privatisation in Saudi Arabia and 2030VFH. I will assess if 2030VFH adequately incorporates solutions for the problems facing the Saudi healthcare provision which may compromise its Sharia compliance. As well, an initial basic assessment of 2030VFH will be completed at the end of this chapter. However, it is important to note that the models of privatisation 2030VFH consists of will be assessed for Sharia compliance in Chapter Five,[376] after the forms and purposes of

[374] Chapter One Section 1.10.6
[375] Jereshah, *Origins of Islamic Law, Content and Characteristics* (Wahbah 1979) [in Arabic]; Kamali, *Shariah Law: An Introduction* (OneWorld 2008); Karcic, 'Applying the Shariah in Modern Societies: Main Developments and Issues.' (2001) 40 *IS* 207; Khaliq,et al. "Revisiting of an Islamic Options Permisibility from Shariah Perspectives." (2015) 1 *GRIEB* 175
[376] Chapter Five Section 5.3

privatisation are discussed in Chapter Four.[377]

3.2 Saudi Healthcare Laws

Healthcare provision in Saudi Arabia is subject to national healthcare laws, and both regional and international conventions. This section will outline these national and international healthcare obligations and assess whether these are compatible with Sharia.

3.2.1 Saudi National Healthcare Laws

In Saudi Arabia, there are several national laws related to healthcare provision, namely the Basic Law of Governance, the Saudi Health Law, the Cooperative Health Insurance Law, the Saudi Commission for Health Specialties Law, and the Saudi Health Profession Practice Law.[378] Collectively, these laws dictate Saudi Arabia's healthcare provision laws and requirements.

I. Availability & Accessibility

According to the Basic Law of Governance Article 31, the state is obliged to 'take care of health issues and provide health care for each citizen'.[379] Moreover, Article 2 of the Saudi Health Law, which states 'all residents in an equitable, and

[377] Chapter Four Section 4.2
[378] The Basic Law of Governance, Royal Decree No.A/90, 31st January 1992; The Cooperative Health Insurance Act, Royal Decree M/10 August (1999); The Saudi Commission for Health Specialities Law, Royal Decree No. M/2, 5th August 1992; The Saudi Health Law, Royal Decree No. M/11, 4th June 2002; The Saudi Health Profession Practice Law, Royal Decree No. M/59, 6th December 2005
[379] The Basic Law of Governance, Royal Decree No.A/90, 31st January 1992

facilitated manner'.[380] Consequently, the state must ensure the availability and accessibility of healthcare services to all citizens.

II. Affordability

Unlike Sharia, the Basic Law of Governance does not explicitly mention the affordability or quality of the healthcare services provided. As affordability is not explicitly mentioned in the text of the law, it can be concluded that the burden of financing healthcare does not lie upon the state and that Saudi law allows transferring the financing of healthcare to nongovernmental bodies. Thus, Saudi law allows for finance privatisation to be implemented. For example, healthcare could be paid for through premiums or fee-for-service payments,[381] all of which are transfers of finance and are considered forms of privatisation, which will be discussed in Chapter Four.[382]

Nonetheless, it could be argued that affordability can be understood as part of the availability and accessibility of healthcare. As mentioned in Chapter Two,[383] healthcare is considered accessible and available when it is financially accessible to all citizens, regardless of financial ability.[384] However, if affordability is to be considered part of the availability and accessibility of healthcare, the state's obligation remains debatable, and would not necessarily

[380] The Saudi Health Law, Royal Decree No. M/11, 4th June 2002
[381] 'Round up: Health sector policy, financing and privatisation' (2011) 19 *RHM* 213; Kahn, et al., *Privatisation and the welfare state* (PUP 2014); Young, 'Privatizing healthcare' (1990) 5 *IJHPM* 237; Zahner S. 'Local public health system partnerships' (2005) 120 *PHR* 76
[382] Chapter Four Section 4.2
[383] Chapter Two Section 2.3.1
[384] Victora et al, 'Making Health Systems more equitable' (2004) 364 *Lancet* 1273; Wagstraff, et al. 'Equity in Health Finance and Delivery' in Newhouse, J. *Handbook of Health Economics* (Elsevier Science 2000); WHO 'A WHO Framework for Health System Performance Assessment' (1999); Yasin, et al. 'Universal Coverage in an era of privatisation: can we guarantee health for all?' (2012) 12 BMC

entail providing free healthcare. Similarly, Sharia does not explicitly state that healthcare must be provided for free, despite the Prophet being said to have treated the ill at his own expense,[385] as mentioned in Chapter Two.[386]

Therefore, I argue that in order for the Saudi government to fulfil the obligation under Article 31 of the Basic Law of Governance and Article 2 of the Saudi Health Law, healthcare would need to be affordable.[387] Affordability of healthcare is essential in Saudi Arabia, considering the high estimated percentage of poverty. According to independent agencies and media estimates, at least 12.5% of Saudis were living in relative poverty in 2013, while some reported percentages were as high as 30% in 2008.[388] Therefore, the pricing of services must accommodate the less fortunate for healthcare to be considered adherent to Article 31 of the Basic Law of Governance.[389] Article 31 of the Basic Law of Governance could also be said to allow for the implementation of forms of healthcare finance, such as finance privatisation, which will be discussed in Chapter Four.[390]

[385] Abdelkader, *Social Justice in Islam* (IIIT 2000); AlAli, *The Prophet's state in Medinah: A study of its establishment and organization* (AlMatbuat 2001) [in Arabic]; AlKatani, *The Prophetic Government: Administrative Formalities* (AlArqam 2008) [In Arabic]; AlKhayat, 'Health as a Human Right in Islam' in *The Right Path to Health: Health Education through Religion* (WHO Regional Office, Cairo, 2004)
[386] Chapter Two Section 2.3.1
[387] The Basic Law of Governance, Royal Decree No.A/90, 31st January 1992; The Saudi Health Law, Royal Decree No. M/11, 4th June 2002
[388] Baker, 'Rich Nation, Poor People: Saudi Arabia by Lynsey Addario' *Time* 23 May 2013; Mackey, "Saudi Video Blogger Reportedly Detained for Showing Poverty in Riyadh' *NYT* (New York 19 October 2011); Sullivan, 'In Saudi Arabia, unemployment and booming population drive growing poverty' *WP* (3 December 2012); Sullivan, 'Saudi Arabia's riches conceal a growing problem of poverty' *Guardian* (London, 1 January 2013)
[389] The Basic Law of Governance, Royal Decree No.A/90, 31st January 1992
[390] Chapter Four Section 4.2.1.4

Similarly, according to the Saudi Health law Article 1 subsection 6, the state is obliged to make healthcare services available to all citizens.[391] However, the Saudi Health Law clearly states that this obligation is not necessarily to be provided or financed by the state.[392] This indicates that the Saudi Health law allows services to be provided and financed by institutions other than the government. This is further reiterated in Article 13, which states that the state will provide healthcare services to foreigners through the Cooperative Health Insurance System, rather than through the state budget.[393] Further, according to Article 14, visitors to Saudi Arabia are obliged to have travel health insurance to cover their healthcare expenses.[394] Collectively, this suggests that forms of finance and the provisions of healthcare similar to those already existing in Saudi Arabia may be further adopted and expanded in accordance to Saudi law. For example, healthcare finance privatisation and the outsourcing of services, both of which are forms of privatisation as will be discussed in Chapter Four, [395] could conform to the Saudi Health Law.

More specific to financing, Saudi Health Law Article 10 states that healthcare services are to be financed by the state budget, the income of the Cooperative Health Insurance for foreigners, Islamic methods of financing such as *Waqf,* donations and others form of Islamic economic systems.[396] The Article clearly identifies the state's liberty in finding a means to finance the healthcare system from within the methods accepted by Sharia. Nonetheless, the Article does not

[391] The Saudi Health Law, Royal Decree No. M/11, 4th June 2002
[392] ibid
[393] ibid
[394] ibid
[395] Chapter Four Section 4.2
[396] The Saudi Health Law, Royal Decree No. M/11, 4th June 2002

explicitly include *Takaful* despite the fact that the Cooperative Health Insurance system is based on *Takaful,*[397] which could be argued to be similar to health finance privatisation. Accordingly, although the Article does not explicitly reference healthcare privatisation as a method for financing healthcare, the Article allows for similar methods of finance to those specified in the Article to be considered. For example, some methods of privatisation, are similar to *Takaful* and the Cooperative Health Insurance system, and are therefore more compatible to the requirements of Article 10 of the Saudi Health Law, as will be demonstrated in Chapters Four and Five.[398]

III. Quality

Although not explicitly stated, quality can be deduced from Article 31 of the Basic Law of Governance.[399] The Article clearly states that the purpose of healthcare is 'to take care of health issues' which can only be achieved if the services provided are of quality.[400] Therefore, it can be deduced that the Saudi state is obliged to provide healthcare services to its citizens, according to Article 31 of the Basic Law of Governance. However, the Basic Law of Governance does not state the details or metrics of the standard and quality required. The

[397] AlMobarak, 'Beneficiaries' Satisfaction with the Cooperative Health Insurance System (CHIS) in the Kingdom of Saudi Arabia: A Case Study of Riyadh City' (PhD Thesis, University of Hull 2010); Alosaimi, et al. *The equity in access to health services in cooperative health insurance system, Jeddah, 2008-2009.* (ABCM 2009); Barakah, et al. 'The Cooperative Insurance in Saudi Arabia: a Nucleus to Health Reform Policy' (2011) 21 *IPEDR* 6; Implementing Regulations of the Cooperative Health Insurance Law in the Kingdom of Saudi Arabia (Amended) Cooperative Council for Health Insurance, Session 73 Ministerial Decision DH/1/30/6131 (2009); Rules of Implementation of Cooperative Health Insurance System & Cooperative Health Policy, Ministry of Health Resolution 460/23/DH (2002); The Cooperative Health Insurance Act, Royal Decree M/10 August (1999)

[398] Chapter Four Section 4.2 and Chapter Five Sections 5.3 and 5.4

[399] The Basic Law of Governance, Royal Decree No.A/90, 31st January 1992

[400] AlAhmadi, et al., 'Quality of primary healthcare in Saudi Arabia: a comprehensive review' (2005) 17 *IJQH* 331; Albejaidi, F. "Healthcare system in Saudi Arabia: An analysis of structure, total quality management and future challenges." (2010) 2 *JAPSS* 794; Aljuaid, et al. "Quality of care in university hospitals in Saudi Arabia: a systematic review." (2016) 6 *BMJ;* Arah, et al. "A conceptual framework for the OECD healthcare quality indicators project." (2006) 18 *IJQH* 5; Loeb, "The current state of performance measurement in healthcare." (2004) 16 *IJQH*

obligation for quality is evident in Article 5 of the Saudi Health Law, which states that the government is obliged to set regulations and guidelines for licensing private healthcare institutions and their staff.[401] Quality is further emphasised in the Saudi Commission for Health Specialties Law, and the Saudi Health Profession Practice Law,[402] both of which state the criteria, metrics and guidelines required of healthcare professionals in both private and public sectors.

To enhance the quality of services, Article 2 of the Saudi Health Law expresses that the government is obliged to ensure that full essential healthcare services are provided to all residents in an equitable and accessible manner and that the state is obliged to monitor these services.[403] Accordingly, the Article ensures the availability, accessibility and essential services to all residents with no discrimination, and obliges the state to govern and supervise these services. This responsibility is emphasized further in Article 5 of the Saudi Health Law, which obliges the government to supervise services provided by the private sector.[404] Governmental supervision of services is argued by some non-Sharia scholars to be an ideal environment for implementing privatisation,[405] as will be discussed in Chapter Four.[406] Therefore, Articles 5 and 2 of the Saudi Health Law set standards for an environment ideal for implementing the privatisation

[401] The Saudi Health Law, Royal Decree No. M/11, 4th June 2002
[402] The Saudi Commission for Health Specialities Law, Royal Decree No. M/2, 5th August 1992; The Saudi Health Profession Practice Law, Royal Decree No. M/59, 6th December 2005
[403] The Saudi Health Law, Royal Decree No. M/11, 4th June 2002
[404] ibid
[405] Akinci, 'The Role of Privatisation in Healthcare Services' (2000) 3 *AEEE* 14; Kahn, et al., *Privatisation and the welfare state* (PUP 2014); WHO (Task Force on Health Economics) 'Privatisation in Health' (1995) WHO/TFHE/TBN/95.1; Yasin, et al. 'Universal Coverage in an era of privatisation: can we guarantee health for all?' (2012) 12 BMC
[406] Chapter Four Section 4.2

of healthcare, according to pro-privatisation scholarship.[407] Nonetheless, practical evidence available in non-Sharia bodies of literature provide contrary opinions,[408] as will be discussed in Chapter Five.[409]

In summary, the national laws for Saudi healthcare are not identical to those in Sharia. Saudi healthcare laws provide loopholes and flexibility with regards to the finance and provision of healthcare, and therefore could be said to allow for different forms and arrangements of finance and provision to be implemented by either governmental or nongovernmental institutions. I argue these arrangements of provision and finance by nongovernmental institutions are forms of privatisation, as will be discussed in Chapter Four.[410]

3.2.2 International Conventions and Saudi Healthcare

Saudi Arabia has been a member of the United Nations since 1945, and has signed and ratified several international and regional human rights conventions. Saudi Arabia has signed and ratified the Arab Charter for Human Rights (ACHR), the Universal Declaration of Human Rights (UDHR), the International Covenant on Economic, Social, and Cultural Rights (ICESCR), the Convention on the Elimination of All Forms of Discrimination Against Women

[407] ibid; Karlaftis, 'Privatisation, regulation and competition: A thirty-year retrospective on transit efficiency' (2008) *ITF* 67; Kemp, *Privatisation: The Provision of Public services by the Private Sector* (McFarland 2007); Saati, 'Privatisation of public hospitals: future vision and proposed framework'. *AlEqtisadiyah* (Riyadh 2 December 2003) [in Arabic]
[408] Aksan et al, 'The change in capacity and service delivery at public and private hospitals in Turkey: A closer look at regional differences' (2010) 10 *BMC* 300; Berer, 'Privatisation in health system in developing countries: whats in a name?' (2011) 19 *RHM* 4; Bienen, et al. 'The political economy of privatisation in developing countries' (1989) 17 *WD* 617; Birdsall, et al., 'Winners and losers: Assessing the distributional impact of privatisation' (2003) 31 *WD* 1617; Coutts, et al., 'Understanding privatisation's impacts on health: lessons from the soviet experience' (2008) 62 *JECH* 664
[409] Chapter Five Section 5.3
[410] Chapter Four Section 4.2

(CEDAW), the Cairo Declaration on Human Rights in Islam (CDHRI), the Convention on the Rights of Persons with Disabilities (CRPD), and the Convention for the Rights of the Child (CRC). All of these conventions contain Articles specific to the right to healthcare.[411]

ACHR, UDHR, and CEDAW all specify that every individual has a right to life.[412] Therefore, ensuring access to essential healthcare is obligatory on ratifying states. However, CRPD goes beyond essential healthcare and accessibility, emphasising that states are obliged to ensure services are provided locally and as close as possible to patients' local communities, including rural areas.[413] Therefore, geographical accessibility is obligatory on ratifying states, which is similar to the obligation according to Sharia outlined in Chapter Two.[414]

Meanwhile, the ICESCR and CRC go beyond essential healthcare to the highest attainable standard of both physical and mental health services, which are available and economically accessible to all, without discrimination.[415] Ensuring the quality of healthcare is obligatory in ratifying states. In addition, CEDAW

---

411 League of Arab States, *Arab Charter on Human Rights*, 15 September 1994; Organization of the Islamic Conference (OIC), *Cairo Declaration on Human Rights in Islam*, 5 August 1990; UN General Assembly, *Convention on the Elimination of All Forms of Discrimination Against Women*, 18 December 1979, United Nations, Treaty Series, vol. 1249, p. 13; UN General Assembly, *Convention on the Rights of Persons with Disabilities : resolution / adopted by the General Assembly*, 24 January 2007, A/RES/61/106; UN General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, p. 3; UN General Assembly, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3; UN General Assembly, Universal Declaration of Human Rights (adopted 1948 UNGA Res 217 A(III) (UDHR)

412 League of Arab States, *Arab Charter on Human Rights*, 15 September 1994; UN General Assembly, *Convention on the Elimination of All Forms of Discrimination Against Women*, 18 December 1979, United Nations, Treaty Series, vol. 1249, p. 13; UN General Assembly, Universal Declaration of Human Rights (adopted 1948 UNGA Res 217 A(III) (UDHR)

413 UN General Assembly, *Convention on the Rights of Persons with Disabilities : resolution / adopted by the General Assembly*, 24 January 2007, A/RES/61/106

414 Chapter Two Section 2.3

415 UN General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, p. 3; UN General Assembly, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3

expands on the types of healthcare services, emphasising that women must be provided appropriate services in connection to pregnancy and post-natal treatments.[416] CEDAW also obliges ratifying states to provide free healthcare services to women when necessary.[417] Hence, ensuring both the acceptability and affordability of healthcare services is obligatory for ratifying states.

However, CDHRI states that essential healthcare and equal access are only obligatory for ratifying states within the limits of their available resources.[418] In other words, the state is not obliged to provide what it is unable to afford. Nonetheless, ratifying states are not discouraged from finding means of increasing and expanding their financial capacity. In other words, the CDHRI does not limit or prescribe the available means of financing healthcare services, which includes forms of privatisation, as will be discussed in Chapter Four.[419]

Saudi Arabia is one of the countries that recognizes the Right to Health as a fundamental right, under both international law and the Sharia and Islamic Ethics obligations.[420] The Right to Health is known as the economic, social, and cultural right to a universal minimum standard of health which all individuals are entitled to. The WHO constitution defines the Right to Health as 'the

[416] UN General Assembly, *Convention on the Elimination of All Forms of Discrimination Against Women*, 18 December 1979, United Nations, Treaty Series, vol. 1249, p. 13
[417] ibid
[418] Organization of the Islamic Conference (OIC), *Cairo Declaration on Human Rights in Islam*, 5 August 1990
[419] Chapter Four Section 4.2
[420] Council of the League of Arab States, The Arab Charter on Human Rights, 2004; Organisation of the Islamic Conference, Cairo Declaration on Human Rights in Islam, 1990; UN, Convention on the Elimination of All forms of Discrimination against Women , 1979; UN, Convention on the Rights of Persons with Disabilities, 2006; UN, International Covenant on Economic, Social and Cultural Rights, 1966; UN, Convention on the Rights of the Child, 1989; UN, The Universal Declaration of Human Rights, 1948; WHO 'The Right to Health' Factsheet August 2007; WHO, 'Islamic Code of Medical and Health Ethics' (2005) EM/RC52/7

enjoyment of the highest attainable standard of health'.[421] Accordingly, states that have signed the WHO constitution, such as Saudi Arabia, must generate conditions in which their citizens can enjoy this right; this includes access to timely, acceptable, and affordable healthcare of appropriate quality.[422]

In summary, by ratifying and signing these conventions, Saudi Arabia is obliged to ensure healthcare is accessible, acceptable, affordable and of quality within the limits of Saudi Arabia's available resources. This can be summarised as what the ICESCR calls the highest attainable standard of both physical and mental health available and economically accessible to all, without discrimination.[423] The combination of both Saudi national healthcare laws and regional and international conventions provides a set of healthcare laws which can be said to resemble the Sharia's healthcare provision requirements and obligations, as outlined in Chapter Two.[424] Accordingly, if healthcare provision in Saudi Arabia is adherent to these laws and conventions, it would be considered compliant with Sharia obligations and requirements. The next section will discuss the current state of Saudi healthcare and assess if it can be considered compliant.

[421] WHO, 'Constitution of the World Health Organization', The International Health conference, New York 22 July 1948
[422] ibid; WHO 'The Right to Health' Factsheet August 2007
[423] UN General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, p. 3; UN General Assembly, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3
[424] Chapter Two Section 2.3

3.3 Healthcare Provision in Saudi Arabia

Saudi Arabia was one of many countries endorsing the WHO's "Health for all by the year 2000" goal.[425] However, based on the literature, it is evident that Saudi Arabia has not fully achieved this goal. Saudi Arabia's progression towards implementing this target is dependent on the continuous evaluation of the services rendered and the financial state of the country, to ensure the state is financially capable of fulfilling its obligations to its citizens.[426] This section will discuss the current state of healthcare provision as portrayed by the Saudi Ministry of Health's scholarship and official figures, the Saudi Government Open Data Portal, the Saudi National Centre for Documentation and Archives and the Saudi General Authority for Statistics. Based on this section's findings, this chapter will establish if Saudi healthcare provision, as it stands today, can be considered compliant with the obligations and requirements of Sharia healthcare provision. If the healthcare provision is not compliant, it will be assessed to see if there exists a state of necessity, which will allow the Sharia scholars' opinion against privatisation to be reconsidered, as mentioned in Chapter One.[427]

3.3.1 The State of Healthcare Provision in Saudi Arabia

According to the World Health Report in 2000 and 2010, the Saudi healthcare system ranked 26th among 190 of the world's health systems.[428] Based on the

[425] WHO, Global Strategy for Health for All by the Year 2000, Geneva, 1981
[426] Bergstrom, Health for all by the year 2000?, (1996) *BMJ* 313; Johnson, O et al, *Information please almanac : atlas and yearbook 1992* (Houghton Mifflin 1992); Mansour, A et al. "A Study of Health Centers in Saudi Arabia" (1996) 33 *IJNS* 309; WHO, Global Strategy for Health for All by the Year 2000, Geneva, 1981
[427] Chapter One Section 1.10.6
[428] The world health report 2000: health systems; improving performance. (WHO 2000); The world health report 2010: health systems financing: the path to universal coverage (WHO 2010)

2000 report, Saudi healthcare was considered better and higher ranked in comparison to other healthcare systems, such as in Canada[429], Australia[430], New Zealand[431], the United Arab Emirates[432], Qatar[433] and Kuwait[434]. However, it has been almost two decades since the celebrated success of the 2000 report, and since then, the Saudi healthcare system has faced many challenges such as the Coronavirus outbreak which led to hospital closures, fatalities and widespread dissatisfaction with the MOH's performance.[435] Moreover, recent results such as the 2019 Healthcare Index for countries published by Numbeo, ranked Saudi Arabia's healthcare as 57th among 84 countries.[436] Nonetheless, it is important to note that the results by Numbeo, are based on surveys completed by the website's visitors, rather than official figures and reports by creditable organizations such as the WHO.[437] Despite the fact that these results cannot be considered reliable, they provide great insight into the degree of patient dissatisfaction with healthcare services in Saudi Arabia.

The population of Saudi Arabia has been growing, and with this increase comes a higher demand on the healthcare system, especially when considering

[429] Ranked 30
[430] Ranked 32
[431] Ranked 41
[432] Ranked 27
[433] Ranked 44
[434] Ranked 45
[435] Coronavirus: Two Deaths and One New Case of CoronaVirus in Riyadh. Alriyadh Newspaper, 10 October 2015 [In Arabic]; MOH penalizes a private hospital that fails to admit suspected coronavirus case, Alriyadh Newspaper, 11 September 2015 [In Arabic]; MOH: No Hospitals are Closed due to Coronavirus, Alriyadh newspaper, 10 March 2015, [In Arabic]
[436] Health Care Index for Country 2019 available on https://www.numbeo.com/health-care/rankings_by_country.jsp accessed 17 Janurary 2019
[437] WHO 'A WHO Framework for Health System Performance Assessment' (1999); WHO: About Us Section available on www.who.int; WHO, 'Constitution of the World Health Organization', The International Health conference, New York 22 July 1948

epidemics of Ebola, coronavirus and other health threats.[438] Saudi Arabia is the world's largest oil exporter, and has an economy that entirely relies on high oil prices.[439] However, with the drastic drop in oil prices, this dependence on oil has proven to be problematic. As oil accounts for 92.5% of the Saudi budget revenues, 97% of export earnings, and 55% of the GDP,[440] the Saudi economy was extremely affected by the drop in oil prices, and consequently the Saudi government stated that its economy can no longer depend on oil.[441] Similarly, the WHO commented in the country profile that the drop in oil revenues and decrease in national revenues will put the national expenditure on health at risk.[442] The WHO also emphasized the need for identifying alternative sources of funding, such public-private funding and introducing social insurance. [443]

According to the World Bank, [444] Saudi oil prices witnessed a -67.9% drop between April 2011 and April 2016, resulting in the price of oil reaching a landmark low of less than $30 per barrel in the beginning of 2016, according to the Organisation of Petroleum Exporting Companies (OPEC).[445] Specialists in

[438] AlHussain, 'Saudi Healthcare System: Where does improving the services and performance begin?!' *Risalat Maahad Alldarah* (Riyadh, December 2004); Alrabeah, et al. "TQM in the Saudi Healthcare System: A National Cultural Perspective." Proceedings of the 26th International Business Research Conference, 7-8 April 2014, Imperial College London; AlYousef, et al., 'Organization of the Saudi health system' (2002) 8 *EMHJ* 645; Khaliq A., 'The Saudi Healthcare System: A View from the Minaret' (2012) 13 *WHP* 52

[439] 'Transforming Saudi Arabia: National Transofrmation Program 2020 Approve' Shearman and Sterling, 14 June 2016; Safi, O. "The Challenges For Saudi Arabia Healthcare System." (2016) 6 *IJAR;* Sons, 'Saudi Arabia: oil as a burden in the struggle for energy diversification' in Thielges, et al., *Sustainable energy in the G20: prospects for a global energy transition* (IASS 2016); Wilson, R. "The political economy of Saudi Arabia." (2008) 44 *JMES*

[440] Saudi Arabian Monetary Agency Annual Statistical Report. Available on SAMA website

[441] Nusair,"The effects of oil price shocks on the economies of the Gulf Co-operation Council countries: Nonlinear analysis." (2016) 91 *EP*; Pierru, et al. "The impact of oil price volatility on welfare in the Kingdom of Saudi Arabia: implications for public investment decision-making." (2014) 35 TEJ; Ross, *The oil curse: How petroleum wealth shapes the development of nations* (PUP 2012); Sons, 'Saudi Arabia: oil as a burden in the struggle for energy diversification' in Thielges, et al., *Sustainable energy in the G20: prospects for a global energy transition* (IASS 2016)

[442] Saudi Arabia Country Profile 2015 available on www.emro.who.int accessed 24 November 2018

[443] ibid

[444] Crude Oil Prices available on World Bank website, IndexMundi Data Portal

[445] OPEC Basket Price , available on OPEC website

the field commented on this drastic drop in prices, and stated that oil was *'cheaper than the price of the barrel it comes in'*.[446] This resulted in a combination of lower growth, and higher debt levels, which leaves Saudi Arabia less well positioned to face future difficulties,[447] and less capable of maintaining high expenditure on healthcare, especially with a high percentage of its revenue being spent on military and security. given recent events such as the on-going war on terror, recent terrorists attacks by ISIS and Houthi members, and the war on the Yemeni border.[448] Fortunately there has been an increase in oil prices since 2016, approximately an average increase of 30% in 2017-2018, with oil priced at slightly less than $60 in November 2018.[449] Nonetheless the changes towards the 2030 Vision and 2020 National Transformation Plan have already commenced, both of which call for less reliance on oil as the primary resource.[450] For example, as part of the 2030 financial changes taxation was implemented in 2018, which is payable by corporates, and is argued to be part of the policies that resulted in the highest budget yet for Saudi Arabia; the 2019 budget.[451] As a result of this landmark budget, $45.8 billion has been allocated to the healthcare and social development sectors combined. Unfortunately, there is no estimation of how much the healthcare expenditure per capita will

[446] Senior Petroleum Analyst Patrick DeHaan in Sheffield, Oil cost falls below $28 a barrel, or less than the price of an actual barrel, The Independent 19 January 2016.
[447] Moody's government of Saudi Arabia Credit Rating, 14 May 2016. Available on Moody's website
[448] Aboudah, "Dealing with Economic Sustainability Challenges Evolving from Declining Oil Production in Saudi Arabia" (MS Thesis, MTU 2015); Aoun,"Oil and Gas Resources of the Middle East and North Africa: a Curse or a Blessing?." in *The New Energy Crisis* (Palgrave Macmillan 2013) 133; Askari, *Saudi Arabia's Economy: Oil and the Search for Economic Development*, (Jai Press 1990); Atzori, "The Political Economy of Oil and the Crisis of the Arab State System." 61 (FEEM 2013)
[449] Saudi Arabia 2019 Budget Report available on Ministry of Finance Website www.mof.gove.sa accessed 20 January 2019
[450] 'Transforming Saudi Arabia: National Transofrmation Program 2020 Approve' Shearman and Sterling, 14 June 2016; Banafea, et al 'Assessment of economic diversification in Saudi Arabia through nine development plan' (2018) 42 *OPECER* 42; Presley, et al. *A guide to the Saudi Arabian economy* (Springer 2017); Ramady *Saudi Aramco 2030: Post IPO challenges* (Springer 2017)
[451] Saudi Arabia 2019 Budget Report available on Ministry of Finance Website www.mof.gove.sa accessed 20 January 2019

be for 2019, and similarly no details were given for 2018. As of March 2019, Saudi MOH website only contains expenses and financial plans up to 2017, with no information as to when those for 2018 and 2019 will be available to the public.[452] The lack of transparency regarding MOH finances and expenditure since the announcement of the 2030VFH is alarming and problematic as Saudi Arabia is destined to undergo a drastic policy change and embark on the road to privatisation which is widely perceived as unfavorable, and which advocates in non-Sharia literature argue to require transparency and public monitoring to ensure its success, [453] as will be discussed in Chapter Four.[454]

Medical Law and Ethics literature discussing Saudi Arabia is limited in terms of volume and scope. Most of the available literature focuses on patient satisfaction and the Sharia opinion regarding topics such as organ donation, abortion, and end of life decisions.[455] Nonetheless, by assessing literature discussing the current state of healthcare provision in Saudi Arabia it is safe to say that Saudi Arabia today does not have a universal healthcare system. As a

[452] Saudi Ministry of Health Archive available on Saudi Ministry of Health website www.moh.gov.sa accessed on 24 February 2019

[453] ibid; 'Transforming Saudi Arabia: National Transofrmation Program 2020 Approve' Shearman and Sterling, 14 June 2016; Banafea, et al 'Assessment of economic diversification in Saudi Arabia through nine development plan' (2018) 42 *OPECER* 42; Presley, et al. *A guide to the Saudi Arabian economy* (Springer 2017); WHO (Task Force on Health Economics) 'Privatisation in Health' (1995); Yasin, et al. 'Universal Coverage in an era of privatisation: can we guarantee health for all?' (2012) 12 BMC Public Health; Young, 'Privatizing health care' (1990) 5 *International Journal of Health Planning and Management* 237

[454] Chapter Four Section 4.2

[455] AbdulHussain, 'Ensoulment & The Prohibiton of Abortion in Islam' (2005) 16 *Islam & Christian-Muslim Relations* 103; Alaiban, "A survey assessing patient satisfaction at public and private healthcare facilities in Riyadh, Saudi Arabia" (2003) 23 *Annals of Saudi Medicine* 417; AlDoghaither, et al., 'Consumers' satisfaction with primary health services in the city of Jeddah, Saudi Arabia' (2000) 21 *Saudi medical journal* 447; AlFaris, et al., 'Patient's satisfaction with accessibility and services offered in Riyadh health centers' (1996) 17 *Saudi medical journal* 11; Makhdoomy, et al., 'Satisfaction with health care among primary health care centers attendees' in Al-Khobar, Saudi Arabia' (1997) 18 *Saudi medical journal* 227; Saeed, 'Satisfaction and correlates of patients‟ satisfaction with physicians‟ services in primary health care centers' (2001) 22 *Saudi Medical Journal* 262; Taher, Moral & Ethical Issues in Liver & Kidney Transplantation, (2005) 16 *Saudi Journal of Kidney Diseases & Transplantation* 375

result, Saudi healthcare is not considered available, accessible, acceptable, or of quality.

One of the main reasons is the fact that most of the healthcare facilities are located in three main cities, Riyadh, Jeddah and Makkah.[456] Since the 2010 WHO report, there has been an increase and expansion of healthcare infrastructure across Saudi Arabia which has improved the healthcare access of individuals in remote areas.[457] Nonetheless, there continues to be a need to refer patients to advanced and specialist care hospitals in main cities.[458] Therefore, hospitals in these main cities, especially the capital Riyadh, are subject to a higher demand due to higher populations.[459] The MOH ensures that hospitals in main cities are adequately equipped and financed to be able to serve these cities.[460] Meanwhile, hospitals in smaller cities and towns cater for smaller populations, and fewer finances are allocated to them.[461] As smaller hospitals are less financed and equipped, the majority of doctors and healthcare

[456] Saudi Arabia Country Profile 2015 available on www.emro.who.int accessed 24 November 2018;Saudi Ministry of Health Archive available on Saudi Ministry of Health website www.moh.gov.sa accessed on 24 November 2018; Safi, "The Challenges For Saudi Arabia Health Care System." (2016) 6 *Indian Journal of Applied Research;*

[457] Albejaidi, F. "Healthcare system in Saudi Arabia: An analysis of structure, total quality management and future challenges." (2010) 2 *Journal of Alternative Perspectives in the Social Sciences* 794-818; Alhowaish, "Healthcare spending and economic growth in Saudi Arabia: A Granger causality approach." (2014) 5 International Journal of Scientific & Engineering Research 1471; Sajjad, et al. ' an assessment of the healthcare services in the Kingdom of Saudi Arabia: An analysis of the old, current and future systems' (2018) *International Journal of Healthcare Management;* 'Transforming Saudi Arabia: National Transofrmation Program 2020 Approve' Shearman and Sterling, 14 June 2016; Saudi Arabia Country Profile 2015 available on www.emro.who.int accessed 24 November 2018; Yusuf, N. "Private and public healthcare in Saudi Arabia: future challenges." (2014).2 *International Journal of Business and Economic Development*;

[458] ibid

[459] Anqari, et al., *Urban and Rural Profiles in Saudi Arabia* (Gebrüder Borntraeger 1989); Milaat, "Public health in the saudi health system: A search for new guardian." (2014) 2 SJMMS 77; Mufti, *The Saudi Healthcare System Issues and Opinions* (Alamn 2002) [in Arabic]; Mughal, et al., 'Urban growth management-the Saudi experience' (2004) 28 *HI* 609; Todd, 'Health inequalities in urban areas: a guide to the literature' (1996) 8 *EU* 141; Vlahov, et al., 'Urbanization, urbanicity, and health' (2002) 79 *JUH* S1

[460] ibid

[461] Garba, 'Managing urban growth and development in the Riyadh metropolitan area, Saudi Arabia' (2004) 28 *HI* 593; Jegasothy, 'Population and rural-urban environmental interactions in developing countries' (1999) 26 *IJSE* 1027; Mainous, et al., 'A comparison of health status between rural and urban adults' (1995) 20 *JCH* 423

workers have been found to prefer work in in bigger cities where finances and better equipment are readily available.[462] Hence, this migration of personnel to urban areas has led to staff shortages in smaller and rural hospitals.[463]

The latest available MOH statistics indicate a misdistribution of health services and professionals across geographical areas.[464] Based on the latest figures by the MOH, 18% of MOH hospitals and 20% of dialysis centres were in Riyadh. In addition, in 2016, there were only nine cardiology centres, and four oncology centres in the whole of Saudi Arabia, all of which were located in main urban cities.[465] The misdistribution of healthcare services and professionals has led patients to travel to bigger cities, which is known as a rural-urban migration.[466] Patients in rural areas travel to see better doctors in better-equipped hospitals in hopes of receiving better care than what is provided in smaller hospitals.[467] As well, rural area residents must travel to the nearest medical facilities for essential treatments, such as dialysis and serious surgeries, which their local

[462] Anqari, et al., *Urban and Rural Profiles in Saudi Arabia* (Gebrüder Borntraeger 1989); Arishi, *A study of Patient Satisfaction with the Medical Care Services Provided by the Royal Commission's Hospitals in Al-Jubail Al-Sinaiayah, Saudi Arabia* (Ph.D. thesis, University of Wales 2000); Makhdoomy, et al., 'Satisfaction with healthcare among primary healthcare centers attendees' in Al-Khobar, Saudi Arabia' (1997) 18 *SMJ* 227; Mitchell, *Job Satisfaction and Burnout Among Foreign-trained Nurses in Saudi Arabia: A Mixed- method Study*. Ann Arbor 2009)

[463] Colliers International, 'Kingdom Of Saudi Arabia Healthcare Overview' (2012) Q1; El Bcheraoui, et al. "Access and barriers to healthcare in the Kingdom of Saudi Arabia, 2013: findings from a national multistage survey." (2015) 5 *BMJ*; Garba, 'Managing urban growth and development in the Riyadh metropolitan area, Saudi Arabia' (2004) 28 *HI* 593; Jannadi, B., et al. "Current structure and future challenges for the healthcare system in Saudi Arabia." (2008) 3 *APJHM* 43

[464] Saudi Ministry of Health Statistical Yearbook available on Saudi Ministry of Health website www.moh.gov.sa

[465] Saudi Ministry of Health Statistical Yearbook available on Saudi Ministry of Health website www.moh.gov.sa

[466] Anqari, et al., *Urban and Rural Profiles in Saudi Arabia* (Gebrüder Borntraeger 1989); Arishi, *A study of Patient Satisfaction with the Medical Care Services Provided by the Royal Commission's Hospitals in Al-Jubail Al-Sinaiayah, Saudi Arabia* (Ph.D. thesis, University of Wales 2000); Makhdoomy, et al., 'Satisfaction with healthcare among primary healthcare centers attendees' in Al-Khobar, Saudi Arabia' (1997) 18 *SMJ* 227; Mitchell, *Job Satisfaction and Burnout Among Foreign-trained Nurses in Saudi Arabia: A Mixed- method Study*. Ann Arbor 2009)

[467] ibid

hospital would not be equipped for. [468] Accordingly, the quality of healthcare in rural areas is hindered. The migration of patients to bigger hospitals in search of better quality healthcare services has led to long wait lists for services in bigger hospitals.[469] As mentioned in Chapter Two,[470] long wait lists indicate that healthcare is not readily available and accessible,[471] which contradicts Sharia, Saudi law and international conventions.

Aside from the shortage of staff in rural areas, another factor contributing to the lack of universal healthcare in Saudi Arabia is the fact that there is an overall shortage of staff in the MOH. According to the WHO, the number of physicians, 16, and nurses, 36, per 10,000 population, in 2010 was lower than Bahrain, Kuwait, Japan, Canada, France and the United States.[472] The latest figures published by the MOH are from 2016, which indicate an increase in numbers of physicians and nurses.[473] As of 2016, there are 28.3 physicians, and 57 nurses per 10,000 population.[474] Nonetheless, these figures remain low in comparison to the total population and high demand. As the MOH expands, employees will

[468] ibid; 'New strategy for health services in Saudi Arabia'. 39. Al-Egtisadia Daily, 9 September 2009 [in Arabic]; AlYousef, et al., 'Organization of the Saudi health system' (2002) 8 *EMHJ* 645; World health statistics28. . Geneva, Word Health Organization, 2010. Arishi, *A study of Patient Satisfaction with the Medical Care Services Provided by the Royal Commission's Hospitals in Al-Jubail Al-Sinaiayah, Saudi Arabia* (Ph.D. thesis, University of Wales 2000); Makhdoomy, et al., 'Satisfaction with healthcare among primary healthcare centers attendees' in Al-Khobar, Saudi Arabia' (1997) 18 *SMJ* 227; Mansour, A.et al "A Study of Satisfaction among Primary Healthcare Patients in Saudi Arabia." (1993) 18 JCH 163

[469] ibid; Alaiban, "A survey assessing patient satisfaction at public and private healthcare facilities in Riyadh, Saudi Arabia" (2003) 23 *ASM* 417; Albaz, *Patient satisfaction with primary healthcare services in Saudi Arabia: A case study of Alriyadh city* (Ph.D. thesis, Washington University 1992); Saeed, 'Satisfaction and correlates of patients‟ satisfaction with physicians‟ services in primary healthcare centers' (2001) 22 *SMJ* 262

[470] Chapter Two Section 2.3

[471] Allan, et al., 'Exploring the influence of income and geography on access to services for older adults in British Columbia: A multivariate analysis using the Canadian Community Health Survey (Cycle 3.1)' (2011) 30 *CJA 69;* Allin et al, *Measuring inequalities in access to Healthcare: A review of the indices* (EUC 2007); AlShahrani, *The accessibility and utilization of primary healthcare services in Riyadh, Kingdom of Saudi Arabia.* (University of East Anglia 2004)

[472] World Health Statistics . Geneva, Word Health Organization, 2010.

[473] Health statistical year book. Riyadh, Saudi Arabia, Ministry of Health, 2016; Ministry of Health Hospital Statistics for 2016, Saudi General Authority for Statistics, 2017 available on stats.gov.sa

[474] ibid

be stretched more thinly to accommodate the population's healthcare needs, which further contributes to the urban-migration. The shortage of staff indicates that healthcare is not readily available and accessible,[475] which, I argue, is in contradiction to Sharia, Saudi law and health related international conventions ratified by Saudi Arabia.[476]

Another factor that could be identified as a contributor to the rural-urban migration and lack of universal healthcare is the fact that the Saudi population favours specialist care, according to scholars such as Khaliq.[477] Despite the availability of primary health centres, there appears to be a high demand on secondary and tertiary facilities. Patients in Saudi Arabia tend to bypass local centres, preferring to see physicians at bigger and better-equipped establishments. [478] As a result, the rural-urban migration creates a financial burden and higher demand on larger medical centres, which, in turn, underutilizes primary centres that the MOH has invested in.[479]

---

[475] Jacobs, et al., 'Addressing access barriers to health services: an analytical framework for selecting appropriate interventions in low-income Asian countries' (2012) 27 *HPP* 288; Konopantelis, et al., 'Patient experience of access to primary care: identification of predictors in a national patient survey' (2010) 11 *BMC* 61; Litaker, et al., 'Context and healthcare access: looking beyond the individual' (2005) 43 *MC* 531

[476] The Basic Law of Governance, Royal Decree No.A/90, 31st January 1992; The Saudi Health Law, Royal Decree No. M/11, 4th June 2002; UN General Assembly, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3; UN General Assembly, Universal Declaration of Human Rights (adopted 1948 UNGA Res 217 A(III) (UDHR)

[477] AlAhmadi, et al., 'Quality of primary healthcare in Saudi Arabia: a comprehensive review' (2005) 17 *IJQH* 331; AlDoghaither, et al., 'Consumers' satisfaction with primary health services in the city of Jeddah, Saudi Arabia' (2000) 21 *SMJ* 447; Ali, et al., 'A study of patient satisfaction with primary healthcare services in Saudi Arabia' (1993) 18 *JCH* 49; Khaliq A., 'The Saudi Healthcare System: A View from the Minaret' (2012) 13 *WHP* 52

[478] ibid

[479] Ali, *Health systems in western Saudi Arabia: Location analysis and spatial planning, monitoring and evaluation* (PhD thesis, The University of Wisconsin-Milwaukee 1984); Bakhashwain, *Acceptance and utilisation of primary healthcare in Jeddah City, Saudi Arabia.* (PhD Thesis University of Hull 1995); Farmer, et al., 'Rural/urban differences in accounts of patients' initial decisions to consult primary care' (2006) 12 *HP* 210; Field, et al., 'Socio-economic and locational determinants of accessibility and utilization of primary health-care' (2001) 9 *HSCC* 299; Makhdoomy, et al., 'Satisfaction with healthcare among primary healthcare centers attendees' in Al-Khobar, Saudi Arabia' (1997) 18 *SMJ* 227

The rural-urban migration can be considered a form of medical tourism within the same country, and is a result of healthcare that is not accessible, available, or of quality in rural areas in comparison to healthcare in urban areas.[480] Consequently, the services are not compliant with the Sharia's obligation to provide universal and equal healthcare to all citizens. It is essential to address this issue and revaluate the workforce distribution over the 13 regions, to ensure the quality, availability and accessibility of healthcare.

It is important to note that recent literature has emerged that claims that gender inequality against women takes place in some Saudi hospitals.[481] In some reports, women were not admitted or discharged from hospitals without male consent despite there being no legal basis for this.[482] However there is insufficient literature available to date to back these claims. Nonetheless, gender inequality in the context of healthcare can involve the inability to seek healthcare, or the inability to make autonomous decisions with regards to health.[483] Consequently, in the case that these claims were true, both the accessibility and availability of healthcare in Saudi Arabia would be affected by

[480] ibid; Albaz, *Patient satisfaction with primary healthcare services in Saudi Arabia: A case study of Alriyadh city* (Ph.D. thesis, Washington University 1992; Albejaidi, F. "Healthcare system in Saudi Arabia: An analysis of structure, total quality management and future challenges." (2010) 2 *JAPSS* 794; AlFaqeeh, 'Acess and utilization of primary healthcare services in Riyadh province, Kingdom of Saudi Arabia' (University of Bedfordshire PhD Thesis 2015)

[481] Walker, "The Right to Health and Access to Health Care in Saudi Arabia with a Particular Focus on the Women and Migrants" in Toebes, et al. *The Right to Health: a multi-country study of law, policy and practice* (Asser Press 2014) 165

[482] ibid; Nahshal, *"My husband knows what is best for me...": An exploration of educated Saudi women's views towards domestic violence* (PhD Keele University 2018)

[483] Hasnain et al, 'Patient-centered care for Muslim women: provider and patient perspectives' (2011) 20 Journal of Women's Health 73; Kelly, S. et al. *Women's Rights in the Middle East and North Africa: Gulf Edition* (Freedom House 2009); Said-Foqahaa, et al. 'Arab women: Duality of deprivation in decision-making under patriarchal authority' (2011) 9 *Hawa: Journal of Women of the Middle East and the Islamic World* 234; Sidahmen, 'Thousands of Saudis sign petition to end male guardianship of women' *The Guardian* 26 September 2016; Walker, L. "The Right to Health and Access to Health Care in Saudi Arabia with a Particular Focus on the Women and Migrants" in Toebes, et al. *The Right to Health: a multi-country study of law, policy and practice* (Asser Press 2014) 165; Zurayk, et al. 'Women's health problems in the Arab World: a historic policy perspective' (1997) 58 *International Journal of Gynecology and Obstetrics* 13

the gender inequality against women in healthcare.[484] Fortunately, in January 2019, and in response to a Royal Decree stating that females should not be required to have male consent to obtain services,[485] the Saudi MOH finally intervened and issued an official statement clarifying that females above 18 years and of sane mind have full autonomy, and that their IDs are accepted in Saudi hospitals and therefore do not need a male guardian for healthcare.[486]

3.3.1.1 Assessment of Sharia compliance

As outlined in Chapter Two,[487] in Sharia healthcare provision is required to be of essential services, available, accessible, affordable and of quality. However, it is evident from the literature and MOH documents that the rural-urban migration has adversely affected the availability, accessibility and quality of healthcare services in Saudi Arabia. Accordingly, this study argues that Saudi healthcare, as it stands today, is not compliant with Sharia, Saudi law or the ratified international conventions. Therefore, it is essential to overcome the obstacles that led to the formation of the urban-rural migration and provide the whole population with universal, equitable, organized, accessible and acceptable healthcare services, as required by law.

---

[484] Walker, "The Right to Health and Access to Health Care in Saudi Arabia with a Particular Focus on the Women and Migrants" in Toebes, et al. *The Right to Health: a multi-country study of law, policy and practice* (Asser Press 2014) 165

[485] A Royal Decree 33322 was passed in 2017 that stated women did not need a male guardian's approval to obtain public services, yet this was not adhered to and females were asked for male guardian consent regeardless. The 2019 Royal Decree was restating the 2017 law and making it illegal to ask for guardian consent.

[486] AlKhabrani, 'MOH: Female patients are allowed to give consent without guardian signature' *Sabq* 16 January 2019; Royal Decree 33322 7 March 2017

[487] Chapter Two Section 2.4

Nonetheless, Sharia is flexible as it accommodates special circumstances, and allows the application of Sharia Law Maxims to reconsider rulings,[488] as mentioned in Chapter One.[489] Accordingly, the state of Saudi healthcare must constitute circumstances of need and necessity for Sharia to reconsider privatisation as a possible remedy. The next section will assess the need and necessity of Saudi healthcare, and determine if the Sharia opinion against privatisation may be reconsidered in light of the current state of the Saudi healthcare system.

3.3.2 Assessment of Need and Necessity

Two important concepts are applied when addressing matters in Sharia: *Maslahah* (Public Benefit), and *Darurah* (Necessity).[490] If a matter is in the *Maslahah* of citizens and is proven to be a *Darurah,* the Sharia ruling may be reconsidered. In such situations, the Sharia law Maxims "Necessity permits the forbidden", "Hardship calls for relief", and "Where it is inevitable, the lesser of the two harms should be done", are applied.[491] These Maxims apply to any matter of daily life, and are the cornerstone of both the behaviour of individual Muslims and the legislation of countries based on Sharia, such as Saudi Arabia.[492]

---

[488] AlHussayen, *Man-made laws and Islamic Laws* (Riyadh 1988) [In Arabic]; Ali, *The Concepts of Islamic Ummah and Shariah* (DarulEhsan 1992); AlMaududi, *On the Application of Shariah in the Present Era* (AlRushd 2012) [In Arabic]; Sattam, *Sharia and the Concept of Benefit: The Use and Function of Maslaha in Islamic Jurisprudence* (I.B Tauris 2015)

[489] Chapter One Section 1.10.6

[490] ibid; AlDaghistani, 'Semiotics of Islamic Law, Maslahah, and Islamic Economic Thought' (2016) 29 *IJSL* 389; Dusuki, et al. 'Maqasi AlShariah, Maslahah and Social Responsibility' (2007) 24 *TAJISS* 25; Ramadan, *Understanding Islamic Law: From Classical to Contemporary* (AlTamira 2006)

[491] ibid; Reinhart, 'Islamic Law as Islamic Ethics' (1983) 11 *JRE* 186; Saeed, *Islamic Thought: An Introduction* (Routeldge 2006); Safi, 'Toward an Islamic Tradition of Human Rights' (2001) 18 *AJISS* 16; Schachet, *An Introduction to Islamic Law* (ULPC 1997); Smock, D. *Applying Islamic Principles in the Twenty-first Century* (Institute of Peace 2005)

[492] ibid

As demonstrated in the previous section, Saudi healthcare is not compliant with the requirements of Sharia, Saudi law or ratified international conventions. Therefore, it can be concluded that there is a necessity to remedy the situation. Furthermore, as concluded in Chapter Two,[493] the improvement of services is an obligation of the government as it is in the *Maslahah* of citizens and is part of the obligation of *Imarat* upon the government. Accordingly, if the available remedy to the situation is not compliant with Sharia, then Sharia law Maxims apply and its compliance with Sharia would be reconsidered. In other words, if privatisation is found to be the only option to remedy the situation of necessity in Saudi healthcare, Sharia compliance would have to be reconsidered.

In addition, analysing the literature and figures by the MOH reveals that the health profile of the population, and subsequent high demand on healthcare, emphasize the necessity to improve healthcare provision and finance. In addition, due to the ethnicity, genetic predisposition and lifestyle of Saudi nationals as reported by the MOH[494] and WHO, there is a high prevalence of degenerative diseases such as diabetes, hypertension and cardiovascular diseases.[495] As well, according to AlNuaim, the sedentary lifestyle as a consequence of the extreme weather conditions in Saudi Arabia has intensified the situation regarding degenerative diseases.[496] Such diseases require

[493] Chapter Two Section 2.5.1.1 A
[494] Health Statistic Report, MOH, The Saudi National Centre for Documentation and Archives ncar.gov.sa; The Saudi General Authority for Statistics stats.gov.sa
[495] ibid; Country cooperation strategy for WHO and Saudi Arabia 2006–32. 2011. Cairo, World Health Organization Regional Office for the Eastern Mediterranean, 2007; WHO, Country Profile: Saudi Arabia, available on WHO website
[496] AlNuaim, 'Overweight & Obesity in Saudi Arabian Adult Population, Role of Sociodemographic Variables' (1997) 22 JCH

maintaining and monitoring, and they also cause other health problems and complications that require additional medical attention and testing, forming a vicious cycle of medical problems.[497] With the increase in life expectancy, degenerative diseases are causing more years of disability, health problems, and dependency, all of which create a major strain on the governmental resources and hospitals.[498] Therefore, the cost and pressure on the healthcare system has increased; as more people fall ill, more time and money are required to treat them.[499]

For example, according to the MOH Statistics, in the year 2014, a total of 737,229 cases were presented to MOH Accident & Emergency (A&E) departments due to diabetes.[500] In addition, research has found that the estimated annual cost of treating diabetes in Saudi Arabia is $1.87 billion,[501] while the cost of a single pancreatic transplant was reported to be $15,000.[502] However, the cost for treating end-stage renal disease, as a complication of diabetes, uses around 3.8% of the total MOH budget.[503] In another study by Mokdad, it was found that the total direct expenditure for diagnosed diabetes in

[497] ibid; AlHarbi, et. al, 'The Changing Face of Healthcare in Saudi Arabia' (2008) 28 ASM; Albejaidi, F. "Healthcare system in Saudi Arabia: An analysis of structure, total quality management and future challenges." (2010) 2 *JAPSS*; AlDossary, 'Health and Development in poor countries with particular reference to Saudi Arabia' (PhD Thesis, University of Aberdeen 1991)

[498] ibid; AlShaikh, 'Saudi Healthcare Sector: Need for More Investment', *Arab News* (Riyadh 7 August 2006); AlSharqi et al, "Diagnosing" Saudi health reforms: is NHIS the right "prescription"? (2013) 28 IJHPM; Milaat, "Public health in the saudi health system: A search for new guardian." (2014) 2 SJMMS

[499] AlHarbi, et. al, 'The Changing Face of Healthcare in Saudi Arabia' (2008) 28 ASM; AlKhaldi, et al. "Audit of Referral of Diabetic Patients to an Eye Clinic from a Primary Healthcare Clinic." (2002) 23 *SMJ* 177; Albejaidi, "Healthcare system in Saudi Arabia: An analysis of structure, total quality management and future challenges." (2010) 2 *JAPSS*; AlDossary, 'Health and Development in poor countries with particular reference to Saudi Arabia' (PhD Thesis, University of Aberdeen 1991); Yusuf, "Private and public healthcare in Saudi Arabia: future challenges." (2014).2 *IJBED*

[500] Health Statistic Report 2014, MOH. Available on MOH Website; The Saudi General Authority for Statistics stats.gov.sa

[501] AlHowaish, Economic Costs of Diabates in Saudi Arabia, (2013) 20 JFCM

[502] MOH website; The Saudi National Centre for Documentation and Archives ncar.gov.

[503] AlSayyari et al., End Stage Chronic Kidney Disease in Saudi Arabia: A rapidly changing scene, (2011) 32 SMJ 399; Hassanien, Renal Care in Saudi Arabia: A Review of the Quality of Healthcare Management, (PhD Thesis Imperical College London 2013)

Saudi nationals was $4.53 billion, with the majority of the cost due to acute complications from the disease.[504] The cost would reach $11.47 billion if non-diagnosed diabetes and the glucose intolerant were included.[505]

The highest estimated annual cost of treating diabetes previously amounted to 1.7% of the year's budget.[506] However, in light of the current financial situation and drop in oil prices, this would mean that 4% of Saudi Arabia's 2016 budget, [507] is required for diabetic patients generally.[508] As a result, there is a high demand on Saudi Arabia's healthcare, which is accompanied by a need to allocate a higher budget to healthcare. To understand this challenge further, it is essential to keep in mind the economic state of the country, due to the drop in oil prices and the expenses on security and military which were outlined previously in this chapter,[509] and the Saudi MOH finances.

Saudi Arabia's public healthcare is administered by the MOH, and is free and fully funded by the government's oil revenue.[510] According to the Ministry of Finance, healthcare was allocated at $28 billion in 2015; 19% of the total

[504] Mokdad et. al, Cost of Diabetes in the Kingdom of Saudi Arabia (2014) 6 JDM
[505] ibid
[506] Ministry of Finance website; The Saudi General Authority for Statistics stats.gov.sa; MOH website; The Saudi National Centre for Documentation and Archives ncar.gov.sa
[507] Ministry of Finance website; The Saudi General Authority for Statistics stats.gov.sa; MOH website; The Saudi National Centre for Documentation and Archives ncar.gov.sa
[508] AlQurashi et al. The prevalence of sickle cell disease in 40. Saudi children and adolescents: a community-based survey (2008) 29 SMJ; AlTurki. Overview of chronic diseases in the Kingdom of 41. (2000) 21 SMJ; Allocation of 110 million riyals for establishment of 20 diabetes care centre. Riyadh, Ministry of Health, 2007 MOH website [in Arabic]; Amuna Epidemiological and nutrition transition in developing countries: impact on human health and development (2008) 67 PNS
[509] Section 3.3.1
[510] Khaliq A., 'The Saudi Healthcare System: A View from the Minaret' (2012) 13 *WHP*; Milaat, "Public health in the saudi health system: A search for new guardian." (2014) 2 SJMMS; Mufti, *The Saudi Healthcare System Issues and Opinions* (Alamn 2002) [in Arabic]; The Saudi Health Law, Royal Decree No. M/11, 4th June 2002

government budget.[511] The revenues were $162 billion, while the expenses were $260 billion,[512] meaning that maintaining the required expenditure has placed the government in debt. In 2016, the situation worsened due to the further drop in oil prices, meaning healthcare was allocated 12.48% of the total government budget, which, in light of the deficit, is equivalent to 22% of GDP.[513] The 2016 fiscal deficit for Saudi Arabia was expected to be $87 billion, excluding military expenses. [514] Further adding to the financial burden is the rapidly growing population.[515] The Saudi population is currently 33 million, rapidly growing with a yearly growth rate of 2.3%, and is expected to reach over 34 million by 2020.[516] As oil accounts for 92.5% of Saudi Arabia's budget revenues, 97% of export earnings, and 55% of the GDP,[517] the Saudi economy was extremely hindered by the recent drop in oil prices. Further, with the switch to green energy, as the 2030 Vision states, oil prices are expected to continue to drop.[518] As a result, there is an urgent need to find other sources of income to finance the healthcare system.

---

511 Ministry of Finance Budget Report 2015; ; The Saudi National Centre for Documentation and Archives ncar.gov.sa; ; The Saudi General Authority for Statistics stats.gov.sa; WHO, Country Profile: Saudi Arabia, available on WHO website

512 ibid

513 Ministry of Finance Budget Report 2016; The Saudi National Centre for Documentation and Archives ncar.gov.sa; ; The Saudi General Authority for Statistics stats.gov.sa; WHO, Country Profile: Saudi Arabia, available on WHO website

514 ibid

515 Ministry of Health website; The Saudi National Centre for Documentation and Archives ncar.gov.sa; The Saudi General Authority for Statistics stats.gov.sa; WHO, Country Profile: Saudi Arabia, available on WHO website

516 ibid

517 Saudi Arabian Monetary Agency Annual Statistical Report. Available on SAMA website

518 AlAmoudi, et al. 'Renewable energy resource facilities in the Kingdom of Saudi Arabia: Prospects, social and political challenges' (2017) 12 *JES* 8; AlSharafi, et al. 'Techo-economic analysis and optimization of solar and wind energy systems for power generation and hydrogen production in Saudi Arabia' (2017) 69 *RSER* 33; Blazquez, et al 'Oil subsidies and renewable energy in Saudi Arabia: a general equilibrium approach' (2017) 38 *Energy* 29; Khan, et al. 'Impact of Green roof and orientation on the energy performance of buildings: A case study from Saudi Arabia' (2017) 9 *Sustainability* 640; Khan, et al. 'Transition towards sustainable energy production- A review of the progress for solar energy in Saudi Arabia' (2017) 36 *EEE* 3

After analysing the literature, although there are other methods to finance the healthcare system, and while these are out of the scope of this thesis, it is likely that the MOH could benefit from considering alternatives such as privatizing some of its services and duties. The lack of the separation of powers, given the size of Saudi Arabia, and the increasing population, might amount to why the service has deteriorated over the years.[519] The many responsibilities of the MOH may have taken their toll, and based on the literature, it is possible to strengthen the MOH by distributing efforts and delegating tasks.[520]

The fact that the Saudi public healthcare system is financed, operated, controlled, supervised and managed by the same body was highlighted by the WHO and AlMalki and colleagues.[521] They emphasize that despite the increasing pressure, there is no separation of powers and all authority is centralized in the MOH, which adds more pressure to the system, resulting in delays and unfulfilled tasks.[522] This lack of separation of powers of the MOH may have been efficient when the population was smaller, but this no longer serves the purpose, and will not be able to cope with the growing population and its medical needs.[523] As a result, Saudi Arabia's healthcare is not available, accessible, acceptable or of quality. By separating the powers, the MOH can

[519] AlBorie et al 'A 'DIRE' needs orientation to Saudi health services leadership' (2013) 26 *LHS*; AlYousef, et al., 'Organization of the Saudi health system' (2002) 8 *EMHJ* 645; Milaat, "Public health in the saudi health system: A search for new guardian." (2014) 2 SJMMS; Mufti, *The Saudi Healthcare System Issues and Opinions* (Alamn 2002) [in Arabic]; Ram, "New Strategic Initiatives-A Case Study of the Saudi Health Ministry" (2014) 3 *IJAREMS*

[520] ibid

[521] AlHussain, 'Saudi Healthcare System: Where does improving the services and performance begin?!' *Risalat Maahad AlIdarah* (Riyadh, December 2004); Almalki et al. The healthcare system in Saudi Arabia: An overview(2011) 7 *EMHJ*; Country cooperation strategy for WHO and Saudi Arabia 2006–32. 2011. Cairo, World Health Organization Regional Office for the Eastern Mediterranean, 2007; Khaliq A., 'The Saudi Healthcare System: A View from the Minaret' (2012) 13 *WHP* 52; Milaat, "Public health in the saudi health system: A search for new guardian." (2014) 2 SJMMS; Mufti, *The Saudi Healthcare System Issues and Opinions* (Alamn 2002) [in Arabic]

[522] ibid

[523] ibid

supervise the distribution of healthcare around the country, while leaving the delivery of healthcare to the hospitals to manage directly.

In summary, with the aforementioned shortcomings and high demands facing the healthcare system, the cradle to grave healthcare of every Saudi is threatened by increasing costs, management inefficiencies and inadequate budget allocation. Consequently, Saudi healthcare is in a state of need, and due to the government's obligation to protect health, there exists a necessity to improve the system. Hence, 2030VFH was announced as an answer to the current situation, despite some scholars arguing that privatisation is against Sharia. Due to the proven severity of the situation, Sharia law Maxims of need and necessity may be applied. If privatisation is found to relieve the situation at hand in light of the circumstances of high demand and scarcity of finances, privatisation could be considered compliant with Sharia. The next section will discuss the calls for privatisation of Saudi healthcare and 2030VFH.

3.4 Saudi Healthcare Privatisation

This section will examine 2030VFH and highlight the problems in the Saudi healthcare system that 2030VFH has failed to address. Based on these findings, Chapter Five will assess the compliance of 2030VFH to Sharia and Saudi law in light of the circumstances of high demand and the scarcity of finances.

3.4.1 The Calls for Privatisation of Saudi Healthcare

My analysis of the literature discussing privatisation has proven that Sharia scholars do not take the multiple meanings or purposes of privatisation into account, and that privatisation may be a method to finance the delivery of rights and ensure the associated *Maqasid AlSharia* are protected.[524] Nonetheless, several Saudi scholars from other disciplines have correctly articulated that there are multiple forms, methods, and purposes of privatisation, which have been called for before the announcement of 2030VFH.[525]

Several Saudi scholars have addressed the privatisation of healthcare, and it is supported by many policy-makers[526] and researchers, such as Saati.[527] The main argument presented by Saati is that individuals should fully pay for their healthcare.[528] Nonetheless, Saati does not specify if financially less fortunate individuals should be exempt from paying, nor does he address compliance with Sharia.[529] However, I argue that a more Sharia appropriate approach would be to adhere to obligations under Sharia by providing free healthcare to those who are unable to pay. Accordingly, healthcare could be argued to be

[524] Ali, *Privatisation* (AlAhram 1996) [In Arabic]; Pomeranz, 'Privatisation and the Ethics of Islam' (1997) 14 AJISS 264; Saba, *Privatisation and a Weak and Absent Public Sector* (AlMawqif 1994) [In Arabic]; Sirry, *Islamic Finance Principles, Characteristics, and Objectives* (AlIskandariya 1988) [In Arabic]
[525] Ahmad, *Privatisation Concepts and Experiences* (AlMajed 1998) [In Arabic]; AlHarthi, *Privatisation of Services* (Arak 2012) [In Arabic]; Alkhamis et al,. 'Financing healthcare in Gulf Cooperation Council countries: a focus on Saudi Arabia' (2014) 29 IJHPM; AlMishaal, *Summary of the Experience of Application of Healthcare Insurance in Taiwan Sehat AlSharqia* (Dammam, January 2008); AlMishaal, 'The Benefits of NHI in Taiwan' *Sehat AlSharqia* (Dammam, January 2008); AlRabeie, *Privatisation and its effect on development in developing countries* (Madbouli 2004) [In Arabic]; Eissa, *Privatisation and a Diversified Economy* (AlMuntalaq 1996) [In Arabic]
[526] The MOH, New strategy for health services in Saudi Arabia. Announced in several Saudi newspapers on 9 September 2009 [in Arabic]
[527] Saati A., Privatisation of public hospitals: future vision and proposed framework. Al-Egtisadia Newspaper, 2 December 2003 [in Arabic].
[528] ibid
[529] ibid

affordable to all and compliant with Sharia as the Basic Law of Governance obliges.

On the other hand, AlKhamis insists that there is no evidence to prove that privatisation is the magical cure for the financial burdens upon MOH.[530] AlKhamis and others acknowledge that all healthcare systems must have an element of privatisation for them to be successful in troublesome economies like that in Saudi Arabia today.[531] He argues investors from Saudi Arabia and abroad should invest in Saudi healthcare, and help ensure the best attainable healthcare services are provided.[532] It is argued that sales in the healthcare system can generate revenue, as did the privatisation of many companies over the years in Saudi Arabia, such as Saudi Telecom Company (STC) and Saudi Airlines.[533] Lessons can be learnt from these companies, as their privatisation led to better quality due to the competition that developed between companies and investors.[534] Each company would compete to attract more customers by providing better services and offers, which benefitted both the consumers and economy. A separate body supervised the services to ensure their high

[530] AlKhamis A, Letter to the Editor, EMHJ, 2012, 18(10): 1078-1079
[531] AlKhamis, Privatisation of health services: a necessity or a luxury? AlEqtisadiah, 21 July 2015 [In Arabic]
[532] Ahmad, *Privatisation Concepts and Experiences* (AlMajed 1998) [In Arabic]; AlHarthi, *Privatisation of Services* (Arak 2012) [In Arabic]; Alkhamis et al,. 'Financing healthcare in Gulf Cooperation Council countries: a focus on Saudi Arabia' (2014) 29 IJHPM; AlRabeie, *Privatisation and its effect on development in developing countries* (Madbouli 2004) [In Arabic]; Eissa, *Privatisation and a Diversified Economy* (AlMuntalaq 1996) [In Arabic]
[533] ibid
[534] Alsumairi, et al. 'A case study: The impact of low-cost carriers on inbound tourism of Saudi Arabia' (2017) 62 *JATM* 129; Alyagout, et al. "Public Sector Transformation: Privatization in Saudi Arabia." in *Public Sector Transformation Processes and Internet Public Procurement: Decision Support Systems: Decision Support Systems* (IGI Global 2012); Askari, *Saudi Arabia's Economy: Oil and the Search for Economic Development*, (Jai 1990); Choudhury, et al. "Oil and non-oil sectors in the Saudi Arabian economy." (2000) 24 *OPECER* 235

standards.[535] Nonetheless, this argument remains in theory, and a critical assessment will be carried out in Chapter Five.[536]

Despite the importance of its contribution to the economy, the private sector currently only contributes 40% of the Saudi GDP.[537] Privatisation will allow for a higher and longer-term contribution to the private sector, open new investment opportunities and encourage innovation and competition.[538] Privatisation allows the government to focus on regulating and monitoring healthcare services, while the private sector and investors deliver services.[539] Furthermore, privatisation eliminates obstacles preventing the private sector from playing a larger role in the development of Saudi healthcare and economy.[540]

However, in contrast, AlMalki and AlHarbi and colleagues believe that privatized hospitals will focus on attracting patients, including those who do not require hospital-level care.[541] However, those with health coverage may

[535] Privatisation of STC introduced new telecom companies to the market which are supervised by the Saudi Communications and Technology Commision. Likewise, Saudi Airlines privatisation allowed new airline companies to be introduced to the market, while the General Authority of Civil Aviation monitors their services.
[536] Chapter 5 Section 5.3
[537] Alaiban, "A survey assessing patient satisfaction at public and private healthcare facilities in Riyadh, Saudi Arabia" (2003) 23 *ASM* 417; AlGhanim, 'Factors Influencing the Utilisation of Public and Private Primary Healthcare Services in Riyadh City' (2004) 19 *JKAU 3;* AlJarAllah, 'The Impact of Health Insurance Programme on the Quality of the Private Hospital's Services in the Kingdom of Saudi Arabia' (PhD Thesis, University of Hull 2007); AlShaikh, 'Saudi Healthcare Sector: Need for More Investment', *Arab News* (Riyadh 7 August 2006); Yusuf, N. "Private and public healthcare in Saudi Arabia: future challenges." (2014).2 *IJBED*
[538] ibid; Ahmad, *Privatisation Concepts and Experiences* (AlMajed 1998) [In Arabic]; AlHarthi, *Privatisation of Services* (Arak 2012) [In Arabic]; Alkhamis et al,. 'Financing healthcare in Gulf Cooperation Council countries: a focus on Saudi Arabia' (2014) 29 IJHPM; AlRabeie, *Privatisation and its effect on development in developing countries* (Madbouli 2004) [In Arabic]; Eissa, *Privatisation and a Diversified Economy* (AlMuntalaq 1996) [In Arabic]
[539] ibid
[540] ibid
[541] AlHarthi, *Privatisation of Services* (Arak 2012) [In Arabic]; Almalki et al. 'The healthcare system in Saudi Arabia: An overview' (2011) 7 *EMHJ* 784

prefer to access big hospitals directly,[542] exacerbating the present rural-urban migration.[543] I will argue in Chapter 5 that this inequality can be overcome by ensuring that there is a body governing the practices of the different hospitals, and guaranteeing the equal distribution of doctors, as required by Sharia and Saudi law.

3.4.2 The 2030 Saudi Vision for Healthcare

The high demand on healthcare and the scarcity of finances led to calls for changes in policy. With this high demand on healthcare and the troubled economy, economic reform has never been as essential. However, there has not been any indication of the compliance of these economic plans in 2030VFH to Sharia, leaving space for this to be challenged.

According to Davis, with the planned shift from oil in Saudi Arabia, privatisation has become an essential step rather than an option.[544] Furthermore, Davis states that privatisation in this situation would strengthen markets, cut costs and improve the efficiency of spending.[545] Unfortunately, upon analysis of 2030VFH, arguably its aims are vague, with no clear plan as to how the MOH aims to achieve them. For example, the aim to optimize and better utilize the capacity of Saudi hospitals and to provide the 'most efficient and highest quality of healthcare' is not clearly spelled out. In addition, 2030VFH fails to fully

[542] AlOmar, et al. The changing face of healthcare in Saudi Arabia.(2008) 28 ASM; Ali, *Health systems in western Saudi Arabia: Location analysis and spatial planning, monitoring and evaluation* (PhD thesis, The University of Wisconsin-Milwaukee 1984); Farmer, et al., 'Rural/urban differences in accounts of patients' initial decisions to consult primary care' (2006) 12 *HP*
[543] ibid; AlAhmadi, et al. Quality of primary healthcare in Saudi Arabia: 26. a comprehensive review (2005) 17 IJQH; Khaliq A., The Saudi Healthcare System: A View from the Minaret (2012) 13 WHP
[544] Davis et al., Fiscal and Macroeconomic Impact of Privatisation, (IMF 2000); IMF, Health and Development (2004)
[545] ibid

address present obstacles that stand in the way of achieving its aims, such as the current shortage of staff and the present rural-urban migration. 2030VFH only focuses on ending the various governmental sectors' 'oil addiction', and does not state if the various steps of the plan will produce results that are in accordance with international standards and Sharia requirements. For example, 2030VFH fails to address privatisation and the implementation of an NHI from a Sharia perspective, and also fails to clearly outline the aimed result once the health sector is privatized. Most importantly, 2030VFH claims to focus on the economy, but has failed to address the shortage of finances. Moreover, although the aim of the 2030VFH is to achieve healthcare for all, it is unlikely that the Vision as it reads now will achieve this considering the emerging evidence of the potential injustice and inequity women are claimed to be subjected to in the context of healthcare provision.[546]

Furthermore, 2030VFH failed to address the rural-urban migration and the consequences, such as the differences in equipment and financing of hospitals, and the resulted migration of physicians. The fact that limited medical aid is present in small town hospitals leads patients to travel for dialysis and other essential treatments and the formation of long waiting lists.[547] The hindered availability and accessibility of healthcare in all 13 regions of Saudi Arabia has affected the Sharia compliance of Saudi healthcare provision. As well, 2030VFH

[546] AlYaemni, et al. 'Gender Inequities in Health: an Exploratory Qualitative study of Saudi Women's Perceptions' (2013) 53 *Women & Health* 741; Walker, L. "The Right to Health and Access to Health Care in Saudi Arabia with a Particular Focus on the Women and Migrants" in Toebes, et al. *The Right to Health: a multi-country study of law, policy and practice* (Asser Press 2014) 165

[547] Albejaidi, "Healthcare system in Saudi Arabia: An analysis of structure, total quality management and future challenges." (2010) 2 *JAPSS*; AlBorie et al 'A 'DIRE' needs orientation to Saudi health services leadership' (2013) 26 *LHS*; Almalki et al. 'The healthcare system in Saudi Arabia: An overview' (2011) 7 *EMHJ*; Khaliq, 'The Saudi Healthcare System: A View from the Minaret' (2012) 13 *WHP*

failed to address the shortage and misdistribution of staff and the different contributors over the 13 regions, resulting in differences in care and services between hospitals. This study argues that the hindered quality of healthcare, especially in rural areas, remains unresolved. Therefore, this study concludes that 2030VFH, as it stands, does not ensure that healthcare is Sharia compliant, as required by Saudi law and international conventions.

There is a wealth of scholarly literature on the current issues of 2030VFH, namely, issues regarding scarcity of finances. Scarcity of finances has, in turn, led to shortages of staff, shortages of beds and long lists, according to several scholars such AlHarbi, AlRabeah, AlMalki, and ElBcheraoui.[548] Finance issues are coupled with a high demand on healthcare by the rapidly growing Saudi population according to scholars such as AlQurashi and AlTurki. This combination of high expenditure and low finances, as reported by the MOF in its annual reports, led to the call for privatisation.[549] It is clear as to why the call to privatisation has been made, however, this study argues that the missing link in the literature is "*can* privatisation of healthcare be implemented in Saudi Arabia?".

[548] AlHarbi, et. al, 'The Changing Face of Healthcare in Saudi Arabia' (2008) 28 ASM 243; Almalki et al. 'The healthcare system in Saudi Arabia: An overview' (2011) 7 *EMHJ* 784; Alrabeah, Abdulrahman, et al. "TQM in the Saudi Healthcare System: A National Cultural Perspective." Proceedings of the 26th International Business Research Conference, 7-8 April 2014, Imperial College; ElBcheraoui, et al. "Access and barriers to healthcare in the Kingdom of Saudi Arabia, 2013: findings from a national multistage survey." (2015) 5 *BMJ*

[549] AlQurashi, et al. The prevalence of sickle cell disease in 40. Saudi children and adolescents: a community-based survey (2008) 29 SMJ; AlTurkI, Overview of chronic diseases in the Kingdom of 41. (2000) 21 SMJ

3.4.3 Sharia and 2030VFH

As mentioned, 2030VFH is a two-phase process, featuring an initial corporatization followed by a full privatisation and NHI implementation. Upon inspection of the Sharia scholar's definition and analysis of the literature, this study argues that both the literature and definition have failed to incorporate corporatization and full privatisation with NHI. Therefore, the Sharia opinion on these models of healthcare privatisation remains unexplored. Nonetheless, Saudi law, as demonstrated earlier in this chapter, allows for different forms of healthcare provision and finance, including by nongovernmental bodies. Furthermore, I argue that their Sharia compliance could be anticipated. However, further analysis is required to reach an informed decision. A discussion and Sharia assessment of the different models of privatisation in healthcare will be in Chapters Four and Five.

3.5 Conclusion

In this chapter, to challenge some Sharia scholars' opinion against privatisation, I assessed if the Sharia Law Maxims could be adopted in Saudi healthcare. Adopting Sharia Law Maxims allows us to reconsider Sharia decisions while taking specific circumstances into consideration. Therefore, it was essential to analyse the current state of Saudi healthcare.

Based on the literature, this study concluded that the rural-urban migration, shortage of staff, scarcity of finances and high demands on healthcare services have adversely affected the Saudi healthcare provision. Consequently, this study

argues that current healthcare provisions in Saudi Arabia are not readily available or accessible in all 13 regions to all. Therefore, the Saudi healthcare provision is not in accordance with the requirements of Saudi law, or international conventions that Saudi Arabia ratified. In addition, this study argues that Saudi healthcare provision is not Sharia compliant. Consequently, I conclude that it is necessary to remedy the state of healthcare, and fulfil the government's obligation to protect the *Maqasid AlSharia* of citizens without discrimination as required in Sharia. In addition, I conclude that, due to the scarcity of finances and growing high demand on healthcare, there is a need to remedy the state of healthcare provision and financing.

The rising political anxiety about the cost of healthcare combined with reduced public tolerance of poor quality provision has prompted the search for new methods of organizing and delivering services. Although there are alternative remedies to the state of Saudi healthcare, the government has decided to embark on the privatisation of the healthcare sector. As a result, Saudi Arabia is moving away from the current free healthcare system that was established in 1925. Such a change is seen as necessary given the country's current financial state. However, privatisation may be harmful to the health system if such revolutionary steps are taken without careful planning. I conclude that this risk is why it is essential to assess and critique 2030VFH to ensure it is acting in accordance with Sharia requirements by maintaining the Right to Health and healthcare that is available, accessible and of quality.

In the next chapter I will discuss privatisation in healthcare and identify the shortcomings of the Sharia scholars' understandings of privatisation. I will also discuss the forms of privatisation specified in 2030VFH, namely corporatization and full privatisation with NHI. Understanding the different forms of privatisation, especially those not included in the Sharia scholarship, will allow this thesis to effectively assess their Sharia compliance, which is a requirement based on the Basic Law of Governance.

Chapter Four Islamic Economic Systems & Privatisation in Healthcare

4.1 Introduction

Despite the opinions of some Sharia scholars against privatisation, the 2030 Vision calls for the privatisation of the Saudi Healthcare system.[550] As mentioned, the Sharia literature has focused on the definition of privatisation as 'a total transfer of ownership to individual possession'.[551] As was concluded in Chapter Two, the total transfer of healthcare to the private personal possession would prevent the state from fulfilling the Sharia obligation of providing healthcare to all. However, upon analysis of the non-Sharia literature, it is evident that privatisation is not limited to one definition or meaning. Therefore, it could be said that the Sharia view of the neglected models of privatisation has not yet been fully explored.

In this chapter, I will discuss privatisation and form an understanding of its different meanings, purposes and arrangements in general, and then I will focus on privatisation in healthcare. Next, I will compare the arrangements and purposes of privatisations in the Sharia and non-Sharia literature and identify the shortcomings of the former. For example, if non-Sharia literature identifies more than one definition of privatisation, therefore, it could be concluded that

[550] 'Operating Costs' *The Economist* (London 30 April 2016) 30; Aboudah, "Dealing with Economic Sustainability Challenges Evolving from Declining Oil Production in Saudi Arabia" (MS Thesis, MTU 2015); Akoum, "Privatisation in Saudi Arabia: is slow beautiful?." *TIBR* 51.5 (2009): 427; Al-Darwish, et al. *Saudi Arabia: Tackling Emerging Economic Challenges to Sustain Growth*. (International Monetary Fund 2015)
[551] Ali, *Privatisation* (AlAhram 1996) [In Arabic]; Saba, *Privatisation and a Weak and Absent Public Sector* (AlMawqif 1994) [In Arabic]; Sirry, *Islamic Finance Principles, Characteristics, and Objectives* (Markaz AlIskandariya LilKetab 1988) [In Arabic]

Sharia literature is limited, which provides us with the opportunity to assess the Sharia compliance of the remaining models

Moreover, I will develop a typology to categorise healthcare privatisation models into four main groups based on the interest of the policy adopted: ownership, management, finance or provision. The typology will help in identifying which healthcare privatisation models are the best to adopt. Healthcare privatisation models that cut costs will be readily identified and assessed for Sharia compliance in the following chapter.

In this chapter, I will engage with the Sharia literature discussing Islamic economic systems, such as *Zakat, Sadaqah* and *Takaful* that have been recommended by Sharia scholars as Sharia compliant alternatives to privatisation.[552] *Takaful* is of importance to this thesis specifically as it is specified in Article 10 of the Saudi Health Law as one of the acceptable methods to finance healthcare in Saudi Arabia.[553] Moreover, there is an implemented form of *Takaful* in Saudi Arabia today known as the Saudi Cooperative Health Insurance System (CHIS) for Foreign Workers.[554] *Takaful* is implemented to finance services in the *Maslahah* of the community through payments of premiums based on financial ability.[555] With *Takaful*, the less privileged are

[552] Ahmad, *Privatisation Concepts and Experiences* (Markaz AlMajed 1998) [In Arabic]; Saati, 'Privatisation of public hospitals: future vision and proposed framework'. AlEqtisadiyah (Riyadh 2 December 2003) [in Arabic]; World Bank Annual Report 2003; Salhab, *A Critical Study of the Privatisation Project* (AlMawqif, 1999) [in Arabic]

[553] The Saudi Health Law, Royal Decree No. M/11, 4th June 2002

[554] Implementing Regulations of the Cooperative Health Insurance Law in the Kingdom of Saudi Arabia (Amended) Cooperative Council for Health Insurance, Session 73 Ministerial Decision DH/1/30/6131 (2009)

[555] Abbasi, et al., 'Islamic Economics: Foundations and Practices' (1989) 16 *International Journal of Social Economics* 5; Abdul Aziz, 'Fulfillment of Maqasid al-Shari'ah via Takaful' (2013) 1 *International Policy Review*; Agil, *Readings in the concept and methodology of Islamic Economics* (Pelanduk Publications 1989)

exempt from payment but are eligible for the same services as other members of society. In this manner, understanding the Sharia systems will facilitate our understanding of how some models of privatisation are either compliant or non-compliant with Sharia. Finally, appreciating Sharia economic systems will allow us to conclude how some models of privatisation could be arranged and adopted in a Sharia-compliant manner.

4.2 Privatisation in Non-Sharia Literature

In the 20th century, privatisation became synonymous with Margaret Thatcher and Milton Freedman, and it is because of them that privatisation gained international momentum.[556] Privatisation enthusiasts saw it as a solution to the problems of nationalisation.[557] This reasoning is also part of the arguments presented by scholars who call for healthcare privatisation in Saudi Arabia,[558] as discussed in Chapters One and Three.[559]

4.2.1 The Meanings of Privatisation in Non-Sharia Literature

Scholars have defined privatisation according to the interest transferred and privatised. [560] For example, Kemp defined privatisation as a transfer of ownership, while Ramamurti defined privatisation based on the transfer of

[556] Hemming, et al. Privatisation and Public Enterprises (International Monetary Fund 1988); Kemp, Privatisation: The Provision of Public services by the Private Sector (McFarland & Co 2007); Saal, et al. International Handbook on Privatisation (Elgar 2003)
[557] ibid; AlRabeie, *Privatisation and its effect on development in developing countries* (Madbouli 2004) [In Arabic]; Alsaqa, *The Experience of Privatisation in the U.K* (AlMujalad Kuwait University 1997) [in Arabic]
[558] Colliers International, 'Kingdom Of Saudi Arabia Healthcare Overview' (2012) Q1; Ismail, "What Derives Public Health Expenditures in Saudi Arabia? Macro-Econometric Analysis." (2016) 6 *IJSR* 623; Jannadi, B., et al. "Current structure and future challenges for the healthcare system in Saudi Arabia." (2008) 3 *APJHM* 43; Jone, et al. 'Challange to Saudi Arabian Hospitals?' (1984) 5 *SMJ* 1
[559] Chapter One Sections 1.6 and 1.10.1; Chapter Three Section 3.4.1
[560] ibid

management and control of public functions; Albreht discussed the financing of healthcare systems and, accordingly, defined privatisation on a financial basis.[561] Yet, through an analysis of the Sharia literature, it is clear that the Sharia definition of privatisation in general, as claimed by Sharia scholars,[562] is actually a definition of the transfer of ownership with no government regulation, known as a deregulation,[563] as mentioned in Chapter Two.[564] I argue not only that the Sharia view is specific to deregulation but also that the Sharia opinion about transfers of management, finance and provision remains undefined.

Therefore, I argue that privatisation can be defined as the total or partial transfer of decision-making authority, delivery or financing from a public to a private entity. This proposed definition allows for the inclusion of the different arrangements that constitute a privatisation. These arrangements range from a full privatisation to contracting out with an array of different models of privatisation in between, which consist of transfers of ownership, management, finance or provision from the public to the private sector.[565] Each arrangement of transfers is known as a model of privatisation. The main models of privatisation are outlined below.

---

[561] Albreht, 'Privatisation processes in healthcare in Europe - a move in the right direction, a 'trendy' option, or a step back?' (2009) 19 *EJPH* 448; Kemp, Privatisation: The Provision of Public services by the Private Sector (McFarland & Co 2007); Ramamurti, 'A multilevel model of privatisation in emerging economies' (2000) 25 *AMR* 525

[562] Ahmad, *Privatisation Concepts and Experiences* (Markaz AlMajed 1998) [In Arabic]; Ali, *Privatisation* (AlAhram 1996) [In Arabic]; AlShabani, *Privatisation from an Islamic Perspective: Selling the Public Sector to Individuals* (AlBayan 1995) [In Arabic]

[563] Karlaftis, 'Privatisation, regulation and competition: A thirty-year retrospective on transit efficiency' (2008) *ITF* 67; Kemp, *Privatisation: The Provision of Public services by the Private Sector* (McFarland 2007); Kettle *Sharing Power: Public Governance and Private Markets.* (Brookings 1993); Kikeri, *Privatisation: trends and recent developments* (WBP 2005)

[564] Chapter Two Section 2.5.1.1 C

[565] Megginson, et al. From state to Market: A survey of empirical studies on privatisation, (2001) 39 *JEL* 321; Murray, 'Privatisation' (1997) 86 *IQR* 51; Parry, *Privatisation* (Kingsley 1990); Perotti. Et al. "Machiavellian Privatisation." (2002) 92 *AER* 240

4.2.1.1 Full Privatisation

A full privatisation[566] is a total transfer of ownership in which a state relieves itself of public assets and reduces its public intervention.[567] According to both Jones and Perotti, full privatisations are preferred by governments aiming for economic reform and allow governments to gain additional political support for their privatisation policies due to the transparency of full privatisation as opposed to asset sales to a single private firm.[568] Generally, larger offerings and more profitable state owned enterprises are more likely to be privatised through shares, making them more attractive to potential investors.[569] This is the form of privatisation that will be adopted by the Saudi government to privatise its oil company, Saudi Aramco.[570] Although this form of privatisation is preferred by states aiming to cut costs, [571] there is a high risk of inequality if the competition and services are not regulated.[572] Furthermore, in this model there is no state involvement in the financing or management of the privatised

[566] Also known as a denationalisation, termination or liquidation.
[567] Boycko, et al. Voucher Privatisation (1994) 35 *JFE* 249; Heller, 'The Budgetary Impact of Privatisation' in Privatisation: issues of principle and implementation (Gill and Mcmillan 1989) ; Pitelis, *The Political Economy of Privatisation* (Routledge 1993); World Bank (PPPIRC), 'Privatisation' (2016)
[568] Jones, et al, Share issue privatisations as financial means to political ends, (1999) 53 *JFE* 217; Mulla, et al. 'Privatisation of general hospitals and its applications in Saudi Arabia' (King Fahad National Library 2001) [in Arabic]; Perotti. et al. "Machiavellian Privatisation." (2002) 92 *AER* 240-258; Saal, *International Handbook on Privatisation*, (Elgar 2003)
[569] ibid
[570] AlQahtani, et al. 'Sharia compliance status & investor demand for IPOs: Evidence from Saudi Arabia' (2017) 46 *Pacific-Basin Finance Journal* 258; Govindan, et al. 'Nationalism and privatisation in state-owned oil multilatinas' (2017) 9 *International Journal of Business and emerging Markets;* Lizzie, 'DEAL: first IPO on Saudi's parallel market' (2017) *International Financial Law Review*
[571] Jones, et al, Share issue privatisations as financial means to political ends, (1999) 53 *JFE* 217; Mulla, et al. 'Privatisation of general hospitals and its applications in Saudi Arabia' (KFNL 2001) [in Arabic]; Perotti. et al. "Machiavellian Privatisation." (2002) 92 *AER* 240-258; Saal, *International Handbook on Privatisation*, (Elgar 2003)
[572] Akinci, 'The Role of Privatisation in Healthcare Services' (2000) 3 *AEEE* 14; Angell, 'Privatizating health care is not the answer: lessons from the United States' (2008) 179 *CMAJ* 916; Basu S. et al, 'Comparative Performance of Private and Public Healthcare Systems in Low and Middle Income Countries: A Systematic Review' (2012) 9 *PLoSMed*

entity.[573] Therefore, the full privatisation is the least favourable form of privatisation implemented, especially in the healthcare sector, unless it is coupled with high government regulation and a form of insurance,[574] as the second step of the 2030VFH aims.[575] In the full privatisation of healthcare, hospitals become privately owned companies while the MOH focuses on its legislative, and regulatory roles.[576]This step is preceded by the corporatisation of Saudi hospitals,[577] which is another form of privatisation and will be outlined below. Scholars such as Collins and Murray advise that a total shift in ownership should be a last resort rather than a starting point when considering models of privatisation as a policy; yet, the Sharia literature suggests that full transfer of ownership is the only model to be considered.[578]

In comparison with the meaning of privatisation in the Sharia literature, the non-Sharia definition is the transfer to the private sector which is regulated by the government.[579] Based on the findings of Chapter Two, it could be argued that adopting a full transfer to the private personal possession would undoubtedly prevent the government from fulfilling its Sharia obligations. For example, a full transfer of the healthcare sector to private personal possession, where there is no state involvement remaining, would not be compliant with Sharia law. Accordingly, I argue that Sharia scholars are justified in their

[573] ibid
[574] ibid
[575] AlDakheel, 'An opinion on the 2030 Vision: A Critical Analytical Reading' (Riyadh 2016); Almashabi, et al., 'Saudi Arabia's Deputy Crown Prince Outlines Plans: Transcript.' Bloomberg, 4 April 2016; Ramady Saudi Aramco 2030: Post IPO challenges (Springer 2017); Reed, Saudi Vision 2030: Winners and Losers (Canergie 2016); Saudi Gazette, Full text of Saudi Arabia's Vision 2030, April 2016
[576] ibid
[577] ibid
[578] Collins, 'Strategic planning for state enterprises in Africa:public versus private options' (1989) 9 Public Administration and Development 65-82; Murray, 'Privatisation' (1997) 86 *IQR* 51-61
[579] ibid

opinion according to their definition against full transfers to the private personal possession of sectors that include state obligations. Nonetheless, non-Sharia literature specifies the private sector in the definitions of privatisation, which is different than private personal possession as mentioned in Chapter Two.[580] Therefore the full privatisation as defined in non-Sharia literature is not included in the Sharia definition and will be assessed in Chapter Five.[581] While denationalisation fully relieves the state from any responsibilities, other models of privatisation outlined in the non-Sharia literature involve greater governmental participation. These models, which were not included in the Sharia literature, will be highlighted in the following sections. [582]

4.2.1.2 Outsourcing

Outsourcing, also known as contracting out, is a model of privatisation that shifts some of the financial risk, provision and responsibility to the private sector while the state maintains accountability and regulation. [583] Outsourcing is argued to improve provision and cut costs and is the most common form of privatisation in healthcare.[584] For example, in the United Kingdom (U.K.), the National Health System (NHS) laundry, cleaning and catering services are

[580] Chapter Two Section 2.5.1.1
[581] Chapter Five Section 5.3
[582] Eissa, *Privatisation and a Diversified Economy* (AlMuntalaq 1996) [In Arabic]; Hatim, *Global Experience in Privatisation* (Cairo 1994) [in Arabic]; Saba, *Privatisation and a Weak and Absent Public Sector* (AlMawqif 1994) [In Arabic]
[583] Kremic, et al. 'Outsourcing decision support: a survey of benefits, risks, and decision factors' (2006) 11 *Supply Chain Management: An International Journal* 6; Roerich, et al, 'Delivering European healthcare infrastructure through public-private partnerships: the theory and practice of contracting and bundling' in *Research in Strategic Alliances* (Information Age Publishing 2013); Rohrer J. Performance contracting for public health: the potential and the implications. (2004) 10 *J Public Health Manage Pract* 23
[584] ibid

contracted out.[585] This form of privatisation allowed the government to settle payments and cut costs; however, the total gross savings amounted to less than 0.5% of the NHS budget.[586] Another example in the U.K. is the nonclinical services that are contracted out to private providers.[587] The purpose behind contracting out nonclinical services in the NHS was to reduce the role of the state in the economy and to create a climate in which the private sector could flourish.[588]

Despite the popularity of outsourcing, Sharia scholars did not include it in their definition or analysis of privatisation.[589] It is possible that these Sharia scholars were not aware of examples from Islamic history and Hadeeth that could be considered models of privatisation. For example, in 1377, Ibn Khaldoun called for the privatisation of production and manufacture.[590] Ibn Khaldoun argued that outsourcing production and manufacture would allow the government to focus on more important matters.[591] This example allows us to question the Sharia opinion of services within governmental sectors, such as catering and

585 Hunter, 'Change of government: one more big bang health care reform in England's National Health Service' (2011) 41 International Journal of Health Services 159; Nicholas, et al 'Variations in the organization and delivery of the 'NHS health check' in primary care' (2013) 35 *JPH* 85; Peedell, 'NHS Reforms: Further Privatisation is inevitable' (2011) 342 *BMJ* 1112

586 Harker, NHS Funding and Expenditure, SN/SG/724, House of Commons Library; Hunter, 'The Slow, lingering death of the english NHS' (2016) 5 Int J Health Policy Manag 55

587 Haskel 'Privatization, Liberalization, Wages and Employment: Theory and Evidence for the UK' (1993) 60 *Economics* 161; Hunter, 'The Slow, lingering death of the english NHS' (2016) 5 Int J Health Policy Manag 55

588 Peedell, 'NHS Reforms: Further Privatisation is inevitable' (2011) 342 *BMJ* 1112; Pollock, *NHS Plc: The Privatisation of Our Health Care* (Verso 2005)

589 Eissa, *Privatisation and a Diversified Economy* (AlMuntalaq 1996) [In Arabic]; Hatim, *Global Experience in Privatisation* (Cairo 1994) [in Arabic]; Saba, *Privatisation and a Weak and Absent Public Sector* (AlMawqif 1994) [In Arabic]

590 Ahmad, 'Economic Development in Islamic Perspective Revisited' (2000) 9 *RIE* 83; Ahmad, *Studies in Islamic Economics* (TIF 1980); Mahmood, The Reference of The Arab Islamic Civilisation (AlSalasil 1984) [In Arabic]; Ragab, 'Islam and Development' (2002) 8 *JWD* 513

591 ibid

laundry services in the public health sector, and anticipate their Sharia compliance based on, and by analogy to, the opinion of Ibn Khaldoun.[592]

Islamic history also contains examples of outsourcing healthcare during the time of the Prophet.[593] An analysis of the available literature in the Hadeeth discussing healthcare provision indicates that the Prophet implemented outsourcing.[594] Healthcare provision was transferred to Rufaidah AlAslamiyah in Madinah, who provided medical services to those in need after she had demonstrated her ability to treat the ill.[595] This example allows us to anticipate the Sharia compliance of outsourcing healthcare services based on, and by analogy to, the outsourcing of these services by the Prophet. Nonetheless, it is essential to emphasise that the Prophet was also obliged to monitor the services of Rufaidah and those after her to ensure the quality and cost of the services provided and to protect *Maqasid AlSharia*.[596]

Similarly, non-Sharia scholars, such as Avery, emphasise that to achieve the claimed benefits of outsourcing, it is essential to ensure ongoing internal evaluation of the quality and prices of services.[597] Thus, I argue that it is essential to take evidence from the non-Sharia literature into consideration

---

[592] ibid

[593] AlAlbani, *The Life of The Prophet* (Damascus 2001) [In Arabic]; AlShayaa, *The Concise Life story of The Prophet* (AlRayyan 2003) [In Arabic]; Sachedina, 'In Search of Principles of Healthcare Ethics in Islam' in Islamic Biomedical Ethics Principles and Applications (OUP 2009)

[594] ibid; AlKatani, *The Prophetic Government: Administrative Formalities* (Dar AlArqam 2008) [In Arabic]; Ferngren, *Medicine and Religion: A Historical Introduction* (JHUP 2014); Hamidullah, *The Prophet's establishing a state and his succession,* (NHC 1988); Watt, *Muhammad at Medina* (OUP 1956)

[595] ibid

[596] ibid

[597] Amirkhanyan, et al. 'Putting the Pieces Together: A Comprehensive Framework for Understanding the Decision to Contract Out and Contractor Performance' (2007) 30 *International Journal of Public Administration* 6; Avery, 'Outsourcing Public Health Laboratory Services: A Blueprint for determining whether to provatise and how' (2002) 60 *Public Administration Review;* Kremic, et al. 'Outsourcing decision support: a survey of benefits, risks, and decision factors' (2006) 11 *Supply Chain Management: An International Journal* 6

while discussing problems with outsourcing and recommendations. Based on an analysis of the non-Sharia literature, I argue that it is essential for governments to exercise internal evaluation and monitoring of outsourced services to ensure their quality and cost.[598] Fortunately, as mentioned in Chapter Two, [599] governmental regulation is a Sharia obligation upon governments meant to ensure the *Maslahah* and protection of *Maqasid AlSharia*.[600] In theory, no new policies would have to be introduced to ensure the success of the outsourcing's implementation. I conclude that based on evidence from both the non-Sharia literature and Islamic history, monitoring outsourced services are key to achieving the claimed benefits and ensuring Sharia compliance for the outsourcing of services.

4.2.1.3 Decentralisation

Decentralisation is another model of privatisation discussed in the non-Sharia literature and is defined as the transfer of management to lower levels. For example, some U.K. hospitals have transferred administrative power to the local level.[601] Decentralisation is based on the theory that smaller organisations are more agile and accountable than larger organisations if properly structured and steered.[602] Oates's theory states that it will always be more efficient for a local

[598] Johns, et al 'Selective contracting in California: Experience in the second year' (1985) 22 Inquiry 335; Mills, 'To contract or not to contract? Issues for low and middle-income countries' (1998) 13 *HPP* 32; Rohrer, Performance contracting for public health: the potential and the implications. (2004) 10 *JPHMP* 23; Schmidt, 'The costs and benefits of privatisation: an incomplete contracts approach' (1996) 12 *JLEO* 1
[599] Chapter Two Section 2.5.1.1 B
[600] AlRaziq, *AlIslam wa Usul AlHukm* [Islam and the Origins of Governance] (Dar AlJanub 1996); Attieh, *Towards Activating The Role of Maqasid AlShariah* (Dar AlFikr 2001) [In Arabic]; Jackson, *Islamic Law and The State* (BRILL 1996); Lambton, *State and Government In Medieval Islam* (OUP 1981)
[601] Arrowsmith 'Decentralization in the public sector: the case of the UK National Health Service' (2002) 57 *Relations Industrielles* 2; Bennett, *Decentralization, local governments, and markets: towards a post-welfare agenda* (Clarendon Press 1990); Saltman, et al., *Decentralisation in health care* (OUP 2007)
[602] Gershberg, A. 'Decentralization, recentralization and performance accountability: building an operationally useful framework for analysis' (1998) 16 *Development Policy Review* 405; Mills,

government to provide services within its respective jurisdiction than for a central government to provide those services across several local authorities.[603] Since the Second World War, various countries have introduced decentralisation strategies, particularly in the healthcare sector.[604] The claimed purposes for decentralising are to cut costs and eliminate bureaucracy. Nonetheless, evidence in the non-Sharia literature indicates that central government transfers have been a primary source of revenue for local governments, which contradicts the aim of cost cutting and the notion of local accountability.[605] According to the WHO, implementing a decentralisation with continued dependency on central revenues could potentially be more expensive than direct centralised provision.[606] Hence, I argue that decentralisation should not be considered if the purpose of privatising is to cut costs. According to the WHO and based on examples of decentralisation, this form of privatisation has the potential to increase service inequalities between regions and affect the

---

ADecentralization and accountability in the health sector from an inter- national perspective: what are the choices? (1994) 14 *Public Administration and Development* 281; Smith, *Decentralization: the territorial dimension of the state* (Allen & Unwin 1985)

[603] Fesler, J. 'Centralization and decentralization' in Sills, D. *International encyclopedia of the social sciences*, vol. 2 (The Macmillan Company and The Free Press 1968); Gershberg, A. 'Decentralization, recentralization and performance accountability: building an operationally useful framework for analysis' (1998) 16 *Development Policy Review* 405; Saltman, et al., *Decentralisation in health care* (OUP 2007)

[604] Bennett, *Decentralization, local governments, and markets: towards a post- welfare agenda*. (Clarendon Press 1990); Saltman, et al., 'Conceptualizing decentralization in European health systems: a functional perspective' (2006) 1 *Health Economics, Policy and Law* 127; Smith, *Decentralization: the territorial dimension of the state* (Allen & Unwin 1985); Wasem, 'A study on decentralizing from acute care to home care settings in Germany'(1997) 41 *Health Policy* s109

[605] Bossert, *Decentralization of Health Systems: Chile, Colombia and Bolivia: Latin American and Caribbean Regional Health Sector Reform Initiative,* Report 29. (2000); Bossert, Analysing the decentralization of health systems in developing coun- tries: decision space, innovation and performance. (1998) 47 *Social Science and Medicine* 1513; Collins, et al 'Decentralization and primary health care: some negative implications in developing countries' (1994) 24 *International Journal of Health Services* 459

[606] Arrowsmith, et al. 'Decentralization in the public sector: the case of the UK National Health Service' (2002) 57 *RI* 2; Haskel, et al. 'Privatisation, Liberalization, Wages and Employment: Theory and Evidence for the UK' (1993) 60 *Economics* 161; Hemming, et al. Privatisation and Public Enterprises (International Monetary Fund 1988); Janoska, 'Privatisation of public health services at european health markets from a law and economic perspective' (2011) 3 *GJYR* 13

availability of services.[607] Examples of problems of privatisation such as this will be further discussed in Chapter Five.[608]

4.2.1.4 Financial Privatisation

Financial privatisation is a model of privatisation that constitutes a transfer of financing, relieving the government of a financial burden.[609] This model of privatisation is commonly adopted in the health sector. In financial privatisation in healthcare, financial responsibility is completely shifted from the government to individuals, private health insurance companies, or funds while the government still provides, manages, regulates and supervises healthcare.[610] As mentioned in Chapter Three,[611] financial privatisation is part of the second step of the two-phase Saudi 2030VFH, and will allow the burden of finance to be transferred from the MOH through the implementation of an NHI system [612] As financial privatisation allows governments to cut costs, it will be assessed for Sharia compliance in Chapter Five.[613]

---

[607] Saltman, et al., *Decentralisation in healthcare* (OUP 2007); Smith, *Decentralization: the territorial dimension of the state* (Allen & Unwin 1985); Wasem, J. 'A study on decentralizing from acute care to home care settings in Germany'(1997) 41 *Health Policy* s109-29; Wolman, H. 'Decentralization: what it is and why we should care' in Bennett, R. *Decentralization, local governments, and markets: towards a post-welfare agenda* (Clarendon Press 1990)

[608] Chapter Five Section 5.3

[609] Drakeford, et al. *Privatisation and Social Policy* (Longman 2000); Gardner, et al. 'Privatisation in healthcare: Shifting the risk' (1988) 45 *MCR* 215; Janoska, 'Privatisation of public health services at european health markets from a law and economic perspective' (2011) 3 *GJYR* 13; Sheshinski, et al., 'Privatisation and its benefits: theory and evidence' (2003) 49 *ES* 429;

[610] Hoffman, et al., 'Health insurance and access to healthcare in the United States' (2008) 1136 *ANYAS* 149; Jack, W., *The evolution of health insurance institutions: theory and four examples from Latin America,* (World Bank Group 2000); Musgrove, P., *Public and Private Roles in Health: Theory and Financing Patterns* (World Bank 1996)

[611] Chapter Three Section 3.4.3

[612] Aboudah, "Dealing with Economic Sustainability Challenges Evolving from Declining Oil Production in Saudi Arabia" (MS Thesis, MTU 2015); Al-Darwish, et al. *Saudi Arabia: Tackling Emerging Economic Challenges to Sustain Growth*. (International Monetary Fund 2015); Alhowaish, "Healthcare spending and economic growth in Saudi Arabia: A Granger causality approach." (2014) 5 International Journal of Scientific & Engineering Research 1471-1476

[613] Chapter Five Section 5.3

4.2.1.5 Public-Private Partnership (PPP)

Based on non-Sharia literature, PPPs are the most common type of privatisation in general, where both public and private sectors cooperate in management, construction, provision or financing to improve efficiency and cut costs.[614] In healthcare, PPPs, such as corporatisation, are argued to improve the government's management of hospitals and lessen their financial burden.[615] In corporatisation, hospitals are public corporations under a government's MOH. An example of this form of privatisation is evident in the United States (U.S.), where the superior performance and expertise of the private sector management is assumed.[616] A claimed benefit of this form of privatisation is the lack of bureaucracy and, therefore, the ability to make decisions quickly, achieving more timely responses to consumer demands than in governmental and federal bureaucracies.[617] This form of privatisation is implemented when the primary aim is to increase the efficiency of services, with cutting costs as a by-product.[618] Corporatisation is often the first step taken by governments to prepare a sector for further privatisation according to the required aim and

[614] Barlow, et al, 'Europe sees mixed results from public-private partnerships for building and managing healthcare facilities and services' (2013) 32 *HA* 146; Roerich, et al, 'Delivering European healthcare infrastructure through public-private partnerships: the theory and practice of contracting and bundling' in Research in Strategic Alliances (Information Age Publishing 2013); Lewis, et al, 'Are public-private partnerships a healthy option?' (2014) 113 *SSM* 110

[615] ibid

[616] Andersen, et al., *Improving access to care in America. Changing the US health care system: key issues in health services policy and management* (Jossey-Bass 2007); Millman, *Access to health care in America*, (National Academies Press 1993); Phillips, et al., 'Health in rural America: remembering the importance of place' (2004) 94 *Am J Public Health* 1661; Weil, 'What can the canadians and americans learn from each other's health care systems?'(2016) 31 Int J Health Plann Mgmt 349

[617] Abdul Ghafour, "Government Hospitals to Become Corporations" Arab News, Monday, 19 February 2007; Geyman, 'The corporate transformation of Medicine and its impact on costs and access to care' (2003) 16 *J Am Board Fam Med* 443; Hellander, et al. *Bleeding the patient: the consequences of corporate health care*. (Common Courage Press 2001); Wynne, 'Hazards in corporatization of healthcare' (2004) 80 *New Doctor* 2

[618] Alexander, et al 'The financial characteristics of hospitals under for-profit and nonprofit contract management' (1984) 21 *Inquiry* 230; Kralewski, et al 'Effects of contract management on hospital performance' (1984). 19 *HSR* 479; Roerich, et al, 'Delivering European healthcare infrastructure through public-private partnerships: the theory and practice of contracting and bundling' in *Research in Strategic Alliances* (Information Age Publishing 2013)

purpose. [619] In the case of Saudi Arabia, corporatisation is the first step of the two-phase Vision,[620] as mentioned in Chapter Three,[621]

Due to the success of different types of PPPs, there has been a sharp increase in the popularity of these types of privatisation in both developed and developing countries during recent years.[622] Nevertheless, evidence in the non-Sharia literature indicates that in some cases corporate medicine encourages the diversion of resources from patient care to meet market priorities, which results in financial benefits at the expense of deteriorating patient care.[623] Geymann argues that in these investor-owned healthcare corporatisations, money is the mission rather than public interest.[624] Therefore, scholars such as Wynne emphasise that it is essential to be vigilant and monitor corporatisations within the healthcare sector to ensure patient-centred care.[625] As mentioned in Chapter Two,[626] regulation of the private sector is a Sharia obligation for

[619] Arora, et al., *Public Payment and Private Provision. The Changing Landscape of Healthcare in the 2000s.* (Nuffield Trust 2013); Arrowsmith, et al. 'Decentralization in the public sector: the case of the UK National Health Service' (2002) 57 *RI* 2; Pollock, NHS Plc: The Privatisation of Our Healthcare (Verso 2005); Waren, ' Privatisation of healthcare' (2009) 180 *CMAJ* 429

[620] Almashabi, et al., 'Saudi Arabia's Deputy Crown Prince Outlines Plans: Transcript.' *Bloomberg*, 4 April 2016; Transforming Saudi Arabia: National Transofrmation Program 2020 Approve' Shearman and Sterling, 14 June 2016; AlDakheel, 'An opinion on the 2030 Vision: A Critical Analytical Reading' (Riyadh 2016)

[621] Chapter Three Section 3.4.3

[622] English, 'Using public-private partnerships to deliver social infrastructure: the Australian experience' in The Challenge of public-private partnerships: learning from international experience (Elgar 2005); Das, Research in Strategic Alliances (Information Age Publishing 2013); Guasch, et al, 'Renegotiation of concession contracts in Latin America: evidence from the water and transport sectors' (2008) 26 *IJIO* 421; Yang, et al, 'On the development of public-private partnerships in transitional economies: an explanatory framework' (2013) 73 *PAR* 301

[623] Lewis, et al, 'Are public-private partnerships a healthy option?' (2014) 113 *SSM* 110; Maceira, D. *Income Distribution and the Public-Private Mix in Healthcare Provision: the Latin American Case* (Inter American Development Bank 1998); Yescombe, Public-private partnerships: principles of policy and finance. (Butterworts-Heinemann 2007)

[624] Geyman, *Healthcare in America: can our ailing system be healed?* (Butterworth-Heinemann 2002)

[625] Wynne, 'Hazards in corporatization of healthcare' (2004) 80 *New Doctor* 2; Geyman, 'The corporate transformation of Medicine and its impact on costs and access to care' (2003) 16 *J Am Board Fam Med* 443; Hellander, et al. *Bleeding the patient: the consequences of corporate healthcare.* (Common Courage Press 2001)

[626] Chapter Two Section 2.5.1.1 B

governments.[627] Theoretically, no new policies would need to be introduced to ensure the success of the implementation of PPPs if proven to be Sharia compliant. An assessment of the Sharia compliance of corporatisation will be carried out in Chapter Five.[628]

4.2.2 The Meanings of Healthcare Privatisation

According to Scarpaci, the term 'privatisation' is equated with reduced levels of public provision, subsidy or regulation of either preventive or curative health services.[629] However, privatisation in the context of healthcare includes a broad range of arrangements, which scholars have divided into four main groups (three of which have already been discussed): full privatisation, outsourcing, corporatisation and load-shedding.[630] The latter is an extreme form of privatisation in which responsibility for specific finances or for the delivery of specific services is transferred to the private sector.[631] For example, if a government fully withdraws from the delivery of radiology services, it no longer considers these services as a responsibility of the public sector.[632]

---

[627] AlRaziq, *AlIslam wa Usul AlHukm* [Islam and the Origins of Governance] (Dar AlJanub 1996); Attieh, *Towards Activating The Role of Maqasid AlShariah* (Dar AlFikr 2001) [In Arabic]; Jackson, *Islamic Law and The State* (BRILL 1996); Lambton, *State and Government In Medieval Islam* (OUP 1981)

[628] Chapter Five Section 5.3

[629] Scarpaci, *Health Services Privatization in Industrial Societies* (Rutgers University Press 1989)

[630] Jindal, 'Privatisation of Healthcare: New Ethical Dilemmas' (1998) 6 *IJME* 85; Kahn, et al., *Privatisation and the welfare state* (Princeton University Press 2014); Karlaftis, 'Privatisation, regulation and competition: A thirty-year retrospective on transit efficiency' (2008) *ITF Round Tables* 67; Kemp, *Privatisation: The Provision of Public services by the Private Sector* (McFarland & Co 2007)

[631] Béchamps, *Privatization and public health: a report of initiatives and early lessons learned.* (Public Health Foundation 1999); Berer, 'who has responsibility for health in a privatised health system?' (2010) 18 *Reproductive Health Matters* 4; Cowan, 'A global overview of privatisation' in *Privatisation and Development* (Institute of Contemporary Studies 1987); Donahue, J. *The Privatization Decision: Public Ends, Private Means* (Basic Books 1989)

[632] Smith, et al *Working with private sector providers for better healthcare, an introductory guide* (London School of Hygiene and Tropical Medicine 2001); Sobel, *The Pursuit of Wealth*, (McGraw Hill 1999); Lipsky, et al 'Privatisation in health and human services: A critique' (1992) 17 *JHPPL* 233; Terzi, et al 'Privatisation of healthcare facilities in Istanbul' (2011) 19 *EPS* 1117

Nevertheless, I argue that the general division of the vast selection of privatisation arrangements within the context of healthcare into four groups is problematic for two main reasons. First, it is difficult to identify the numerous different models of privatisation in healthcare included in these four main groups. Second, it is difficult to decide which policy of the different privatisations to implement. In the next section, I propose a typology which I argue will overcome these two problems.

4.2.3 Healthcare Privatisation Typology

According to Scarpaci, the choice of privatisation model for health services depends on the specific nature of the problem being addressed and the purpose to be achieved.[633] Therefore, when choosing a policy, it is vital that the model of privatisation is chosen that best resolves the problem and fulfils the purpose.[634] For example, in the case of financial disparity, it is best to adopt a model of privatisation that allows financial objectives to be achieved.[635] It is expedient, efficient and practical to divide the different models of privatisation according to the main interest and purpose of the policy – finance, management or provision – each of which consists of the four types of privatisation outlined earlier: outsourcing, corporatisation, load-shedding and full privatisation. Based on this typology, a form of privatisation that can be adopted in cases of financial disparity is load-shedding, where financing for physicians and hospitals are

[633] Scarpaci, *Health Services Privatization in Industrial Societies* (Rutgers University Press 1989); Scarpaci, *Introduction: The theory and practice of health services privatization*. in Schachet, *An Introduction to Islamic Law* (Universal Law Publishing Company 1997)
[634] Arora, et al., *Public Payment and Private Provision. The Changing Landscape of Healthcare in the 2000s.* (Nuffield Trust 2013); Van der Gaag, *Private and public initiatives: working together for health and education. Directions in development Series.* (The World Bank 1995)
[635] ibid

transferred from state responsibility. For example, physicians can be financed through philanthropy, which, I argue, is similar to the Sharia scholar proposal to finance the healthcare system through *Zakat*,[636] which will be critiqued later in this chapter.[637]

Adopting a goal-oriented typology for models of healthcare privatisation is essential to this thesis specifically, as this typology will identify models of privatisation focusing on finance and fulfilment of Sharia healthcare requirements. Despite the vast variety of privatisation models available, this thesis will only focus on and assess the Sharia compliance of privatisation models that focus on cost cutting,[638] as the 2030VFH aims.[639] I argue that when a model of privatisation is implemented, adopting a goal-oriented typology will allow for appropriate monitoring of the privatisation objectives, which is essential for the success of the privatisation policy. Both the U.K.'s private provision of nursing home services and the U.S.'s use of Medicaid-managed care arrangements demonstrate the importance of having appropriate monitoring mechanisms in place to maintain private care quality and to protect patients against any undesirable effects of privatisation.[640] Moreover, examples from

[636] Saleh, *The role of Zakat in Financial and Social Development* (AlBayan 2011) [In Arabic]; Vickers, et al., *Privatisation: an Economic Analysis* (MIT Press 1988); Wagstraff, et al 'Equity in Health Finance and Delivery' in Newhouse, J. *Handbook of Health Economics* (Elsevier Science 2000)
[637] Section 4.3.2
[638] Allotey, et al., 'Universal Coverage in an era of privatisation can we guarantee health for all?' (2012) 12 *BMC PH* s1; AlMishaal, 'The Benefits of NHI in Taiwan' *Sehat AlSharqia* (Dammam, January 2008); Banoob, Private and public financing-healthcare reform in eastern and central Europe. (1994) 15 *WHF* 329; Basu, et al, 'Comparative Performance of Private and Public Healthcare Systems in Low and Middle Income Countries: A Systematic Review' (2012) 9 *PLoSMed*
[639] AlDakheel, 'An opinion on the 2030 Vision: A Critical Analytical Reading' (Riyadh 2016); Almashabi, et al., 'Saudi Arabia's Deputy Crown Prince Outlines Plans: Transcript.' Bloomberg, 4 April 2016; Ramady Saudi Aramco 2030: Post IPO challenges (Springer 2017); Reed, Saudi Vision 2030: Winners and Losers (Canergie 2016); Saudi Gazette, Full text of Saudi Arabia's Vision 2030, April 2016
[640] Andersen, et al., *Improving access to care in America. Changing the US healthcare system: key issues in health services policy and management* (Jossey-Bass 2007); Weil, 'What can the canadians and americans

Russia, the Czech Republic and Hungary have shown that the need for hasty implementation of privatisation initiatives can lead to several redesigns and compromises in practice.[641]

In summary, conceptualising privatisation as a simple dichotomy between public and private would disregard the evolutionary character of privatisation and the wide range of possible models in between. Based on my analysis, I have found that defining privatisation is difficult in the healthcare sector because of the various methods and models available. Saltman describes privatisation as the transfer of public assets to private owners, while Albreht believes privatisation is the transfer of both ownership and functions.[642] However, upon close inspection of the literature, it becomes clear that in the context of healthcare, forms of transfers exist that are not included in either of these respected scholars' definitions.[643] Although these definitions are specific and do not account for these transfer models, this does not mean that these models are not forms of privatisation. On the contrary, it affirms that privatisation is a broader concept than the specific definitions of different schools of thought suggest. For example, transfers of management, provision or financing are not included in the definitions but still constitute privatisations.

---

learn from each other's healthcare systems?'(2016) 31 *IJHPM* 349; Whitehead, *The Health Divide: Inequalities in Health in the 1980's in U.K.* (The Health Education Authority 1987)

[641] Dethier, *Governance, decentralization and reform in China, India and Russia* (Kluwer Academic Publishers 2000); Gesler, *Health Care in Developing Countries* (Association of American Geographers 1984); Mills, *Private Health Providers in Developing Countries: Serving the Public Interest?* (Zed Books 1997); Rondinelli, *Decentralization in developing countries*, Staff Working Paper 581 (World Bank 1983); Sekhri, 'Private health insurance: implications for developing countries' (2005) 83 *Bulletin of the World Health Organization* 127

[642] Albreht, 'Privatization processes in health care in Europe: a move in the right direction, a "trendy" option, or a step back?' (2009) 19 *European Journal of Public Health* 448; Saltman, et al., 'Conceptualizing decentralization in European health systems: a functional perspective' (2006) 1 *Health Economics, Policy and Law* 127; Saltman, et al., *Decentralisation in health care* (OUP 2007)

[643] Akinci, 'Privatisation in Healthcare: Theoretical Considerations and Real Outcomes' (2002) 3 *JEER* 62; Akinci, 'The Role of Privatisation in Healthcare Services' (2000) 3 *AEEE* 14; Zahner S. 'Local public health system partnerships' (2005) 120 *PHR* 76

As mentioned above, Sharia literature discussing privatisation was restricted to one arrangement and focused on improving efficiency.[644] In response to calls for privatisation, Sharia scholars recommended methods of financing to cut costs from within Sharia as alternatives to privatisation. The next section will engage with Sharia literature discussing Islamic economic systems and the recommended methods of finance from within Sharia.

4.3 Proposed Healthcare Financing from Sharia

It was not until regional scholarly opinions from fields other than Sharia law, such as Saati and AlJazzaf, began to demonstrate that privatisation could help governments cut costs that Sharia scholars began to consider cost cutting in their analysis.[645] In response to these calls for privatisation, Sharia scholars began to argue that other means of financing from within Sharia law, such as *Zakat, Sadaqah* and *Takaful*, would be sufficient to finance healthcare.[646] Upon analysis of these Sharia scholars' recommendations, I argue that they did not consider the practicality of their propositions. The next sections will discuss three recommendations presented by Sharia scholars.

[644] Ali, Privatisation (AlAhram 1996) [in Arabic]; AlShabani, *Privatisation from an Islamic Perspective: Selling the Public Sector to Individuals* (AlBayan 1995) [In Arabic]; Eissa, *Privatisation and a Diversified Economy* (AlMuntalaq 1996) [In Arabic]

[645] Saati, 'Privatisation of public hospitals: future vision and proposed framework'. *AlEqtisadiyah* (Riyadh 2 December 2003) [in Arabic]; World Bank Annual Report 2003

[646] Ahmad, *Privatisation Concepts and Experiences* (Markaz AlMajed 1998) [In Arabic]; Saati, 'Privatisation of public hospitals: future vision and proposed framework'. AlEqtisadiyah (Riyadh 2 December 2003) [in Arabic]; World Bank Annual Report 2003; Salhab, *A Critical Study of the Privatisation Project* (AlMawqif, 1999) [in Arabic]

4.3.1 *Sadaqah*

Some Sharia scholars, such as Lutfi, have argued that *Sadaqah* (donations) are sufficient to finance both healthcare and entrepreneurial start-ups.[647] Confident in the success of this proposal, Lutfi demanded that the government exempt donors from other communal payments.[648] However, further analysis shows that Lutfi failed to demonstrate how sufficient donations would be collected to finance both the healthcare system and start-ups, as he claimed. It is highly unlikely that donations by individuals would be sufficient to finance complete government sectors, as Lutfi proposes. Yet, these individual donations could be sufficient for micro-financing if an appropriate method of collection were implemented. Moreover, since the Saudi healthcare system serves a population of over 30 million, 30% of which live in poverty,[649] I argue that financing a healthcare system of this size through donations alone would neither be sufficient nor practical.

4.3.2 *Zakat*

Other scholars, such as Saleh, have argued that *Zakat* would be sufficient to finance infrastructure and governmental sectors.[650] *Zakat* is a 2.5% annual Islamic taxation on savings of eligible individuals, whose annual savings have

---

[647] Ahmed, 'Financing microenterprises: An analytical study of Islamic microfinance institutions' (2002) 9 *Islamic Economic Studies* 27; Ashraf, 'Performance of microfinance institutions in Muslim countries' (2014) 30 *Humanomics* 162; Lutfi, et al, 'Sadaqah-based crowdfunding model for healthcare' (National University of Malaysia 2016)

[648] ibid

[649] Baker, A. 'Rich Nation, Poor People: Saudi Arabia by Lynsey Addario' *Time* 23 May 2013; Mackey, R. "Saudi Video Blogger Reportedly Detained for Showing Poverty in Riyadh' *The New York Times* (New York 19 October 2011); Sullivan, K. 'In Saudi Arabia, unemployment and booming population drive growing poverty' *The Washington Post* (3 December 2012); Sullivan, K. 'Saudi Arabia's riches conceal a growing problem of poverty' *The Guardian* (London, 1 January 2013)

[650] Hasan, *The third wave of Zakah optimizing Islamic philanthropy for social justice* (IISS 2016); Saleh, AlZakat LelTanmiyah AlEqtisadiyah wa AlIjtima'iyah [The role of Zakat in Financial and Social Development] (AlBayan 2011) [In Arabic]; Nienhaus, *Zakat, taxes, and public finance in Islam*. in Behdad, et al., *Islam and the Everyday World: Public Policy Dilemmas* (Routledge 2006)

exceeded a set amount, payable to the national treasury for distribution to the needy.[651] In response, scholars such as AlRifaei have argued that *Zakat* is only payable, as specified in the Quranic verse, to *'the poor, the indigent, those who work on it, those whose hearts are to be reconciled, to free those in bondage, to the debt-ridden, for the cause of God and the wayfarer'*, which clearly does not include financially supporting the government.[652]

Regardless, the opinions of AlRifaei and other scholars can be challenged morally. I argue that the purpose of *Zakat* is to achieve financial balance in society and to minimise the gap between social classes as part of maintaining the *Maslahah* of the community and protecting the associated *Maqasid AlSharia.*[653] Correspondingly, I argue that depriving the government of *Zakat* money to finance infrastructure and governmental sectors could deprive some citizens of their related rights, including the right to healthcare. Therefore, *Maqasid AlSharia* and *Maslahah* would be at risk, which is in contradiction to the aim of *Zakat* in Sharia and the obligations of the government.[654] More specific to this thesis is Saleh's analysis, which is based on Saudi Arabia. According to Article 21 of the Basic Law of Saudi Arabia, *Zakat* should only be

[651] Badawi, *Zakat And Social Justice* (Finance in Islam Publications 2005); Nienhaus, *Zakat, taxes, and public finance in Islam*. in Behdad, et al., *Islam and the Everyday World: Public Policy Dilemmas* (Routledge 2006); Ybarra, 'Zakat in Muslim society: an analysis of Islamic economic policy' (1996) 35 *Social Science Information* 643

[652] AlRifaei, Ala Men Tajib AlZakat? [Who is Eligible for Zakat?] (Alalookah 2012) [In Arabic]; The Quran 9:60

[653] Badawi, *Zakat And Social Justice* (Finance in Islam Publications 2005); Nienhaus, *Zakat, taxes, and public finance in Islam*. in Behdad, et al., *Islam and the Everyday World: Public Policy Dilemmas* (Routledge 2006); Ybarra, 'Zakat in Muslim society: an analysis of Islamic economic policy' (1996) 35 *Social Science Information* 643

[654] ibid ; Kamali, Shariah Law: An Introduction (OneWorld 2008); Saleh, The role of Zakat in Financial and Social Development (AlBayan 2011) [In Arabic]; Sirry, Islamic Finance Principles, Characteristics, and Objectives (Markaz AlIskandariya LilKetab 1988) [In Arabic]; Umeh. 'Healthcare financing in the Kingdom of Saudi Arabia: a review of the options' (1995) 31 World Hospitals and Health Services 3; Ybarra, 'Zakat in Muslim society: an analysis of Islamic economic policy' (1996) 35 *Social Science Information* 643

paid to 'legitimate beneficiaries'.[655] I argue that such vague terminology allows room for interpretation and for questioning, given the current situation,[656] outlined in Chapters One and Three,[657] whether Saudi citizens at risk of being deprived of their rights to access healthcare can be considered to meet the criteria of *Zakat* beneficiaries.

Two realistic and important questions should be asked that are absent from the *Zakat* discussion in the available literature: Would the *Zakat* money of eligible citizens in Saudi Arabia be sufficient to finance the healthcare system? If proven to be sufficient, how would *Zakat* payments by eligible individuals be practically enforced? These questions are essential considering that 30% of the Saudi population live in poverty, as mentioned previously, and that *Zakat* is only 2.5% of an individual's annual savings exceeding a set amount.[658] According to statistics by the Ministry of Labour and Social Development, over 50% of the population are successfully registered in the Citizen's Account Program, a benefits program introduced in December 2017 to avoid high poverty rates, and, hence, would not be eligible to pay *Zakat*.[659] Hence, not all individuals in the remaining 70% of the population above the poverty line would be eligible to

[655] The Basic Law of Governance of Saudi Arabia Article 21
[656] Alhowaish, "Healthcare spending and economic growth in Saudi Arabia: A Granger causality approach." (2014) 5 IJSER; AlHussain, 'Saudi Healthcare System: Where does improving the services and performance begin?' (RMA December 2004) [In Arabic]; Dossary, 'Health and Development in poor countries with particular reference to Saudi Arabia' (PhD Thesis, UA 1991); Mulla, et al. 'Privatisation of general hospitals and its applications in Saudi Arabia' (KFNL 2001)
[657] Chapter One Sections 1.6 and 1.10.1; Chapter Three Section 3.4.1
[658] Badawi, *Zakat And Social Justice* (Finance in Islam Publications 2005); Baker, A. 'Rich Nation, Poor People: Saudi Arabia by Lynsey Addario' *Time* 23 May 2013; Mackey, R. "Saudi Video Blogger Reportedly Detained for Showing Poverty in Riyadh' *The New York Times* (New York 19 October 2011); Nienhaus, *Zakat, taxes, and public finance in Islam*. in Behdad, et al., *Islam and the Everyday World: Public Policy Dilemmas* (Routledge 2006); Sullivan, K. 'In Saudi Arabia, unemployment and booming population drive growing poverty' *The Washington Post* (3 December 2012); Sullivan, K. 'Saudi Arabia's riches conceal a growing problem of poverty' *The Guardian* (London, 1 January 2013)Ybarra, 'Zakat in Muslim society: an analysis of Islamic economic policy' (1996) 35 *Social Science Information* 643
[659] ibid; Ministry of Labor and Social Development Statistics on MLSD website

pay *Zakat,* and the amount of collected money would be limited. To date, there is no enforcement to pay *Zakat* in Sharia, as the Quran states *'there is no compulsion in religion*', which entails the freedom of choice with regard to religious beliefs and practices, including the payment of *Zakat*.[660] Sharia explains the obligations on individuals but has not set enforcement tactics or punishments for lack of fulfilment.[661] In Saudi Arabia, the General Authority of Zakat and Tax (GAZT) is a government agency linked to the Ministry of Finance that collects mandatory *Zakat* payments from money earning businesses.[662] GAZT acknowledges that there is a duty on all eligible residents of Saudi Arabia to pay *Zakat*, however there is no enforcement tactic against individuals as of now.[663] Consequently, I argue that before depending on *Zakat* to finance full sectors, such as healthcare, a practical and efficient system for *Zakat* collection should initially be implemented, which requires sufficient research and realistic assessments. I also argue that depending on *Zakat* to finance infrastructure and the public sector is both problematic and risky.

[660] Al-Omar, *Management of Zakah Through Semi-Government Institutions. Management of Zakah in Modern Muslim Society* (Islamic Development Bank 1985); AlSuhaim, Fatwa 195, (Dawa and Guidance 2000); Hasan, *The third wave of Zakah optimizing Islamic philanthropy for social justice* (IISS 2016); Nienhaus, *Zakat, taxes, and public finance in Islam*. in Behdad, et al., *Islam and the Everyday World: Public Policy Dilemmas* (Routledge 2006); Kamali, Shariah Law: An Introduction (OneWorld 2008); The Quran 2:256; Ybarra, 'Zakat in Muslim society: an analysis of Islamic economic policy' (1996) 35 *Social Science Information* 643

[661] Filiz, "Etiquette Of Life In Islam." NEU 7 (1997). 351 [Arabic Translation of Turkish Publication]; Madkour, Islamic Jurisprudence (Alqawmiyah 1384H)[in Arabic]; Schacht, An Introduction to Islamic Law (Clarendon 1983); Schacht et al, The Encyclopaedia of Islam (Brill 1991)

[662] www.gazt.gov.sa accessed 30 January 2019

[663] ibid

4.3.3 *Takaful*

Some scholars have argued in favour of more practical methods of financing from within Sharia law, such as *Takaful.*[664] These scholars emphasise that through *Takaful*, society becomes stronger and more closely united for *Maslahah*.[665] Yet, I argue that although favourable, the unity of society is irrelevant when considering finances. Fundamentally, as mentioned in Chapter One,[666] although many scholars consider conventional insurance is forbidden, there is a resemblance between conventional insurance and *Takaful*.[667] Therefore, scholars have proposed implementing *Takaful* as an Islamic alternative in response to calls for privatisation and new methods of finance.[668]

Conventional insurance is usually adopted as part of the implementation of a full or financial privatisation in non-Sharia abiding countries,[669] therefore, it is important to understand the Sharia scholar stance against insurance. In the next sections I will explain the products that Sharia scholars argue to exist in conventional insurance and are non-compliant,[670] and assess the scholars' opinions in relation to *Maqasid AlSharia* and *Maslahah*. Subsequently, I will

---

[664] Ismail, et al., *Essential Guide to Takaful (Islamic Insurance)* (CERT Publications 2008); Murtuza, *Insurance in Islam, Some Aspects of Islamic Insurance* (Islamic Economics Research and Bureau 1991); Siddiqi, M. *Insurance in an Islamic Economy* (The Islamic Foundation 1985)

[665] Ali, K. M. M. (2006). Basis And Models of Takaful: The need for Ijtihad. ICMIF Takaful

[666] Chapter One Section 1.10.9

[667] Ali, 'Principles and Practices of Insurance under The Islamic Framework' (1989) Insurance Journal 29; Fisher, et al. Prospects for Evolution of Takaful in the 21st century, 2000

[668] Ismail, et al., Essential Guide to Takaful (CERT 2008); Murtuza, Insurance in Islam, Some Aspects of Islamic Insurance (IERB 1991)

[669] Alvarez, et al. 'The Colombian health insurance system and its effect on access to health care' (2011) 41 *International Journal of Health Services* 355; Ayo-Yusuf, et al., 'Health insurance, socio-economic position and racial disparities in preventive dental visits in South Africa' (2013) 10 *International journal of environmental research and public healthc* 178; Banoob, "Global directions for reforming health systems and expanding insurance. What is suitable for the Arab Gulf countries?" (2001) 22 *Saudi Medical Journal* 743; Churchill, C. 'What is insurance for the poor' in Churchill, C. *Protecting the Poor: A Microinsurance Compendium* (ILO 2006) 12; Hadley, 'Sicker and poorer--the consequences of being uninsured: a review of the research on the relationship between health insurance, medical care use, health, work, and income' (2003) 60 *Med Care Res Rev* 3S

[670] These are: interest (*Riba*), uncertainty (*Gharar*) and chancing (*Qimar*) as mentioned in Chapter One Section 1.10.9

discuss the implementation of *Takaful* in the healthcare sector with special reference to the Saudi CHIS.

4.3.3.1 *Qimar*

Sharia scholars argue that insurance similar to gambling (*Qimar*) for two reasons.[671] The first reason is that the insured individual pays premiums but is subject to the risk of losing the money paid if no claim is made.[672] The second is that when the insured makes a claim, there is a risk that the amount paid out will not be equivalent to the amount of the claim.[673] Nonetheless, the reasoning of Sharia scholars can be argued against, based on the fact that in Sharia law the intentions behind actions are essential in any legal decision.[674] The intention of healthcare insurance is not for the insured individual to obtain financial gains, as a gambler would, but to ensure financial security and ability to seek medical care when needed without financial barriers. [675] Accordingly, the insured will be able to protect *Maqasid AlSharia*.

4.3.3.2 *Gharar*

Gharar is an Islamic finance term that includes all risky transactions in which the delivery of the benefit of a transaction is unknown.[676] According to Sharia

671 Quran 2:219

672 Ali, 'Principles and Practices of Insurance under The Islamic Framework' (1989) Insurance Journal 29; Billah, *Principles and Practices of Takaful and Insurance Compared* (GECD Printing 2001)

673 ibid

674

675 ibid; Churchill, 'What is insurance for the poor' in Churchill, C. *Protecting the Poor: A Microinsurance Compendium* (ILO 2006) 12

676 Khorshid, *Islamic Insurance: A Modern Approach to Islamic Banking* (Routledge, 2004); Murtuza, *Insurance in Islam, Some Aspects of Islamic Insurance* (Islamic Economics Research and Bureau 1991); Siddiqi, M. *Insurance in an Islamic Economy* (The Islamic Foundation 1985); Tripp, *Islam and the Moral economy: The Challenge of Capitalism* (Cambridge University Press 2006)

law, all transactions into which one enters must be free from uncertainty to avoid fraud and exploitation.[677] Sharia scholars argue that in insurance, the insured pays a premium but is uncertain of how much financial benefit he or she will receive if he or she does make a claim.[678] Similarly, in medical insurance, an individual pays an annual premium yet is unsure of when and how much he or she will claim.[679]

4.3.3.3 *Riba*

Sharia scholars argue that conventional insurance is a form of *Riba,* which is usury and includes all unjust exploitative gains from business.[680] Sharia scholars classically define *Riba* as an unearned or unequally distributed surplus value without a counterpart.[681] This act is considered unlawful in Sharia law and is condemned in numerous verses in the Quran.[682] Sharia scholars acknowledge that *Riba* is a pre-Islamic practice; Arabs would lend money and double the debt each time the borrower failed to pay and defaulted.[683] *Riba* was a cause of enslavement of many Arab borrowers who became insolvent because their debt doubled continuously.[684] In other words, *Riba* was a form of exploitation, which is contrary to Sharia.[685] For example, rather than circulating

677 ibid
678 ibid
679 ibid
680 Abbasi, et al., 'Islamic Economics: Foundations and Practices' (1989) 16 *International Journal of Social Economics* 5; Murtuza, *Insurance in Islam, Some Aspects of Islamic Insurance* (Islamic Economics Research and Bureau 1991); Siddiqi, M. *Insurance in an Islamic Economy* (The Islamic Foundation 1985); Tripp, *Islam and the Moral economy: The Challenge of Capitalism* (Cambridge University Press 2006); Yusuf, *Economic Justice in Islam* (Lahore 1977)
681 ibid
682 Quran 2:275-276
683 Tripp, *Islam and the Moral economy: The Challenge of Capitalism* (Cambridge University Press 2006); Yusuf, *Economic Justice in Islam* (Lahore 1977)
684 ibid
685 ibid; Martin, "Riba". *Encyclopedia of Islam and the Muslim World* (Macmillan 2004); Rahman, 'Islamic microfinance: An ethical alternative to poverty alleviation' (2010) 26 *Humanomics*, 284

wealth through *Zakat*, on the contrary, *Riba* creates a great divide between the rich and poor and encourages economic stagnation, monopoly and imperialism, all of which are unlawful under Sharia.[686]

Similarly, monotheistic Abrahamic religions also share the same views on usury; the Torah prohibits lending with interest, and early Christianity prohibited this action, without exception.[687] It is no surprise that in 1985, Islamic Fiqh Academy scholars agreed that *Riba* is forbidden.[688] Similarly, in 1976 at the First International Conference on Islamic Economics in Makkah, scholars, economists and intellectuals agreed that all forms of interest were considered *Riba*, with no exceptions. [689] This decision gave rise to the founding of Islamic banks, which were advertised as free of conventional interest.[690] Today, Islamic banks provide products that achieve a similar result as interest but are claimed to be Sharia compliant.[691]

In Saudi Arabia, all commercial banks conduct their business on the basis of interest, except Al-Rajhi Bank, which prides itself for being 'Islamic'.[692] The Saudi Arabian Monetary Agency Charter states that the agency shall not pay or

---

[686] ibid

[687] Kuran, *The Long Divergence: How Islamic Law Held Back the Middle East* (Princeton University Press 2011); Martin, "Riba". *Encyclopedia of Islam and the Muslim World* (Macmillan 2004); Siddiqi, M. *Insurance in an Islamic Economy* (The Islamic Foundation 1985); Tripp, *Islam and the Moral economy: The Challenge of Capitalism* (Cambridge University Press 2006); Yusuf, *Economic Justice in Islam* (Lahore 1977)

[688] Islamic Fiqh Academy, Resolution 9(2) held in Jeddah, Saudi Arabia 22-28 December 1985

[689] The first International Conference on Islamic Economics held in Makkah, Saudi Arabia February 21-26, 1976

[690] Aggarwal, et al. 'Islamic Banks and Investment Financing' (2000) 32 *Journal of Money, Credit and Banking* 93; Ahmad, *Theoretical Foundations of Islamic Economics* (Islamic Development Bank 2002); El-Gamal, *A basic guide to contemporary Islamic banking and finance* (Rice University 2000)

[691] Ahmed, *Risk Management: An analysis of issues in Islamic Financial Industry* (Islamic Development Bank 2001); Al-Sultan, Financial Characteristics of Interest-Free Banks and Conventional Banks. (PhD,The University of Wollongong, 1999); AlMubarak, 'Applications of Maqasid al-Shari'ah and Maslahah in Islamic Banking practices: an analysis' at the International Seminar on Islamic Finance in Kochi, India 4 - 6 October 2010

[692] ibid; Al-Rajhi Company for Cooperative Insurance. *Decision no. 3 on 26/07/2009, the Shariah Board*

receive interest but will only charge a service fee in order to cover the agency's expenses.[693] The Saudi Banking Control law issued by a Royal Decree, however, has not stated anything regarding this matter.[694] The Saudi Banking Control law is in accordance with the school of thought followed by many scholars, with whom I agree, who consider that there are many misconceptions about *Riba* as the verses on *Riba* were all revealed in the final days of the Prophet's life.[695] Hence, according to the available Hadeeths, it is believed that the Prophet was not able to properly explain and address any questions about the verses on *Riba*.[696]

As mentioned in Chapter One,[697] the Prophet's elaboration of laws through his actions and statements in authentic Hadeeths is an important primary source of Sharia law.[698] Since neither the Prophet nor the prominent immediate rulers after him have made any statements or taken action against *Riba*, it can be deduced that there are misconceptions about this concept, which leaves room for speculation.[699] Accordingly, it could be argued that not all that is labelled *Riba* is equivalent to the form of usury about which the Quranic verse warns. I argue that the form of *Riba* in the verse is one that leads to exploitation and harm to *Maqasid AlSharia*, whereas insurance is a protection from harm and

693 Saeed, A. Islamic Banking and Interest: A study of prohibition of riba and its contemporary interpretation, (Brill 1999); The Saudi Arabian Monetary Agency Charter, Royal Decree No. 23, 15 December 1957

694 Royal Decree no. M/5

695 Ahmed, *Risk Management: An analysis of issues in Islamic Financial Industry* (Islamic Development Bank 2001); Iqbal, *Challenges facing Islamic Banking* (Islamic Development Bank 1998); Khan, What Is Wrong with Islamic Economics?, 2013; The Saudi Banking Control Law, Royal Decree No. M/5, 11 June 1966; Obaidullah, 'Islamic Risk Management: Towards greater ethics and efficiency' (2002) 3 *International Journal of Islamic Financial Services;* Rejda, *Principles of Risk Management and Insurance* (Dorling Kindersley 2006)

696 ibid

697 Chapter One Section 1.10.4.1 I

698 Coulson, *A History of Islamic Law* (Universal Law Publishing Company 1997); Fadel, 'The True, the Good, and the Reasonable: The Theological and Ethical Roots of Public Reason in Islamic Law' (2008) 21 *Canadian Journal of Law and Jurisprudence;* Hallaq, *The Origins and Evolution of Islamic Law* (CUP 2005)

699 ibid

risk.[700] In other words, insurance can be considered the opposite of the definition of *Riba.* I argue that this concept can be justified as a necessity of modern day life, which includes getting a loan, keeping money in a bank account and participating in productive investment, all of which do not include exploitation as specified in the Quranic verse.[701] Healthcare insurance could be justified in a similar way as it assists individuals in the protection of their health, rather than subjecting them to exploitation.

4.3.4 Sharia Compliance of Conventional Health Insurance

The basis of Sharia scholars' stance against insurance is the claimed protection of *Maqasid AlSharia* from risk due to the existence of elements of *Qimar, Gharar* and *Riba* in insurance*,* as explained above.[702] In contrast, evidence from the non-Sharia literature shows that insurance is a form of protection against unforeseen risk and harm.[703] Therefore, contrary to the opinions of Sharia scholars, I argue that conventional health insurance serves as protection of the insured individual's *Mal* and *Nafs*, which are two of the *Maqasid AlSharia*, rather than as a risk.*[704]*

---

[700] Abbasi, et al., 'Islamic Economics: Foundations and Practices' (1989) 16 *International Journal of Social Economics* 5; Quran 2:275-276; Siddiqi, *Insurance in an Islamic Economy* (The Islamic Foundation 1985); Tripp, *Islam and the Moral economy: The Challenge of Capitalism* (Cambridge University Press 2006); Yusuf, *Economic Justice in Islam* (Lahore 1977)

[701] Ahmed, 'Defining ethics in Islamic Finance: Looking beyond legality' (2012). A paper presented at the 8th International Conference on Islamic Economics and Finance, Qatar, 11 February; Ahmed, *Risk Management: An analysis of issues in Islamic Financial Industry* (Islamic Development Bank 2001); Iqbal, *Challenges facing Islamic Banking* (Islamic Development Bank 1998)

[702] Ismail, et al., Essential Guide to Takaful (CERT 2008); Murtuza, Insurance in Islam, Some Aspects of Islamic Insurance (IERB 1991); Siddiqi, Insurance in an Islamic Economy (IF 1985)

[703] ibid; Siddiqi, *Insurance in an Islamic Economy* (The Islamic Foundation 1985); Tripp, *Islam and the Moral economy: The Challenge of Capitalism* (Cambridge University Press 2006); Yusuf, *Economic Justice in Islam* (Lahore 1977)

[704] Kamali, *Maqasid AlShariah Made Simple* (International Institute of Islamic Thought 2008); Laldin 'The Foundations of Islamic Finance and The Maqasid al-Shari'ah Requirements' (2013) 2 *Journal of Islamic Finance*; Syahida, 'Risk Management via Takaful from a perspective of Maqasid Alshariah' (2012) 65 *Social and Behavioral Sciences* 535

Contrary to the Sharia scholars' opinion, I argue that preventive measures and arranging beforehand for compensation for likely losses involved in cases of pure risk is entirely compatible with the belief in predestination and submission to the will of God, which are obligations in Sharia.[705] The absence of any provision for security against unforeseen contingencies and calamities will adversely affect economic efficiency, give rise to general dissatisfaction and cause social disequilibrium.[706] Collectively, these issues will affect the *Maslahah* of society and put *Maqasid AlSharia* at risk.[707] Examples of the permissibility of preventative measures under Sharia law include the Prophet's provision of preventative care to protect health from an unforeseen malady and the distribution of *Zakat* to protect from unforeseen poverty and, relatedly, the inability to protect *Maqasid AlSharia*.[708] Moreover, when applying the Sharia law maxims, such as *'necessity permits the forbidden',* '*prevention of harm*', *'hardship calls for relief'* and *'where it is inevitable, the lesser of two harms should be done'*, insurance could be considered lawful if it is a necessity to lessen the

[705] AlKhayat, *Health: An Islamic Perspective* (WHO 1997); AlShohaib, et al. *Health and Well-being in Islamic Societies: A Background, Research and Applications* (Springer 2014); Chittick, *The Vision of Islam* (AUC Press 2006)
[706] ibid; Obaidullah, 'Islamic Risk Management: Towards greater ethics and efficiency' (2002) 3 *International Journal of Islamic Financial Services;* Rejda, *Principles of Risk Management and Insurance* (Dorling Kindersley 2006); Saleh, *The role of Zakat in Financial and Social Development* (AlBayan 2011) [In Arabic]
[707] Abdullah, 'Maqasid AlShariah, Maslahah and corporate social responsibility' (2007) 24 *The American Journal of Islamic Social Sciences* 25; Ahmad, 'Role of finance in achieving Maqasid al-Shariah' (2011) 19 *Islamic Economic Studies* 1; Syahida, 'Risk Management via Takaful from a perspective of Maqasid Alshariah' (2012) 65 *Social and Behavioral Sciences* 535; Yazid, et al., 'The practices of Islamic Finance in upholding the Islamic values and the Maqasid AlShariah' (2015) 4 *IRMBRJ* 286
[708] Badawi, *Zakat And Social Justice* (Finance in Islam Publications 2005); Deuraseh, 'Health and Medicine In the Islamic Tradition Based on The Book of Medicine (Kitab AlTibb) of Sahih Bukhari' (2006) 5 *JISHIM* 2; ElKadi, 'Health and Healing in the Quran', (1985) 2 *American Journal of Islamic Social sciences* 291; Hasan, *The third wave of Zakah optimizing Islamic philanthropy for social justice* (IISS 2016)

risk of harm.[709]

Thus, I conclude that although Sharia scholars agreed to prohibit insurance at the First International Conference on Islamic Economics,[710] its objectives of prevention of harm and protection are desirable in Sharia. Hence, applying a form of healthcare insurance could be considered compliant with Sharia law as it allows the protection of *Maqasid AlSharia* and *Maslahah.*[711] Nonetheless, to implement insurance its policies would have to meet Sharia requirements, such as equitable premiums based on ability to pay to avoid exploitation of individuals and harming the *Maqasid AlSharia* of *Mal* which includes finances and property. Accordingly, further research is required to practically assess if implementing a form of conventional insurance in healthcare can be Sharia compliant. Nonetheless, it is essential to note that although I argue that health insurance is compliant with Sharia, this thesis is focused on 2030VFH specifically. Accordingly, the investigation of how conventional insurance can be adapted to be Sharia compliant is irrelevant to this thesis because Saudi Arabia currently only allows the implementation of *Takaful* based insurance with governmental supervision, similar to that applied in the CHIS.[712] The next

709 ibid; Biu, et al. 'The relevance of Islamic Legal Maxims in determining some contemporary legal issues' (2016) 24 IIUMLJU 415; Khan, What Is Wrong with Islamic Economics?, 2013; Mohammed, 'The Islamic Law Maxims' (2005) 44 *JSTOR* 191; Pakeeza, 'Role of Islamic Legal Maxims in Ijtihad' (2014) 5 *PI* 39

710 The first International Conference on Islamic Economics held in Makkah, Saudi Arabia February 21-26, 1976

711 Abdullah, 'Maqasid AlShariah, Maslahah and corporate social responsibility' (2007) 24 *The American Journal of Islamic Social Sciences* 25; Chapra, *The Islamic Vision of Development in the Light of the Maqasid Al-Shari`ah* (Islamic Development Bank 2008); Dusuki, et al., 'The framework of maqasid al-shariah (Objective of the shariah) and its implications for Islamic finance' (2011) ISRA Research paper (No.2/2011); Syahida, 'Risk Management via Takaful from a perspective of Maqasid Alshariah' (2012) 65 *Social and Behavioral Sciences* 535

712 AlUlfi, 'AlTa'meen AlSihhi Dirasah Tatbeeqiyah' [Health Insurance: An Emprical Study] *AlHIkmah* (Riyadh 2006); Ansari, Analysis of the impact of reforms on insurance industry of Saudi Arabia (2011) 1 *Interdisciplinary Journal of Research in Business* 28; Banoob, "Global directions for reforming health

section will discuss the available evidence in the literature of the current applications of *Takaful* to cut costs.

4.3.4.1 Modern-Day *Takaful*

Takaful is widely adopted by Muslim states, such as Saudi Arabia, and has been adopted in many countries with Muslim majorities, such as Nigeria and Malaysia.[713] *Takaful* has also been introduced in non-Muslim African countries to serve as a tool for financial inclusion and poverty alleviation and has, with some measure of success, grown in these areas.[714] In 2010, *Takaful* premiums increased by 19%, with global contributions totalling $8.3 billion USD; 5.6 billion of these were in the Gulf Corporation Countries (GCC), of which 4.3 billion were in Saudi Arabia.[715] In 2010 alone, 51% of global *Takaful* contributions were in the Saudi Arabia cooperative insurance market.[716] This high percentage is no surprise, as Saudi Arabia is the only country which does

---

systems and expanding insurance. What is suitable for the Arab Gulf countries?" (2001) 22 *Saudi Medical Journal* 743; Barakah, et al 'The Cooperative Insurance in Saudi Arabia: a Nucleus to Health Reform Policy' (2011) 21 *IPEDR* 6

[713] Abdul Rahman, Takaful: Potential Demand and Growth, (2009) 22 *J.KAU: Islamic Economics* 55; Aidid, Economic Determinants of Family Takaful Consumption: Evidence from Malaysia (2009) 5 *International Review of Business Research Papers* 193; Maysami, 'An analysis of Islamic Takaful Insurance: A Cooperative Insurance Mechanism' (1999) 18 Journal of Insurance Regulation 109; Mokhtar, et al. 'Towards developing a sustainable microtakaful program in Malaysia'. *2nd ISRA Colloquium 2012*, 1; Yusuf, 'Prospects of Takaful's (Islamic Insurance) Contribution to the Nigerian Economy' (2012) 1 Journal of finance and Investment Analysis 217

[714] ibid; Al-Amri 'A survey of the Islamic insurance literature – takaful' . (2015) 6 *Insurance Markets and Companies;* Alshahrani, et al. *Economic growth and government spending in Saudi Arabia: An empirical investigation*. (International Monetary Fund 2014); Billah, *Principles and Practices of Takaful and Insurance Compared* (GECD Printing 2001); Farooq, 'An Analytical Study of the Potential of Takaful Companies.' (2010) *EJEFAS;* Fisher, et al.Prospects for Evolution of Takaful in the 21st century, (*Proceedings of the Fifth Harvard University Forum on Islamic Finance* 2000) 237; Jaffer, 'Takaful industry: global challenges and opportunities' (2005) *Islamic Finance Review* 45

[715] Abdul Ghafour, P.K. (2007d) "Saudi Insurance Market to Reach S.R 30bn: Analysts", Arab News, Wednesday, 14, February; INCEIF, *Takaful Realities and Challenges* (Pearson 2012)

[716] ibid; Abdullah, 'Risk Management via Takaful from a Perspective of Maqasid of Shari'ah' (2012) 65 *Social and Behavioral Sciences* 535; Al-Amri 'A survey of the Islamic insurance literature – takaful' . (2015) 6 *Insurance Markets and Companies;* Syahida, 'Risk Management via Takaful from a perspective of Maqasid Alshariah' (2012) 65 *Social and Behavioral Sciences* 535

not have a conventional insurance market and solely relies on *Takaful.*[717] To ensure the compliance of the policies and transactions to Saudi law and Sharia principles, the Saudi Arabian Monetary Agency regulates the cooperative insurance market in Saudi Arabia.[718]

As mentioned in Chapter One,[719] *Takaful* is not restricted to loans and investments; it can also be applied to health insurance, i.e. health *Takaful.*[720] The next section will discuss *Takaful* in the Saudi CHIS. Investigating how *Takaful* is implemented will allow for an accurate assessment of the Saudi and Sharia compliance of this implementation in the healthcare sector as an alternative to conventional insurance adopted in financial and total privatisations.

4.3.4.2 The Saudi CHIS for Foreigners

The CHIS scheme was implemented over a three-year period in three phases, companies were subjected to the regulations as follows: first companies with more than 500 non-Saudi employees; second companies with at least 100 non-Saudi employees; and at the end of third phase the regulations applied to all

[717] ibid; INCEIF, *Takaful Realities and Challenges* (Pearson 2012); Islamic Economics, *Risk Management in Islam Takaful* (Islamic Relief Worldwide 2003); Ismail, et al., *Essential Guide to Takaful (Islamic Insurance)* (CERT Publications 2008)
[718] Abdul Ghafour, P.K. (2007d) "Saudi Insurance Market to Reach S.R 30bn: Analysts", Arab News, Wednesday, 14, February The Saudi Arabian Monetary Agency Charter, Royal Decree No. 23, 15 December 1957
[719] Chapter One Section 1.12.9.1
[720] Billah, *Principles and Practices of Takaful and Insurance Compared* (GECD Printing 2001); Fisher, et al Prospects for Evolution of Takaful in the 21st century, (*Proceedings of the Fifth Harvard University Forum on Islamic Finance* 2000) 237

companies.[721] All non-Saudis are included in the cooperative healthcare insurance scheme, regardless of whether they are employed in the private or non-private sectors.[722] Due to its success, the CHIS was extended to include Saudis working in the private sector.[723] In 2007, more than 1,135,000 people were insured, 970,169 expatriates and 165,712 Saudis.[724] According to the latest official figures available on the Council of Cooperative Healthcare Insurance,[725] the number of total beneficiaries of the CHIS is 11,235,431 which includes Saudis, Non-Saudis and their dependents.[726] Unfortunately, these are from 2015 and no later figures are available.

Based on the available literature, the CHIS has a direct positive effect on specific divisions of the Saudi economy, particularly the insurance industry, and it has relieved the government of some expenses.[727] The goal of this social health insurance system is fairness in financing in that beneficiaries pay according to their means while they are guaranteed the right to health services according to

---

[721] Abdul Ghafour, 'CCHI Set to Extend Health Insurance to Aged' Arab News, 23 February 2007; Abdul Ghafour, "Saudi Arabia: Health Insurance Mandatory from Jan", Arab News, 25 October 2005; Abdul Ghafour, "Saudi Insurance Market to Reach S.R 30bn: Analysts", Arab News, 14 February 2007; Cooperative Health Insurance System Booklet (CHISB) (1999) Riyadh, Saudi Arabia: The Council of Cooperative Health Insurance; The Cooperative Health Insurance Act, Royal Decree M/10 August (1999)

[722] ibid; Alosaimi et al. *The equity in access to health services in cooperative health insurance system, Jeddah, 2008-2009.* (Arab Board in Community Medicine 2009)

[723] ibid; Implementing Regulations of the Cooperative Health Insurance Law in the Kingdom of Saudi Arabia (Amended) Cooperative Council for Health Insurance, Session 73 Ministerial Decision DH/1/30/6131 (2009)

[724] Barakah, D. & AlSaleh, S, 'The Cooperative Insurance in Saudi Arabia: a Nucleus to Health Reform Policy' (2011) 21 *IPEDR* 6; Nadim, 'The effect of medical insurance on medical services: positive or Negative?' in *Cooperative Health Insurance*, No. 3 (2008)

[725] Known as CCHI according to Article 58 of the rules of implementation of the CHIS the CCHI "shall supervise and monitor the universality of the Health Insurance coverage and shall ensure that the parties in the Health Insurance relationship perform the tasks and responsibilities entrusted to them under these rules" available on www.cchi.gov.sa

[726] CCHI Annual Report 2015 available at www.cchi.gov.sa accessed 13 february 2019; Health Insurance Indicators available on the Council of Cooprative Health Insurance website www.cchi.gov.sa accessed 13 february 2019

[727] AlMobarak, 'Beneficiaries' Satisfaction with the Cooperative Health Insurance System (CHIS) in the Kingdom of Saudi Arabia: A Case Study of Riyadh City' (PhD Thesis, University of Hull 2010); Barakah, 'The Cooperative Insurance in Saudi Arabia: a Nucleus to Health Reform Policy' (2011) 21 *IPEDR* 6; Homaidahi, K "Health Insurance as part of health economics" (2002) 478 *Riyadh Commerce* 48; Nadim, (2008) The effect of medical insurance on medical services: positive or Negative? Cooperative Health Insurance, No. 3

need.[728] In social health insurance systems, households and enterprises generally pay via contributions based on salaries or income, which I argue to be similar to income tax.[729] In *Takaful*, both the surplus and burden of loss are spread across the community to ensure the concept of cooperation and social harmony between groups and individuals.[730] Based on the claimed success of the CHIS, which is celebrated in the literature,[731] the Sharia compliance of its expansion and implementation on a wider scale can be anticipated as an alternative to financial privatisation.

The Council of Senior Scholars in Saudi Arabia examined the CHIS and expressed its approval of the CHIS's compatibility with Islamic values in the General Presidency of Scholarly Research and Ifta Decision No. 51.[732] The Council of Senior Scholars stated that the CHIS contract allows groups or individuals to create a common fund to which the fund's subscribers can apply for benefits in the event of unexpected incidents, which can affect the financial position of a family or a community, such as in natural catastrophes.[733] The

[728] ibid; Alosaimi, et al. *The equity in access to health services in cooperative health insurance system, Jeddah, 2008-2009.* (Arab Board in Community Medicine 2009); Cooperative Health Insurance System Booklet (CHISB) (1999) Riyadh, Saudi Arabia: The Council of Cooperative Health Insurance; Implementing Regulations of the Cooperative Health Insurance Law in the Kingdom of Saudi Arabia (Amended) Cooperative Council for Health Insurance, Session 73 Ministerial Decision DH/1/30/6131 (2009); The Cooperative Health Insurance Act, Royal Decree M/10 August (1999)
[729] ibid
[730] ibid; Abdul Ghafour, P.K. (2007d) "Saudi Insurance Market to Reach S.R 30bn: Analysts", Arab News, Wednesday, 14, February; Al-Amri 'A survey of the Islamic insurance literature – takaful' . (2015) 6 *Insurance Markets and Companies;* AlJarAllah, 'The Impact of Health Insurance Programme on the Quality of the Private Hospital's Services in the Kingdom of Saudi Arabia' (PhD Thesis, University of Hull 2007); Alomair, (2001) "The role of Insurance Companies in the Health Insurance Sector and the Experience of NCCI", Riyadh; Cooperative Health Insurance System Booklet (CHISB) (1999) Riyadh, Saudi Arabia: The council of Cooperative Health Insurance
[731] ibid
[732] Al-Rajhi Company for Cooperative Insurance. *Decision no. 3 on 26/07/2009, The Shariah Board*; Cooperative Health Insurance System Booklet (CHISB) (1999) Riyadh, Saudi Arabia: The Council of Cooperative Health Insurance; General Presidency of Scholalry Research and Ifta, The Takaful Islamic Insurance Company, Decision No. 51 dated 25 March 1977; Implementing Regulations of the Cooperative Health Insurance Law in the Kingdom of Saudi Arabia (Amended) Cooperative Council for Health Insurance, Session 73 Ministerial Decision DH/1/30/6131 (2009)
[733] ibid

Council considered such a system to be compatible with Sharia.[734] Since the main objective of a cooperative health insurance (CHI) is not to generate profit but to serve the community and distribute the surplus to subscribers, it is socially and morally justifiable. According to Article 3 of the Cooperative Health Insurance Act,[735] every employer is obliged to pay premiums on behalf of the beneficiaries,[736] and will be fined a charge if there is a delay, therefore there is a high rate of beneficiary satisfaction with the CHI implementation and expansion to include Saudis in the private sector.[737] According to Barakah and AlSaleh, the success of the Saudi CHIS in ensuring the right to healthcare for foreigners highlighted the firm need to extend this *Takaful* system and include the remainder of the Saudi population.[738]

Nonetheless, before expanding the current CHIS system it is essential to make improvements where needed, especially that 21.5% of respondents in a study by AlMobarak on CHIS beneficiaries in Riyadh expressed their dissatisfaction with the CHIS.[739] Although the results of the study cannot be generalized, nonetheless they provide insight to aspects where the CHIS can be improved. The first reason stated by the respondents for their dissatisfaction was the long waiting hours, and the second was that some services were refused.[740] As per

[734] ibid
[735] The Cooperative Health Insurance Act, Royal Decree M/10 August (1999)
[736] The policy period equivalent to the resident permit period in the case of non-Saudis or period of employment in the case of Saudi employees
[737] Al-Otaibi, 'Assessment of the Health Insurance in the Kingdom of Saudi Arabia' (Master thesis, Maastricht University 2005); Al-Shaikh, 'Saudi Health Care Sector: Need for More Investment' *Arab News* 7 August 2006
[738] ibid; Barakah, et al. 'The Cooperative Insurance in Saudi Arabia: a Nucleus to Health Reform Policy' (2011) 21 *IPEDR* 6; Hassan, Javid "Insurance Sector in Good Health" *Arab News* 6 December 2006; Rules of Implementation of Cooperative Health Insurance System & Cooperative Health Policy, Ministry of Health Resolution 460/23/DH (2002); The Cooperative Health Insurance Act, Royal Decree M/10 August (1999)
[739] AlMobarak, 'Beneficiaries' Satisfaction with the Cooperative Health Insurance System (CHIS) in the Kingdom of Saudi Arabia: A Case Study of Riyadh City' (PhD Thesis, University of Hull 2010)
[740] ibid

the latest available data from the CCHI, only 5,248 healthcare providers have been accredited to provide cooperative health insurance services to the beneficiaries. Although the CCHI website does not specify if the accredited facilities are mainly individual clinics or big hospitals with medical centers nonetheless, considering the number of beneficiaries, I argue these are not sufficient. Long waiting times is a sign of limited accessibility,[741] and can be due to the number of accredited facilities being less than the required to accommodate the number of patients, or if the physician is overworked and is seeing non-CHI users. Nonetheless, long waiting times can be overcome by accrediting more healthcare facilities and increasing the number of available physicians.[742] As for the second reason for dissatisfaction of respondents,[743] although these are set and provided to both the insurance companies and accredited facilities, the CCHI website does not contain details of what services are included or how the facilities are accredited.[744] However, the CCHI also offers an add-on coverage plan for individuals who prefer more coverage than what is offered by the basic plan which only provides essential services to patients[745]

[741] Andersen, et al., 'Exploring dimensions of access to medical care' (1983) 18 *Health services research* 49; Andersen, et al., *Improving access to care in America. Changing the US health care system: key issues in health services policy and management* (Jossey-Bass 2007); Cooper, et al., 'Overcoming barriers to health service access: influencing the demand side' (2004) 19 *Health policy and planning* 69

[742] ibid

[743] AlMobarak, 'Beneficiaries' Satisfaction with the Cooperative Health Insurance System (CHIS) in the Kingdom of Saudi Arabia: A Case Study of Riyadh City' (PhD Thesis, University of Hull 2010)

[744] www.cchi.gov.sa

[745] AlMobarak, 'Beneficiaries' Satisfaction with the Cooperative Health Insurance System (CHIS) in the Kingdom of Saudi Arabia: A Case Study of Riyadh City' (PhD Thesis, University of Hull 2010); Al-Otaibi, 'Assessment of the Health Insurance in the Kingdom of Saudi Arabia' (Master thesis, Maastricht University 2005); AlTassan, 'The Emergence of Health Insurance in the Kingdom of Saudi Arabia' (PhD Manchester Metropolitan University, 2003); Barakah, 'The Cooperative Insurance in Saudi Arabia: a Nucleus to Health Reform Policy' (2011) 21 *IPEDR* 6; Homaidahi, "Health Insurance as part of health economics" (2002) 478 *Riyadh Commerce* 48

From the governmental point of view, the CHIS transferred the liability to provide health care to a third of the population,[746] and accordingly reduced the burden laid on government hospitals.[747] Therefore the CHIS allowed the finances to be allocated in executing other essential tasks such as building more hospital in rural areas,[748] which will I argue will help combat the existing urban-migration in Saudi Arabia and increase healthcare accessibility and availability.[749]

It is important to note that the CHIS is monitored by several separate governmental and pseudo-governmental bodies. The healthcare provided is monitored by the CCHI, the MOH, the National Center for Performance Measurement, the Saudi Patient Safety Center, and the Saudi Central Board for Accreditation of Healthcare Institutions.[750] Insurance companies also play a role in monitoring healthcare facilities services and are required to report directly to the CCHI.[751] With regards to the insurance companies and employers, these are also monitored by several separate bodies, such as the Saudi Arabian Monetary Agency (SAMA), Saudi Arabia's insurance regulator, the CCHI, the Ministry of Labour and Social Affairs, the Ministry of Finance and

[746] Based on the available number of beneficiaries on CCHI which is from 2015 in relation to the population of Saudi Arabia in the same year. No recent data is available on the CCHI website www.cchi.gov.sa accessed 15 February 2019
[747] Al-Otaibi, 'Assessment of the Health Insurance in the Kingdom of Saudi Arabia' (Master thesis, Maastricht University 2005); Al-Shaikh, 'Saudi Health Care Sector: Need for More Investment' *Arab News* 7 August 2006; Homaidahi, "Health Insurance as part of health economics" (2002) 478 *Riyadh Commerce* 48
[748] ibid
[749] Khaliq, 'The Saudi Healthcare System: A View from the Minaret' (2012) 13 *World Health & Population* 52; Milaat, "Public health in the saudi health system: A search for new guardian." (2014) 2 Saudi Journal of Medicine and Medical Sciences 77; Mufti, *The Saudi Healthcare System Issues and Opinions* (Quwa Alamn 2002) [in Arabic]; Ram, P. "New Strategic Initiatives-A Case Study of the Saudi Health Ministry" (2014) 3 *International Journal of Academic Research in Economics and Management Sciences* 236
[750] The Cooperative Health Insurance Act, Royal Decree M/10 August (1999)
[751] ibid

National Economy and the Ministry of Trade.[752] I argue that this extensive network and separate bodies that collectively monitor the standard of healthcare and the performance of insurance companies and employers has resulted in beneficiaries' satisfaction with the level of healthcare provision and the performance of the insurance companies and employers under the CHIS.[753]

Upon reflection on the findings thus far and the Council of Senior Scholars' opinion and review of the CHIS,[754] I conclude that the outcomes of the CHIS are predominantly beneficial and the negative outcome of long waiting times can be overcome by increasing accredited providers. Moreover, I conclude that the principles behind the CHIS's implementation are clearly similar, if not identical, to those I presented in favour of conventional health insurance earlier in this chapter. I argue that both *Takaful* and insurance aim to protect individuals in the event of unexpected incidents, which contributes to the protection of *Maqasid AlSharia* and *Maslahah.* The objective of both *Takaful* and insurance is not to generate profit at the expense of exploiting individuals but to serve the community (*Maslahah*) through protection of the individual (*Maqasid AlSharia*). Consequently, these findings allow us to anticipate that the implementation of a model of privatisation such as financial privatisation, may be compliant with

[752] ibid; Al-Otaibi, 'Assessment of the Health Insurance in the Kingdom of Saudi Arabia' (Master thesis, Maastricht University 2005); Barakah, 'The Cooperative Insurance in Saudi Arabia: a Nucleus to Health Reform Policy' (2011) 21 *IPEDR* 6; Homaidahi, "Health Insurance as part of health economics" (2002) 478 *Riyadh Commerce* 48

[753] ibid; AlMobarak, 'Beneficiaries' Satisfaction with the Cooperative Health Insurance System (CHIS) in the Kingdom of Saudi Arabia: A Case Study of Riyadh City' (PhD Thesis, University of Hull 2010); AlTassan, 'The Emergence of Health Insurance in the Kingdom of Saudi Arabia' (PhD Manchester Metropolitan University, 2003)

[754] Al-Rajhi Company for Cooperative Insurance. *Decision no. 3 on 26/07/2009, The Shariah Board*; General Presidency of Scholalry Research and Ifta, The Takaful Islamic Insurance Company, Decision No. 51 dated 25 March 1977; Implementing Regulations of the Cooperative Health Insurance Law in the Kingdom of Saudi Arabia (Amended) Cooperative Council for Health Insurance, Session 73 Ministerial Decision DH/1/30/6131 (2009); Rules of Implementation of Cooperative Health Insurance System & Cooperative Health Policy, Ministry of Health Resolution 460/23/DH (2002)

Sharia law if modified and adapted in a manner similar to CHIS. The assessment of Sharia compliance will be completed in the following chapter.

4.4 Conclusion

Through analysis of the non-Sharia literature, it is evident that privatisation is an umbrella term with more than one meaning. The non-Sharia literature discusses different arrangements that constitute a privatisation and fulfil the purpose of improving efficiency or cutting costs. However, analysis of the Sharia literature indicates that Sharia scholars' understanding of privatisation is restricted to the transfer of ownership to private personal possession which is lacking in non-Sharia literature.[755] I conclude that the Sharia scholars have accordingly restricted their discussions to this model.

Several privatisation models have been neglected in Sharia scholars' definition of privatisation. Their use of a narrow definition has resulted in a limited meaning and lack of understanding of privatisation in comparison to the non-Sharia literature. Furthermore, the focus on improving efficiency as the purpose of privatisation in the Sharia literature has limited Sharia scholars' ability to discuss the benefits of privatisation, including cutting costs, claimed by pro-privatisation scholars in the non-Sharia literature. I argue that this limited understanding has a funnel-like effect on the Sharia literature discussing privatisation.

[755] Eissa, *Privatisation and a Diversified Economy* (AlMuntalaq 1996) [In Arabic]; Hatim, *Global Experience in Privatisation* (Cairo 1994) [in Arabic]; Saba, *Privatisation and a Weak and Absent Public Sector* (AlMawqif 1994) [In Arabic]

Based on the findings of this chapter, I concluded that some models of privatisation that have been neglected in the Sharia scholarship were, in fact, adopted throughout Islamic history. For example, the Prophet outsourced healthcare services, such as in the example of Rufaidah. I argue that outsourcing of services, including the provision of healthcare services, is Sharia compliant based on, and by analogy to, the examples in Islamic history. The need for governments to regulate outsourced services must still be emphasised to ensure their success and continued compliance with Sharia. However, as there are no examples of the other privatisation models, their Sharia compliance must be assessed with reliance on Sharia principles and evidence of examples of these models of privatisations in the non-Sharia literature, as will be considered in Chapter Five.

Due to the various methods and models available in the context of healthcare, I proposed a typology. I argued that dividing these models of privatisation into groups according to the main objective and purpose of the policy is efficient and practical. Thus, healthcare privatisation should be divided into models of privatisation that focus on finance, management or provision in light of the four main categories identified by scholars: outsourcing, full privatisation, load-shedding and corporatisation. More importantly, as this thesis focuses on cost cutting, the typology promotes ease in identifying privatisation models that allow governments to cut costs in the context of healthcare. These models will be assessed for Sharia compliance in the following chapter.

Chapter Five Sharia Compliance of Privatisation in Healthcare

5.1 Introduction

Non-Sharia literature discussing the privatisation of healthcare has outlined different models of privatisation with two main purposes: to improve efficiency and to cut costs. In accordance to the 2030VFH, I will adopt the typology developed in the previous chapter to identify models of privatisation in the healthcare sector that improve the fiscal impact. Thenceforth, I will assess if these cost-cutting models of privatisation can be considered compliant with Sharia.

As mentioned in the previous chapter, examples of arrangements similar to outsourcing were found in Islamic history. The presence of these examples allows us to anticipate the Sharia compliance of outsourcing based on and by analogy to their adaptation by the Prophet and prominent Sharia-abiding rulers and scholars. Nonetheless, the Sharia compliance of the remaining models of privatisation in healthcare—namely full privatisation as defined in non-Sharia literature,[756] financial privatisation, decentralisation, and corporatisation—remains unknown. To assess Sharia compliance, I will apply the *Usul AlFiqh* methodology and combine the evidence from non-Sharia literature that discusses the problems with the remaining healthcare privatisation models and the Sharia requirements for healthcare provision. I will also demonstrate that the total transfer in Sharia literature cannot be considered as a full privatisation

[756] Sharia literature was focused on a full transfer to private personal possession; deregulation, while non-Sharia defines full privatisation as a transfer to the private sector. These are two distinct ownerships as mentioned in Chapter Two Section 2.5

according to the definitions in non-Sharia literature as it fully eliminates state regulation by transferring to private personal possession.[757]

I will then discuss how *Takaful* may resemble finance privatisation and premium payments, as outlined in the previous chapter. I will focus on the Saudi Cooperative Health Insurance for Foreign Workers, in accordance to Article 10 of the Saudi Health Law.[758] Then, I will demonstrate how the Saudi Government has transferred the finance of foreign workers' healthcare to their employers through the implementation of *Takaful.* I argue that this transfer of finance from the public sector to the private constitutes a privatisation according to the understanding of privatisation in non-Sharia literature. The resemblance between forms of privatisation and Islamic economic systems will demonstrate that some models of privatisation can be considered compliant with Sharia.

5.2 Cost-cutting Models of Privatisation in Healthcare

It is essential to differentiate all models and meanings of privatisation from liberalisation and deregulation, which are the establishment of competitive markets and the removal of all government supervision and rules that hinder competition, respectively. [759] Privatisation allows competition, but unlike

[757] AlMaamiry *Private Personal Ownership and its limitations in Islam* (Lancer 1987); Bhalla, *The institution of property: Legally, Historically and Philosophically Regarded* (EBC 1984); Messick, "Property and the Private in a Sharia System." (2003) *JSR* 711; Taleqani, *Islam and Ownership* (Lexington 1983) Gulaid, *Ownership in Islam* (IDI 1991)
[758] The Saudi Health Law, Royal Decree No. M/11, 4 June 2002
[759] Harik, et al. *Privatization and liberalization in the Middle East* (Indiana University Press 1992); Haskel et al. 'Privatization, Liberalization, Wages and Employment: Theory and Evidence for the UK' (1993) 60 *Economics* 161; Hemming, et al. *Privatisation and Public Enterprises* (International Monetary Fund 1988)

liberalisation, it still allows room for governments to impose entry barriers if the entity remains under state ownership.[760] Moreover, if the privatised entity is transferred to the private sector, the markets in which privatised companies operate remain heavily regulated by the government, unlike in deregulation.[761] I argue that, due to rights of ownership in Sharia law outlined in Chapter Two, the privatisation model discussed by Sharia scholars' was one that eliminated state regulation, and therefore can be described as a deregulation.

To identify models that cut costs, I will adopt the typology developed in the previous chapter and classify models of privatisation that involve a transfer of finances. These finance transfers can include provision and management, or just be specific to finance; they can also be full or partial transfers.[762] Models of healthcare privatisation that directly focus on decreasing the financial responsibility on the government are full privatisation, financial privatisation, corporatisation, and outsourcing.[763]

[760] ibid; Karlaftis, 'Privatisation, regulation and competition: A thirty-year retrospective on transit efficiency' (2008) *ITF* 67; Kemp, *Privatisation: The Provision of Public services by the Private Sector* (McFarland 2007); Kettle *Sharing Power: Public Governance and Private Markets.* (Brookings 1993); Kikeri, *Privatisation: trends and recent developments* (WBP 2005)

[761] ibid

[762] Janssen, et al. 'Privatisation in health care: Concepts, motives and policies' (1990) 14 Health Policy 191; Jindal, 'Privatization of Healthcare: New Ethical Dilemmas' (1998) 6 Indian Journal of Medical Ethics 85; Keane et al. Privatization and the scope of public health: a national survey of local health department directors. (2001) 91 *Am J Public Health* 611

[763] In full privatisation the state sells all assets to private owners as a means of relieving the financial burden. Financial privatisation is a specific shifting of the full financial responsibility from the government to individuals through user fees or health insurance. Corporatisation is a total partial transfer of the finances where both the public sector and private investors jointly contribute to the financing, but management and provision are a local responsibility. In outsourcing of services, there is a specific partial transfer, which is claimed to form a competitive market that leads to lower costs and better quality of services.

As mentioned in Chapter One,[764] the aim of this thesis is not to find the ideal method to finance the healthcare system but to assess the Sharia compliance of the privatisation of healthcare; therefore, I will not discuss or recommend alternatives to privatisation, such as financing through taxation, or other more ethical financing methods. The following section will discuss the evidence in non-Sharia literature for the identified models of privatisation that are claimed to cut costs. The assessment in theory alone would be insufficient to identify models of privatisation that are Sharia compliant; therefore, the evidence coupled with the Sharia healthcare provision requirements, outlined in Chapter Two,[765] will allow this thesis to assess whether or not these models of privatisation fulfil these requirements both in theory and in practice.

5.3 The Sharia Compliance of Models of Healthcare Privatisation

According to non-Sharia literature, the favoured sectors for privatisation programs have been telecommunications, electricity, gas, water, airlines, and airports.[766] Public healthcare and public education pose a common theoretical challenge for privatisation, as both are characterised as public goods and are required to be non-diminishable and non-exclusionary.[767] In other words, no one can be excluded from using these services, and using the services does not

[764] Chapter One Section 1.8
[765] Chapter Two Section 2.3
[766] Donahue, *The Privatisation Decision: Public Ends, Private Means* (Basic Books 1989); Drakeford, et al. *Privatisation and Social Policy* (Longman 2000); Hemming, et al. *Privatisation and Public Enterprises* (IMF 1988); Kemp, *Privatisation: The Provision of Public services by the Private Sector* (McFarland & Co 2007); Saal, et al. International Handbook on Privatisation (Elgar 2003); Saltman, 'Melting public-private boundaries in European health system' (2003) 13 *JPH* 24
[767] Kahn, et al., *Privatisation and the welfare state* (PUP 2014); Keane et al. Privatization and the scope of public health: a national survey of local health department directors. (2001) 91 *Am J Public Health* 611; Keane et al. Public health privatization: proponents, re- sisters, and decision-makers. (2002) 23 *J Public Health Policy* 133; Khan,"Protecting the poor in the era of utility privatization." (2003) 7 *Energy for sustainable Development* 49; McLaughlin, 'Privatization and health care' in Halverson, et al. *Managed Care & Public Health* (Aspen Publishers 1998)

diminish the services or take them away from another. Therefore, opponents of privatisation argue that governments should keep healthcare public to ensure social equality is achieved and that the communal benefits, such as effective vaccinations and communicable disease control, are obtained by all.[768]

The claimed benefits of healthcare privatisation include improved efficiency, access, and quality,[769] which makes privatisation models particularly appealing for countries that face rapidly escalating healthcare costs, increasing dissatisfaction with the efficiency and quality of care provided in public health facilities, and shrinking public resources to support the provision of healthcare services.[770] When contracting out services, local healthcare departments aim to increase access, gain expertise, and improve efficiency, while partnerships in the healthcare sector aim to expand public healthcare services and expertise, and reduce inefficiencies.[771] Advocates of privatisation believe that the sale or administrative transfer of public goods and services to the private sector will stimulate market competition and improve the efficiency and quality of service provision.[772] As described by the Organisation for Economic Cooperation and Development (OECD), in systems where both financing and delivery of care is a

[768] ibid
[769] Banoob, Private and public financing-health care reform in eastern and central Europe. (1994) 15 *WHF* 329; Manga, Privatisation of health care services in Canada: Reform or regress? (1987) 10 *JCP* 1; McLaughlin, et al. *Managed Care & Public Health* (Aspen 1998); Scarpaci, *Health Services Privatisation in Industrial Societies* (RUP|1989); Young, Privatizing health care: Caveat emptor (1990) 5 *IJHPM* 237
[770] ibid
[771] ibid
[772] Collins, 'Strategic planning for state enterprises in Africa:public versus private options' (1989) 9 Public Administration and Development 65-82*;* Donahue, J. *The Privatization Decision: Public Ends, Private Means* (Basic Books 1989); Gollust, et al., 'Privatisation of public services: Organizational reform efforts in public education and public health' (2006) 96 *Public Health* 1733

public responsibility, privatisation also 'markets to function and generate efficiencies from competition and has proved generally effective'.[773]

Although privatisation is widely criticised, some scholars, such as Glennerster, argue that a clear distinction between finance and provision is required to ensure the efficient delivery of welfare services, such as healthcare.[774] This distinction between finance and provision can only be achieved through some form of privatisation, and is evident in many healthcare systems today.[775] Since its establishment, the NHS has never been a monolithic state service;[776] instead, the service consists of different forms of privatisation, such as outsourcing, corporatisation, and financial privatisation.[777] In theory, adopting these privatisation policies in healthcare would allow governments to generate finances and alleviate the financial burden.[778]

Nonetheless, the question at hand is: can methods of privatisation in the healthcare sector allow the government to cut costs as claimed, while ensuring that the healthcare requirements under Sharia law are fulfilled? The following sections will assess the Sharia compliance of these four models of cost-cutting

[773] Fielding, et al, Can managed competition solve the problems of market failure? (1993) *HA* 216; Goodman, et al. *The economics of health and health care* (Prentice-Hall, 2001); OECD, *OECD Economic Surveys: Luxembourg 2008* (OECD 2008)

[774] ibid; Glennerster, Understanding the finance of welfare (Policy 2009); Podgorsak, 'Privatization is not an answer to healthcare access problems, increased public funding is' (2009) 16 *Current Oncology* 2; Scarpaci, *Health Services Privatization in Industrial Societies* (Rutgers University Press 1989)

[775] ibid

[776] Harker, NHS Funding and Expenditure, SN/SG/724, House of Commons Library; Hunter, 'The Slow, lingering death of the english NHS' (2016) 5 Int J Health Policy Manag 55; Mohan, 'Rolling back the state?: Privatization of health services under the Thatcher governments' in Scarpaci, *Health Services Privatization in Industrial Societies* (Rutgers University Press 1989); Nicholas, et al 'Variations in the organization and delivery of the 'NHS health check' in primary care' (2013) 35 *JPH* 85

[777] ibid

[778] Arora, et al., *Public Payment and Private Provision. The Changing Landscape of Health Care in the 2000s.* (Nuffield Trust 2013); Arrowsmith, 'Decentralization in the public sector: the case of the UK National Health Service' (2002) 57 *RI* 2; Carr-Hill, et al. *A Formulae for Distributing NHS Revenue Based on Small Area Use of Hospital Beds.* (Centre for Health Economics 1994); Hunter, 'The Slow, lingering death of the english NHS' (2016) 5 *IHPM* 55

privatisation, in accordance to the Sharia requirements of availability, accessibility, affordability, and quality to all. These four principles of healthcare were also outlined in non-Sharia literature by Marshall, who argues that they cannot be achieved unless basic services are free at the point of consumption, the right to the service is universal, those who use the service all get the same treatment, and the service provided is the best the economy can provide.[779] Based on Marshall's opinion, it can be gathered that some models of privatisation would not allow healthcare to be available, accessible, affordable, and of quality to all, and therefore these models would not be compliant with Sharia.

5.3.1 Full Privatisation

The first privatisation in the UK was the denationalisation of the steel industry in the early 1950s.[780] It was not until the privatisation of British Telecom in November 1984 that privatisation was established as a basic economic policy in the UK.[781] In 1985, Margaret Thatcher focused on healthcare and with the aid of the American economist Alain Enthoven, argued the need for greater competition in healthcare and the formation of an internal market for that purpose, similar to that in the States at the time.[782] Upon assessment of

[779] Allotey, et al., 'Universal Coverage in an era of privatisation can we guarantee health for all?' (2012) 12 *BMC Public Health* s1; Marshall, *Social policy in the twentieth century.* (Hutchinson University 1965)
[780] Alsaqa, *The Experience of Privatisation in the U.K* (KU 1997) [In Arabic]; Angell, 'Privatizating health care is not the answer: lessons from the United States' (2008) 179 CMAJ 916; Béchamps et al *Privatization and public health: a report of initiatives and early lessons learned.* (Public Health Foundation 1999); Haskel, et al. 'Privatization, Liberalization, Wages and Employment: Theory and Evidence for the UK' (1993) 60 *Economics* 161
[781] ibid
[782] Arrowsmith, et al. 'Decentralization in the public sector: the case of the UK National Health Service' (2002) 57 *Relations Industrielles* 2; Goddard, et al., 'Equity of access to health care services: Theory and evidence from the UK' (2001) 53 *Social Science & Medicine* 1149; Haskel, et al. 'Privatization, Liberalization, Wages and Employment: Theory and Evidence for the UK' (1993) 60 *Economics* 161;

Thatcher's reforms, the general consensus was that there was less change than anticipated.[783] According to many scholars, 'the incentives were weak and the constraints were too strong',[784] which led to 'weakening the NHS public sector ethos'.[785] As a result, the current form of the NHS may not be able to withstand the changes and reforms.[786] Professor David Hunter explains that several reforms have been made and failed because they were made without taking into consideration the available evidence, solely focusing efforts on forming 'market-style policies embracing choice and competition' without effectively regulating the sector.[787]

Upon analysis of the literature, it is evident that full asset sales in full privatisations allow governments to cut costs and generate revenue.[788] According to Jones, 59 governments were able to raise over US $446 billion through 630 full privatisations from 1977 to 1997.[789] Thatcher's privatisations increased the number of shareholders in Britain from 3 million in 1979, to 6 million in 1985, and to over 10 million by her resignation in 1990.[790] Similar sales have reduced the fiscal deficit in 18 developing countries, as reported by

---

Mohan, 'Rolling back the state?: Privatization of health services under the Thatcher governments' in Scarpaci, *Health Services Privatization in Industrial Societies* (Rutgers University Press 1989)

[783] Ibid

[784] ibid, Le grand, Mays, and Dixon, 1998; 129

[785] Hunter, change of government: one more big bang health care reform in england's national health service, (2011) 41 ijhs 159

[786] Arora, et al., *Public Payment and Private Provision. The Changing Landscape of Health Care in the 2000s.* (Nuffield Trust 2013); Arrowsmith, 'Decentralization in the public sector: the case of the UK National Health Service' (2002) 57 *RI* 2; Carr-Hill, et al. *A Formulae for Distributing NHS Revenue Based on Small Area Use of Hospital Beds.* (Centre for Health Economics 1994); Hunter, 'The Slow, lingering death of the english NHS' (2016) 5 *IHPM* 55

[787] ibid

[788] Jones, et al, Share issue privatisations as financial means to political ends, (1999) 53 *JFE* 217; Mulla, et al. 'Privatisation of general hospitals and its applications in Saudi Arabia' (KFNL 2001) [in Arabic]; Perotti. et al. "Machiavellian Privatisation." (2002) 92 *AER* 240-258; Saal, *International Handbook on Privatisation*, (Elgar 2003)

[789] ibid

[790] Bos, *Privatisation: a theoretical treatment* (OUP 1991); Boycko et al.,'A theory of privatisation' (1996) 106 *EJ* 309; Hanke, S., *Privatisation and Developmemt* (Institute for Contemporary Studies, 1987)

Davies.[791] However, can these sales through full privatisations allow healthcare to meet the four requirements of Sharia?

A. Availability

Healthcare is available when there is a sufficient quantity of functioning healthcare facilities to meet the requirements of the society they serve.[792] Ideally, these will be public facilities; however, in the case of full privatisation, all healthcare facilities are part of the private sector.[793] An analysis of the available literature discussing full privatisations in healthcare shows that because private enterprises are driven by profit, rather than by social benefit, the availability of privatised services correlates with the patient's ability to pay for them.[794] Opponents of privatisation argue that privatising such services may lead to abandoning the social obligations towards those who are unable to pay or where services are less profitable.[795] An example of the effect that the full privatisation of healthcare has on availability is seen in Germany with the purchase of the Erfurt city clinic by the company Helios in 2001.[796] Following the sale, the availability of services was high for those who were able to pay and

[791] Davis et al., Fiscal and Macroeconomic Impact of Privatisation, IMF 2000
[792] Larkin, *Social Aspects of Health, Illness and Healthcare*, (McGraw- Hill Education 2011); Litaker, et al., 'Context and healthcare access: looking beyond the individual' (2005) 43 *Medical care* 531; O'Connell et al, 'What does Universal Healthcare Coverage mean?' (2014) 383 Lancet 277; Pollock, *NHS Plc: The Privatisation of Our Health Care* (Verso 2005); Price, 'The consequences of health service privatisation for equality and equity in health care in South Africa' (1988) 27 Soc Sci Med 703
[793] ibid; Smith, et al. 'Political and economic aspects of the transition to universal health coverage' (2012) 380 *Lancet* 924; WHO 'Health Systems Financing: The Path to Universal Health Coverage' (2010)
[794] ibid
[795] ibid; Allotey, et al., 'Universal Coverage in an era of privatisation can we guarantee health for all?' (2012) 12 *BMC Public Health* s1; Yasin, et al. 'Universal Coverage in an era of privatisation: can we guarantee health for all?' (2012) 12 BMC Public Health
[796] Busse et al. 'Measuring, Monitoring, and Managing Quality in Germany's Hospitals' (2009) 28 *Health affairs* 294; Clarke et al. *Healthcare Systems: Germany* (Civitas 2013); Tiemann et al. 'Effects of ownership on hospital efficiency in Germany' (2009) 2 *Business Research* 115

non-existent for those who were unable to pay.[797] Accordingly, the services were not available to all.

The definition of availability also includes the availability of sufficient healthcare workers.[798] When privatising healthcare, privately managed hospitals are able to attract employees because employees prefer higher paying hospitals.[799] Therefore, the highest paying hospitals will have the highest number of employees, which puts patients at lower paying hospitals at a disadvantage due to a shortage of sufficient healthcare workers.[800]

Therefore, I argue that a full privatisation would increase an already existing urban-rural imbalance of healthcare services in Saudi Arabia. Scholars, such as Almalki, Khaliq, Albejaidi, and Al-Borie, have found large hospital versus primary healthcare centre-related care and regional disparities evident in resources, infrastructure, medical technology, equipment, and staff.[801] Consequently, healthcare is available more often in urban areas than in rural areas.[802] The differences in availability of healthcare led to what is known as

[797] Kane, et al. 'Assessing the impact of privatisation public hospitals in three American states: implications for universal health coverage' (2013) 16 *VH* S24; Karlaftis, 'Privatisation, regulation and competition: A thirty-year retrospective on transit efficiency' (2008) *ITF* 67; Keane, The effects of managerial beliefs on service: Privatisation and discontinuation in local health departments. (2005) 30 *HCMR* 52
[798] Coutts, et al., 'Understanding privatisation's impacts on health: lessons from the soviet experience' (2008) 62 *Journal of Epidemiology and Community Health* 664; Cowan, 'A global overview of privatisation' in *Privatisation and Development* (Institute of Contemporary Studies 1987); Dixon-Warren, 'Privatisation of health care', (2009) 180 CMAJ 429
[799] ibid
[800] ibid
[801] Almalki et al. 'The healthcare system in Saudi Arabia: An overview' (2011) 7 *East Mediterr Health J* 784; Khaliq A., 'The Saudi Healthcare System: A View from the Minaret' (2012) 13 *World Health & Population* 52; Albejaidi, F. "Healthcare system in Saudi Arabia: An analysis of structure, total quality management and future challenges." (2010) 2 *Journal of Alternative Perspectives in the Social Sciences* 794; AlBorie et al 'A 'DIRE' needs orientation to Saudi health services leadership' (2013) 26 *Leadersh Health Serv*
[802] ibid

urban-migration, a form of medical tourism within the same country, which I argue to be in contradiction to Sharia requirements. [803]

B. Accessibility

Healthcare services are required to be physically and economically accessible with no discrimination.[804] The accessibility and availability of healthcare are interlinked—what affects the availability of healthcare would affect its accessibility. [805] Therefore, a full privatisation would affect economical accessibility by providing services to paying and insured patients only;[806] access to healthcare would depend on the patient's ability to pay for services, rather than their medical needs, [807] as mentioned in Chapter Two,[808] this is known as inequitable healthcare, or the 'inverse care law'.[809] The availability and accessibility of services is one of the issues raised by scholars against Saudi healthcare privatisation, such Almalki and Al-Harbi,[810] who agree that as hospitals become privatised, they will focus on attracting patients to raise a profit, including those who do not require hospital-level care.[811] Furthermore, according to Almalki, privatised hospitals would focus on establishments in

[803] ibid
[804] Larkin, *Social Aspects of Health, Illness and Healthcare*, (McGraw- Hill Education 2011); Litaker, et al., 'Context and healthcare access: looking beyond the individual' (2005) 43 *Medical care* 531; O'Connell et al, 'What does Universal Healthcare Coverage mean?' (2014) 383 Lancet 277; Pollock, *NHS Plc: The Privatisation of Our Health Care* (Verso 2005); Price, 'The consequences of health service privatisation for equality and equity in health care in South Africa' (1988) 27 Soc Sci Med 703
[805] ibid
[806] ibid
[807] ibid; Andersen, et al., 'Access to Medical Care for Low-Income Persons: How do Communities Make a Difference?' (2002) 59 *Medical Care Research and Review* 384; Andersen, et al., 'Exploring dimensions of access to medical care' (1983) 18 *Health services research* 49
[808] Chapter Two Section 2.3.1
[809] Mooney, 'The Health of Nations: Toward a New Political Economy' (Zed Books 2012); Victora et al, Making Health Systems more equitable (2004) 364 Lancet 1273
[810] Almalki et al. 'The healthcare system in Saudi Arabia: An overview' (2011) 7 *East Mediterr Health J* 784; AlHarbi, et. al, 'The Changing Face of Healthcare in Saudi Arabia' (2008) 28 Annals of Saudi Medicine 243
[811] ibid

highly populated urban areas with wealthy individuals,[812] neglecting areas that are rural or populated with less wealthy individuals. Based on the scholarship, I argue that a full privatisation of healthcare would result in limited availability and accessibility of healthcare services for uninsured patients or those in rural areas, which contradictions Sharia requirements.[813]

C. Acceptability

Acceptability means providing services that are culturally acceptable and patient-centred.[814] Privatisation would lead to competition and a focus on profit, which would entail taking a business approach to ensure 'customer' satisfaction.[815] To increase profit, hospitals would have to ensure that services provided are client-centred, as well as commonly known and accepted.[816] However, a client-centred approach is also risky and may lead to further focusing on profit and providing services that the client does not require.[817] Consequently, the availability of healthcare and accessibility would be affected, as hospitals would focus on high paying consumers and neglect other patients. I

[812] ibid
[813] Ibid; Al-Harbi, et. al, The Changing Face of Healthcare in Saudi Arabia, (2008) 28 *ASM* 243; AlRabeah, et. al, TQM in the Saudi Healthcare System: A National Cultural Perspective, (2015) 5 WRBR 120
[814] Larkin, *Social Aspects of Health, Illness and Healthcare,* (McGraw- Hill Education 2011); Litaker, et al., 'Context and healthcare access: looking beyond the individual' (2005) 43 *Medical care* 531; O'Connell et al, 'What does Universal Healthcare Coverage mean?' (2014) 383 Lancet 277; Pollock, *NHS Plc: The Privatisation of Our Health Care* (Verso 2005); Price, 'The consequences of health service privatisation for equality and equity in health care in South Africa' (1988) 27 Soc Sci Med 703
[815] Glazer, et al. 'Payer Competition and Cost Shifting in Health Care' (1994) 5 *Journal of Economics and Management Strategy* 71; Karlaftis, 'Privatisation, regulation and competition: A thirty-year retrospective on transit efficiency' (2008) *ITF Round Tables* 67; Noether, Competition Among Hospitals, (1988) 7 *Journal o f Health Economics* 259; Zigante, 'Consumer choice, competition and privatisation in European health and long term care systems: Subjective well being effects and equity implications' (PhD Thesis, The London School of Economics and Political Science 2013)
[816] ibid
[817] ibid; Fielding, et al. 'Can managed competition solve the problems of market failure?' (1993) *Health Affairs* 216; Greer, et al., 'When does marketization lead to privatisation? Profit-making in English health services after the 2012 health and social care act' (2015) 124 *Social science and medicine* 215; Janoska, 'Privatisation of public health services at european health markets from a law and economic perspective' (2011) 3 German Journal for Young Researchers 13

argue that although the full privatisation of healthcare may enhance acceptability of healthcare and increase profit, the resulting risk of limited availability and accessibility of healthcare services are in contradiction to Sharia requirements.[818]

D. Quality

Quality is related to the services and facilities alike.[819] Advocates of privatisation claim that privatising a sector would improve the quality of services by creating a competitive market,[820] which is argued to better services and efficiency unlike when the government is the sole provider.[821] According to Fielding and Rice, allowing market competition to operate through privatisation results in economically efficient outcomes[822] and in the long run, according to Welch, will lead to competitive firms operating at the lowest possible cost and charging the lowest price.[823] As summarised by Shleifer, 'a good government that wants to further 'social goods' would rarely own producers to meet its objectives'.[824] Ibn Khaldoun expressed a similar opinion when he called for the privatisation of production and manufacture in the Sharia abiding state.[825]

[818] ibid
[819] Albreht, 'Privatisation processes in health care in Europe - a move in the right direction, a 'trendy' option, or a step back?' (2009) 19 *EJPH* 448; Kemp, Privatisation: The Provision of Public services by the Private Sector (McFarland 2007); Ramamurti, 'A multilevel model of privatisation in emerging economies' (2000) 25 *AMR* 525
[820] Glazer, et al. 'Payer Competition and Cost Shifting in Health Care' (1994) 5 *Journal of Economics and Management Strategy* 71; Karlaftis, 'Privatisation, regulation and competition: A thirty-year retrospective on transit efficiency' (2008) *ITF Round Tables* 67; Noether, Competition Among Hospitals, (1988) 7 *Journal o f Health Economics* 259; Zigante, 'Consumer choice, competition and privatisation in European health and long term care systems: Subjective well being effects and equity implications' (PhD Thesis, The London School of Economics and Political Science 2013)
[821] ibid
[822] Fielding, et al. 'Can managed competition solve the problems of market failure?' (1993) *Health Affairs* 216
[823] Welch, et al. *Economics: Theory and Practice* (The Dryden Press 1992)
[824] Shleifer, State versus Private Ownership, (1998) 12 *Journal of Economic Perspectives* 133
[825] Ahmad, 'Eonomic Development in Islamic Perspective Revisited' (2000) 9 *RIE* 83; Ahmad, *Studies in Islamic Economics* (TIF 1980); Hussain, Islam: Its Law and Society (Federation 2004); Mahmood, The

However, not all privatisations are as successful and fruitful as its enthusiasts claim.

Privatisation would affect the quality of the services and facilities, allowing the better financed entities to have higher quality facilities and to attract the best professionals to deliver highest quality services.[826] Therefore, these entities would attract the most patients, affecting availability, acceptability, and accessibility alike.[827] In contrast, less financed privatised hospitals would have to resort to employing staff that are less in numbers, expertise, and qualifications as a means of saving money.[828] This risk of shortage in staff and expertise would affect the quality—and consequently the availability, acceptability, and accessibility—of healthcare.

For example, the quality and acceptability of healthcare in Russia were affected after its decentralisation.[829] Patients in less financed hospitals were left at risk of suffering serious complications due to the lack of quality monitoring systems

---

Reference of The Arab Islamic Civilisation (AlSalasil 1984) [In Arabic]; Ragab, 'Islam and Development' (2002) 8 *JWD* 513

[826] Saha, et al., 'Patient centeredness, cultural competence and healthcare quality' (2008) 100 *Journal of the National Medical Association* 1275; Busse, et al. 'Measuring, Monitoring, and Managing Quality in Germany's Hospitals' (2009) 28 *Health affairs* 294; Farsi 'Changes in hospital quality after conversion in ownership status' (2004) 4 *International Journal of Health Care Finance and Economics* 211

[827] ibid; Larkin, *Social Aspects of Health, Illness and Healthcare*, (McGraw- Hill Education 2011); Litaker, et al., 'Context and healthcare access: looking beyond the individual' (2005) 43 *Medical care* 531; O'Connell et al, 'What does Universal Healthcare Coverage mean?' (2014) 383 Lancet 277; Pollock, *NHS Plc: The Privatisation of Our Health Care* (Verso 2005); Price, 'The consequences of health service privatisation for equality and equity in health care in South Africa' (1988) 27 Soc Sci Med 703

[828] Saha, et al., 'Patient centeredness, cultural competence and healthcare quality' (2008) 100 *Journal of the National Medical Association* 1275; Busse, et al. 'Measuring, Monitoring, and Managing Quality in Germany's Hospitals' (2009) 28 *Health affairs* 294; Farsi 'Changes in hospital quality after conversion in ownership status' (2004) 4 *International Journal of Health Care Finance and Economics* 211

[829] Buchanan, 'Privatistaion and just healthcare' (1995) 9 *Bioethics* 220; Coutts, et al., 'Understanding privatisation's impacts on health: lessons from the soviet experience' (2008) 62 *Journal of Epidemiology and Community Health* 664; Drakeford, et al. *Privatisation and Social Policy* (Longman 2000); Dethier, *Governance, decentralization and reform in China, India and Russia* (Kluwer Academic Publishers 2000)

and supervision.[830] Similarly, Great Britain's experience with the private provision of nursing home services and the United States' experience with Medicaid managed care arrangements demonstrate the importance of having appropriate monitoring mechanisms in place to maintain the quality of care provided by the private sector and to protect consumers against any undesirable effects of privatisation.[831] I argue that the differences in quality, availability, acceptability, and accessibility between providers may consequently lead to an urban-migration.

Unregulated competition between firms was also harmful in the UK, when acute hospital care services were privatised and resulted in closures.[832] Moreover, privatisations in Russia and Latin America were accompanied by large scale corruption, where those with political connections were able to gain unfairly large wealth.[833] Similarly, in Egypt firms privatised during the reign of Mubarak were found to practice crony capitalism with the overthrown regime,[834] which demolished the competitive market and did not enhance efficiency as expected

[830] ibid
[831] Andersen, et al., *Improving access to care in America. Changing the US health care system: key issues in health services policy and management* (Jossey-Bass 2007); Weil, 'What can the canadians and americans learn from each other's health care systems?'(2016) 31 *IJHPM* 349; Drache, et al. Health Reform: Public success, Private failure (Routledge 2005);
Whitehead, *The Health Divide: Inequalities in Health in the 1980's in U.K.* (HEA 1987)
[832] Arrowsmith et al 'Decentralization in the public sector: the case of the UK National Health Service' (2002) 57 *Relations Industrielles* 2; Goddard, et al., 'Equity of access to health care services: Theory and evidence from the UK' (2001) 53 *Social Science & Medicine* 1149; Hunter, 'The Slow, lingering death of the English NHS' (2016) 5 Int J Health Policy Manag 55
[833] Dethier, *Governance, decentralization and reform in China, India and Russia* (Kluwer Academic Publishers 2000); Guasch, et al, 'Renegotiation of concession contracts in Latin America: evidence from the water and transport sectors' (2008) 26 *Intl J Indust Org* 421; Jack, W., *The evolution of health insurance institutions: theory and four examples from Latin America,* (World Bank Group 2000); Lucas, et al, *Privatisation in Latin America:The Rapid rise, recent fall, and continuing puzzle of a contentious economic policy*, (Center for Global Development 2004)
[834] Waterbury, J., "The political context of public sector reform and privatization in Egypt, India; Mexico and Turkev." Paper presented at the Privatization Working Conference: (Princeton University 1988); Waterhouse, *Privatization: the facts* (Price Waterhouse 1990); World Bank (PPPIRC), 'Privatisation' (2016)

of privatisation,[835] and were re-nationalised when Mubarak was overthrown in 2011. The lack of transparency and absence of regulatory institutions led to the sale of state-owned assets at minuscule amounts to those with political connections.

The method and process of privatisation and how it is implemented are seriously flawed.[836] Therefore, scholars emphasise that for these competitive markets to operate effectively, they should be regulated by institutions, both governmental and independent, that aim to improve their operation.[837] The importance of regulation in the private sector is also expressed in Sharia law, which obliges governments to regulate as part of preserving the *Maslahah* and protecting *Maqasid AlSharia,*[838] as explained in Chapter Two.[839]

Nonetheless, in some countries, a full privatisation is never a total transfer of all governmental interests, as governments may retain some control through license granting and regulation.[840] This governmental regulation is what distinguishes full privatisations from private commercial enterprises, where the

[835] ibid; Akhmetova, 'The Arab Spring, Good Governance and Citizens' Rights' (2014) 5 *Islam and Civilisational Renewal* 334; Rutherford, *Egypt after Mubarak: Liberalism, Islam, and Democracy in the Arab World* (PUP 2013)
[836] Banoob, Private and public financing-health care reform in eastern and central Europe. (1994) 15 *WHF* 329; Basu et al, 'Comparative Performance of Private and Public Healthcare Systems in Low and Middle Income Countries: A Systematic Review' (2012) 9 *PLoSMed*; Bienen, et al. 'The political economy of privatisation in developing countries' (1989) 17 *WD* 617; Dethier, *Governance, decentralization and reform in China, India and Russia* (Kluwer 2000)
[837] ibid
[838] Ahmad, 'Islamic Law, Adaptability and Financial Development' (2006) 13 *IES* 79; Chapra, *The Islamic Vision of Development in the Light of the Maqasid Al-Shari`ah* (IDB 2008); Crone, God's Rule: Government and Islam, (CUP 2005); Dusuki, et al. 'Maqasid AlShariah, Maslahah and Social Responsibility' (2007) 24 *AJISS* 25; Kamali, *Citizenship and Accountability of Government: An Islamic Perspective* (IAIS & Ilmiah Publishers 2013)
[839] Chapter Two Section 2.5.1.1
[840] Rondinelli, *Decentralization in developing countries*, Staff Working Paper 581 (World Bank 1983); World Bank (PPPIRC), 'Privatisation' (2016)

government does not retain any form of control.[841] One example of a full privatisation with the government retaining control is the privatisation of water and sanitation companies in England and Wales, where the government grants licenses and regulates services.[842] I argue that government regulation and licensing could be beneficial for the consumer and the privatised sector, as private entities may risk having their licenses evoked if they fail to achieve goals or maintain standards set by the government. Therefore, although the purpose of these privatisations is to cut costs, the efficiency of these private entities indirectly improves through governmental regulation.[843] Accordingly, I argue that both purposes of privatisation can be achieved through this form of regulated full privatisation.[844]

Conventional economics theory argues that if certain conditions are met, allowing market competition to operate will result in economically efficient outcomes—better quality services at lower prices.[845] However, there are several conditions that need to be met for a competitive market to form and the outcomes that privatisation advocates celebrate to occur.[846] First, there must be

[841] ibid
[842] Haskel, et al. 'Privatisation, Liberalization, Wages and Employment: Theory and Evidence for the UK' (1993) 60 *Economics* 161; Karlaftis, 'Privatisation, regulation and competition: A thirty-year retrospective on transit efficiency' (2008) *ITF* 67; Laffont, et al. 'Privatisation and incentives' in Laffont, *A theory of incentives in procurement and regulation* (MIT 1993) Rondinelli, *Decentralization in developing countries*, Staff Working Paper 581 (WB 1983); World Bank (PPPIRC), 'Privatisation' (2016)
[843] ibid
[844] A full privatisation in accordance to its definition in non-Sharia literature, not the Sharia scholar definition of privatisation.
[845] Hammer, et al 'Strategies for Pricing Publicly Provided Health Services' in Schieber *Innovations in Health Care Financing* (WB 1997);
[846] Glazer, et al. 'Payer Competition and Cost Shifting in Health Care' (1994) 5 *Journal of Economics and Management Strategy* 71; Karlaftis, 'Privatisation, regulation and competition: A thirty-year retrospective on transit efficiency' (2008) *ITF Round Tables* 67; Noether, Competition Among Hospitals, (1988) 7 *Journal o f Health Economics* 259; Zigante, 'Consumer choice, competition and privatisation in European health and long term care systems: Subjective well being effects and equity implications' (PhD Thesis, The London School of Economics and Political Science 2013)

numerous buyers and sellers in the market, each with no power over price. Second, entry into and exit from the market must be free. Third, the goods and services produced must be homogeneous, and consumers and producers must possess perfect information regarding the price and quality of alternative choices. Scholars such as Fielding and Shiefer believe these can only be achieved through some form of regulation and supervision of the market and privatised industry.[847]

From a Sharia perspective, I argue that the above conditions can be met through the government fulfilling its obligation to regulate the private sector. As mentioned in Chapter Two,[848] the reason behind the obligation on the state to regulate is to ensure the preservation of *Maslahah* and protection of *Maqasid AlSharia.*[849] I further argue that in the context of healthcare, the *Maslahah* would be for individuals to obtain the correct healthcare at the lowest price and highest quality; however, I also suggest that although regulation could allow lower prices and better quality, with the financing also being shifted from the government, there remains a demographic of society that may not be able to obtain healthcare due to financial reasons and it is essential ensure their healthcare is funded.

[847] Bienen, et al. 'The political economy of privatisation in developing countries' (1989) 17 *WD* 617; Boycko et al.,'A theory of privatisation' (1996) 106 *EJ* 309; Parry, *Privatisation* (Kingsley 1990); Fielding, et al. 'Can managed competition solve the problems of market failure?' (1993) *HA* 216; Shleifer, State versus Private Ownership, (1998) 12 *JEP* 133

[848] Chapter Two Section 2.5.1.1

[849] Ahmad, 'Islamic Law, Adaptability and Financial Development' (2006) 13 *IES* 79; Chapra, *The Islamic Vision of Development in the Light of the Maqasid Al-Shari`ah* (IDB 2008); Crone, God's Rule: Government and Islam, (CUP 2005); Dusuki, et al. 'Maqasid AlShariah, Maslahah and Social Responsibility' (2007) 24 *AJISS* 25; Kamali, *Citizenship and Accountability of Government: An Islamic Perspective* (IAIS & Ilmiah Publishers 2013)

Kenneth Arrow, Evans, and Ginzberg argue that it is impossible to form a competitive market in the health sector.[850] A competitive market is based on the assumption that the consumers have the necessary knowledge and expertise to enable them to make free choices.[851] Accordingly, I argue that consumer knowledge is particularly problematic in the healthcare sector, since it is inadequate to make such informed decisions as assumed in a competitive market. In order to make informed decisions in the medical field, one would need to be aware of the medical details, latest advancements and options available, all of which the lay man is seldom fully aware of.[852] Accordingly, the benefits of full privatisations discussed above would not be achieved, unless the MOH actively focused on raising health awareness and improving healthcare information availability for the public.[853] Accordingly, the *Maslahah* and *Maqasid AlSharia* could be preserved in a full privatisation if the government regulates the hospitals and services, ensures that health information is available to patients, and provides a form of financing for patients unable to pay for healthcare.

[850] Ginzberg, 'Privatization of health care: A US perspective' (1988) 530 *Annals of the New York Academy of Sciences* 111

[851] Glazer, et al. 'Payer Competition and Cost Shifting in Health Care' (1994) 5 *Journal of Economics and Management Strategy* 71; Karlaftis, 'Privatisation, regulation and competition: A thirty-year retrospective on transit efficiency' (2008) *ITF Round Tables* 67; Noether, Competition Among Hospitals, (1988) 7 *Journal o f Health Economics* 259; Zigante, 'Consumer choice, competition and privatisation in European health and long term care systems: Subjective well being effects and equity implications' (PhD Thesis, The London School of Economics and Political Science 2013)

[852] ibid

[853] Through several methods such as pamphlets, educational videos, seminars, information on MOH website and awareness days.

5.3.2 Financial Privatisation

Scholars in favour of privatisation argue that financial privatisation allows the state to transfer financial burdens to the private entities while focusing on other duties, and in theory, demolishes bureaucracy and enhances availability and quality.[854] One example of financial privatisation is seen in the UK,[855] where foreigners in the UK are obliged to pay a one-off premium to use the NHS, depending on their type and length of stay.[856] Paying the immigration health surcharge (IHS) is a requirement for a visa application to the UK.[857]

The IHS was not welcomed when it was first adopted. According to Schweitzer, the IHS affects access to healthcare and contradicts the purpose of the NHS under the Health and Social Act to have regard to the need to reduce health inequalities,[858] and the NHS Act,[859] which sets out the duty of the Minister of Health to provide services free of charge for 'the people of England and Wales'.[860] Nonetheless, 9 out of 10 people in the UK will use NHS services every year, which in England equals

[854] Hartley, et al., 'Urban and rural differences in health insurance and access to care' (1994) 10 *J Rural Health* 98; Hoffman, et al., 'Health insurance and access to health care in the United States' (2008) 1136 *Ann N Y Acad Sciv*149; Saltman, 'Melting public-private boundaries in European health system' (2003) 13 *JPH* 24

[855] Dayan et al. *How good is the NHS?* (Nuffield Trust 2018); OECD Health Statistics 2014, How does Spain compare? (OECD 2014); Hunter, 'The Slow, lingering death of the english NHS' (2016) 5 Int J Health Policy Manag 55

[856] Appleby, 'Migrants' healthcare: who pays?' (2013) *BMJ* 347; Britz, et al 'Charging migrants for health care could compromise public health and increase costs for the NHS' (2016) 38 *Journal of Public Health* 384; Department of Health 'Guidance on overseas visitors hospital charging regulations'(2012) last updated 25 May 2018; Department of Health *Visitor and Migrant Cost Recovery – Extending Charging: Impact Assessment*, (2015); Home Office, 'Controlling Immigration Regulating migrant access to health services in the UK Results of the public consultation' 22 October 2013

[857] ibid

[858] Health and Social Care Act 2012

[859] National Health Services Act 2006

[860] Evans, 'Politics, Coercion and Power: An analysis of economic failure in healthcare systems' (PhD Thesis, Brunel University 2006); Schweitzer, 'Providing public healthcare to irregular migrants. The everyday politics and local negotiation of formal entitlements and effective access in London and Barcelona' (2016) GRITIM-UPF Working Paper Series 29; Schweitzer, et al. 'From Social Workers to Immigration Officers? Public Welfare Institutions as a Tool for Migration Control' (2018)

48,150,000 people per year.[861] According to OECD, the NHS only had 2.95 beds per 1,000 patients in 2011, which increased the strain on the system.[862] The shortage of beds alongside with the high demand on healthcare is argued to have led to the implementation of a form of financial privatisation for foreigners.[863] The aim of the IHS is to relieve the financial burden on the NHS and help generate a new source of income to help deal with the NHS's current issues, such as the shortage of beds.[864]

A. Availability

An analysis of the available literature discussing healthcare finance privatisation demonstrates that healthcare is not readily available to all.[865] The availability of services depends on the financial ability of the individual to pay premiums and service fees, which excludes the financially unfortunate.[866] For example, the IHS charge does not take into consideration the financial abilities

[861] Ipsos MORI. Public Perceptions of the NHS and Social Care Survey: Spring 2013 and Winter 2013 Waves.
[862] Dayan et al. *How good is the NHS?* (Nuffield Trust 2018); OECD Health Statistics 2014, How does Spain compare? (OECD 2014); Hunter, 'The Slow, lingering death of the english NHS' (2016) 5 Int J Health Policy Manag 55
[863] Appleby, 'Migrants' healthcare: who pays?' (2013) *BMJ* 347; Britz, et al 'Charging migrants for health care could compromise public health and increase costs for the NHS' (2016) 38 *Journal of Public Health* 384; Department of Health 'Guidance on overseas visitors hospital charging regulations'(2012) last updated 25 May 2018; Department of Health *Visitor and Migrant Cost Recovery – Extending Charging: Impact Assessment*, (2015); Home Office, 'Controlling Immigration Regulating migrant access to health services in the UK Results of the public consultation' 22 October 2013
[864] Arrowsmith 'Decentralization in the public sector: the case of the UK National Health Service' (2002) 57 *RI*; Goddard, et al., 'Equity of access to health care services: Theory and evidence from the UK' (2001) 53 *SSM* 1149; Haskel 'Privatisation, Liberalization, Wages and Employment: Theory and Evidence for the UK' (1993) 60 *Economics* 161
[865] Alvarez et al 'The Colombian health insurance system and its effect on access to health care' (2011) 41 *International Journal of Health Services* 355; Andersen, et al., 'Access to Medical Care for Low-Income Persons: How do Communities Make a Difference?' (2002) 59 *Medical Care Research and Review* 384; Benson, 'The impact of privatization on access in Tanzania'(2001) 52 *Social Science & Medicine* 1903
[866] Larkin, *Social Aspects of Health, Illness and Healthcare*, (McGraw- Hill Education 2011); Litaker, et al., 'Context and healthcare access: looking beyond the individual' (2005) 43 *Medical care* 531; O'Connell et al, 'What does Universal Healthcare Coverage mean?' (2014) 383 Lancet 277; Pollock, *NHS Plc: The Privatisation of Our Health Care* (Verso 2005); Price, 'The consequences of health service privatisation for equality and equity in health care in South Africa' (1988) 27 Soc Sci Med 703

of the applicant.[867] Furthermore, the IHS does not cover all essential treatments. Although A&E services are free with the payment of the IHS, obstetric services including childbirth and emergency treatment if admitted are chargeable.[868] Accordingly, I argue that healthcare availability depends on the financial ability of the patient; therefore, the financially unfortunate may be deprived of essential treatments. Implementing a system similar to the IHS in Saudi Arabia would not be compliant with Saudi law or Sharia healthcare requirements.[869]

Nonetheless, a different situation is seen in financial privatisation with healthcare insurance schemes,[870] such as in Germany, where about 85% of the population bought compulsory high regulated, non-profit public insurance.[871] Healthcare insurance is argued to liberate people from financial hardship and provide them with swift and easy services, less waiting times, and the ability to select their desired specialist.[872] Nonetheless, I argue that the less financially fortunate who are unable to obtain insurance would be deprived of these benefits and of healthcare, which is contradictory to healthcare requirements in

[867] Britz, et al 'Charging migrants for health care could compromise public health and increase costs for the NHS' (2016) 38 *Journal of Public Health* 384; Department of Health 'Guidance on overseas visitors hospital charging regulations'(2012) last updated 25 May 2018

[868] ibid

[869] Abdelkader, *Social Justice in Islam* (IIIT 2000); AlDosari, *Human Rights in Islam* (PhD Thesis UCL 2010); AlKhayat, 'Health as a Human Right in Islam' in *The Right Path to Health: Health Education through Religion* (WHO Regional Office, Cairo, 2004); The Saudi Health Law, Royal Decree No. M/11, 4th June 2002; WHO, 'Islamic Code of Medical and Health Ethics' (2005) EM/RC52/7

[870] Hadley, 'Sicker and poorer--the consequences of being uninsured: a review of the research on the relationship between health insurance, medical care use, health, work, and income' (2003) 60 *Med Care Res Rev* 3S; Hajlzadeh, et al. 'Equity of health care financing in Iran: The effect of extending health insurance to the uninsured' (2010) 38 Oxford Development Studies 461; Hall, et al., 'Expanding the Definition of Access: It Isn't Just About Health Insurance' (2008) 19 *Journal of Health Care for the Poor and Underserved* 625; Hoffman, et al., 'Health insurance and access to health care in the United States' (2008) 1136 *Ann N Y Acad Sciv*149

[871] ibid; Allin et al, *Measuring inequalities in access to Healthcare: A review of the indices* (European Commission 2007); Banoob, Private and public financing-health care reform in eastern and central Europe. (1994) 15 *World Health Forum* 329

[872] AlMishaal, 'Summary of the Experience of Application of Healthcare Insurance in Taiwan' *Sehat AlSharqia* (Dammam, January 2008); Bennett, et al. *Health insurance schemes for people outside formal sector employment* (The WHO 1998); Hargaves, et al., 'The Contribution of Insurance Coverage and Community Resources to Reducing Racial/Ethnic Disparities in Access to Care' (2003) 38 *Health Services Research* 809

Sharia. Considering there was 15% of the population who were not included in the insurance purchased under the financial privatisation of healthcare, 10% of whom buys private insurance,[873] the German government changed the model of privatisation from a financial privatisation to a public-private partnership (PPP).[874] PPPs are models of privatisation where both the public and private sector cooperate in the management, construction, provision, and finance,[875] as mentioned in Chapter Four,[876] Accordingly, the 5% of the population who are not financially able to purchase insurance were granted sick funds, and healthcare became available to all.[877] Accordingly, a financial privatisation with sick funds for those who cannot pay would be in accordance to Sharia requirements of availability of healthcare.

B. Quality

In financial privatisations, the quality of the services depends on the financial ability of the entity and the budget allocated based on premium payments of users.[878] Hospitals that are allocated higher budgets and are able to employ more skilful professionals will in theory provide higher quality services in comparison to hospitals allocated lower budgets.[879] Therefore, I argue that patients at hospitals with lower budgets will be at risk of low quality healthcare

[873] ibid; Clarke et al. *Healthcare Systems: Germany* (Civitas 2013)
[874] ibid; Lewis, et al, 'Are public-private partnerships a healthy option?' (2014) 113 *SSM* 110; Maceira, *Income Distribution and the Public-Private Mix in Health Care Provision: the Latin American Case* (IADB 1998); Yescombe, Public-private partnerships: principles of policy and finance. (Butterworts 2007)
[875] ibid
[876] Chapter Four Section 4.2.1.5
[877] Clarke et al. *Healthcare Systems: Germany* (Civitas 2013)
[878] Hadley, 'Sicker and poorer--the consequences of being uninsured: a review of the research on the relationship between health insurance, medical care use, health, work, and income' (2003) 60 *Med Care Res Rev* 3S
[879] Jack, W., *The evolution of health insurance institutions: theory and four examples from Latin America,* (World Bank Group 2000); Keane, et al. Local health departments' mission to the uninsured.(2003) 24 *J Public Health Policy* 30; Nadim, (2008) The effect of medical insurance on medical services: positive or Negative? Cooperative Health Insurance, No. 3

services, which will put the health of these individuals at risk and is contradictory to the healthcare requirements in Sharia. Moreover, the difference in quality between hospitals will contribute to the formation of an urban-migration, further affecting the availability of healthcare.

C. Accessibility

After analysing privatisation processes in Europe, Albreht argues that financial privatisation threatens the accessibility of healthcare due to increased costs.[880] For example, as mentioned in the German example where about 5% of the German population were left with no insurance when it was first implemented. The compulsory highly regulated, non-profit public insurance is called "Gesetzliche Krankenversicherung" (GKV), and the expenses are split between the individual and the employer.[881] The cost of GKV varies from person to person; for instance, people with no children have to pay more.[882] However, citizens who are self-employed or have a net income of €50,000 or more per year must purchase private insurance.[883] I argue that uninsured individuals' access to healthcare is affected by financial privatisation, which is contradictory to the requirements of healthcare in Sharia. However the German government overcame the variation in accessibility by introducing strictly regulated sick funds for unemployed individuals and finances their healthcare.[884]As these sick funds are paid by the government the model of privatisation is a PPP as

[880] Albreht, 'Privatization processes in health care in Europe: a move in the right direction, a "trendy" option, or a step back?' (2009) 19 *European Journal of Public Health* 448
[881] ibid; Allin et al, *Measuring inequalities in access to Healthcare: A review of the indices* (European Commission 2007); Banoob, Private and public financing-health care reform in eastern and central Europe. (1994) 15 *World Health Forum* 329
[882] ibid
[883] ibid
[884] Clarke et al. *Healthcare Systems: Germany* (Civitas 2013); Müller et al, *Understanding the German Health care system,* (Mannheim Institute 2013)

mentioned,[885] however, if these sick funds were financed by the wealthy or through a joint guarantee, the GKV would be a total financial privatisation.[886] In other words, it is possible to relieve the government of all finances yet maintain accessibility of public healthcare to all individuals. I argue a similar approach may be adopted in Sharia-abiding countries by employing *Takaful,*[887] which was outlined in Chapter Four.[888]

Another example is in the UK, where foreign-nationals with an outstanding debt of more than £1,000 for NHS treatment are to be denied entry to healthcare facilities.[889] Due to the link between the Home Office and the NHS, undocumented migrants do not present to healthcare facilities out of fear of disclosure and deportation.[890] I argue that these individuals are deprived of accessible healthcare, moreover, failure to treat the deprived and identify risks may put public health at risk, which is in contradiction to the aim of the NHS.[891]

---

[885] ibid; Lewis, et al, 'Are public-private partnerships a healthy option?' (2014) 113 *SSM* 110; Maceira, *Income Distribution and the Public-Private Mix in Health Care Provision: the Latin American Case* (IADB 1998); Yescombe, Public-private partnerships: principles of policy and finance. (Butterworts 2007)

[886] Busse, et al. 'Measuring, Monitoring, and Managing Quality in Germany's Hospitals' (2009) 28 *HA* 294; Clarke et al. *Healthcare Systems: Germany* (Civitas 2013); Müller et al, *Understanding the German Health care system,* (Mannheim Institute 2013); Tiemann 'Effects of ownership on hospital efficiency in Germany' (2009) 2 *BR* 115

[887] Abdul Aziz, 'Fulfillment of Maqasid al-Shari'ah via Takaful' (2013) 1 *International Policy Review*; Maysami, 'An analysis of Islamic Takaful Insurance: A Cooperative Insurance Mechanism' (1999) 18 Journal of Insurance Regulation 109; Nienhaus *Takaful Islamic Insurance: Concepts and Regulatory Issues* (John Wiley & Sons 2009); Syahida, 'Risk Management via Takaful from a perspective of Maqasid Alshariah' (2012) 65 *Social and Behavioral Sciences* 535

[888] Chapter Four Section 4.3.3

[889] ibid; Department of Health, '2012 Review of overseas visitors charging policy Summary Report' April 2012; Department of Health 'Guidance on overseas visitors hospital charging regulations' (2012) last updated 25 May 2018; National Audit Office 'Recovering the cost of NHS treatment for overseas visitors' (2016); National Health Service (NHS) 'The National Health Service (charges to overseas visitors) (amendment) regulations 2017', 19 July 2017

[890] ibid; Hunter, 'The Slow, lingering death of the English NHS' (2016) 5 IHPM 55; Home Office, 'Controlling Immigration Regulating migrant access to health services in the UK Results of the public consultation' 22 October 2013; Howe A. 'RCGP response to government consultation on 'Controlling Immigration Regulating Migrant Access to Health Services in the UK' 28 August 2013

[891] ibid; Goddard, et al., 'Equity of access to health care services: Theory and evidence from the UK' (2001) 53 *Social Science & Medicine* 1149; Hargreaves, et al ' Extending migrant charging into emergency services' (2016) 352 *BMJ;* Home Office, 'Controlling Immigration — Regulating migrant access to health services in the UK Results of the public consultation' 22 October 2013; Howe A. 'RCGP response to government consultation on 'Controlling Immigration – Regulating Migrant Access to Health Services in the UK' 28

From a Sharia perspective, I argue that compromised access to healthcare is contradictory to Sharia healthcare requirements, and such a scenario would put public health at risk, which is against the Sharia obligation to maintain *Maslahah* and protect *Maqasid AlSharia*.[892]

Nonetheless, as mentioned in Chapter Two,[893] examples of healthcare finance transfers from the state also exist in Islamic history.[894] For example, *Dar Al Shifa* were financed through *Waqf* (endowments),[895] or revenue generated from the ruler's personal expenses.[896] In both arrangements, the management and provision of hospitals were both governmental responsibilities; however, financing was not. I argue that the presence of examples of finance transfers from the public to the private sector in Islamic history, allows us to understand that arrangements of financial privatisation can be Sharia compliant if the same strategies are applied. For example, although the state was not financing *Dar Al Shifa*, it obliged these establishments to not charge or turn anyone away untreated regardless of race, religion, citizenship, gender, financial ability or age. Accordingly, if this were to be applied today, that would mean that it is the government's responsibility to ensure that all demographics of society have access to healthcare regardless of their financial ability. One method to achieve

---

August 2013; Smith, et al., 'Ethnic inequalities in health: a review of UK epidemiological evidence' (2000) 10 *CPH* 375

[892] AlMubarak, 'Applications of Maqasid al-Shari'ah and Maslahah in Islamic Banking practices: an analysis' at the International Seminar on Islamic Finance in Kochi, India 4 - 6 October 2010; Attieh, Towards Activating The Role of Maqasid AlShariah (Dar AlFikr 2001) [In Arabic]; Auda, *Maqasid Al-Shariah as Philosophy of Islamic Law: A Systems Approach* (The International Institute of Islamic Thought 2008); Laluddin, et al, 'The Relationship between Islamic Human Rights and the Maqasidic Approach' (2012) 7 *The Social Sciences* 111

[893] Chapter Two Section 2.3.1

[894] AlAnsari, Bimaristans and Waqf in Islam (PhD Thesis UOS 2013); Baer, 'The Waqf as a prop for the social system (16th-20th Centuries), (1997) 4 *JILS* 264; Leeuwen, Waqfs and Urban structures: The Case of Ottoman Damascus (BRILL 1999); Lindsay, Daily Life in the Medieval Islamic World (Greenwood 2005); Mehdi, et al. 'Medical care in Islamic tradition during the middle ages (historicl review)' (2013) 10 *LSJ*

[895] Where the hospital generated its own income

[896] ibid

this would be if the state established a *Takaful* based healthcare insurance system, similar to CHIS, where all financially able members of society contributed to. Another method for the government to ensure healthcare accessibility in financial privatisation is through the establishment of above-mentioned sick funds.

5.3.3 Corporatisation

An example of corporatisation is seen in the UK, where hospitals are granted trust status and operate as corporates within the realm of the NHS requirements.[897] Scholars in favour of privatisation argue that corporatisation, like decentralisation, allows the state to transfer management to local governments while focusing on other duties.[898] However, in decentralisation finances are not transferred to the local level but are allocated directly from the central government.[899] Thus, I argue that decentralisation and corporatisation with a high level of accountability to the central government could minimise bureaucracy and enhance availability and quality.

A. Availability

An analysis of the available literature discussing healthcare corporatisation in the UK demonstrates that services may vary between providers in different

[897] Dayan et al. *How good is the NHS?* (Nuffield Trust 2018); Enthoven, *Reflections of the management of the NHS.* London: (Nuffield & Provincial Hospitals Trust 1985); Peedell, 'NHS Reforms: Further Privatisation is inevitable' (2011) 342 *BMJ* 1112; Pollock, *NHS Plc: The Privatisation of Our Health Care* (Verso 2005)

[898] Falkenberg, 'How privatisation and corporatization affect healthcare employee's work climate, work attitudes and ill-health' (Thesis, Stockholm University 2010); Hellander, et al. *Bleeding the patient: the consequences of corporate health care.* (Common Courage Press 2001); Londono, et al. *Decentralization and Reforms in Health Services, The Colombian Case.* (The World Bank 1999); Saltman, et al., *Decentralisation in health care* (OUP 2007); Wynne, 'Hazards in corporatization of healthcare' (2004) 80 *New Doctor* 2

[899] ibid

areas, forming what is known as a postcode lottery, and that services may not be readily available to all.[900] Some scholars argue that the degree of accountability to the central government varies, which may lead to a variation in availability of the services provided between regions in decentralisation and corporatisation.[901] For example, Spain devolved political power within 17 regions in 1978. Each region had its own local health department and minister while the central government provided the common framework for healthcare.[902] Due to high level accountability to the central government, and regulation by the central government, Spain has eliminated differences in availability, accessibility, and quality of services between regions, and the Spanish healthcare system has ranked among the highest in the world, according to both the OECD and the WHO.[903]

Similar to the situation in full privatisations, when corporatizing healthcare, privately managed hospitals are able to employ and attract employees as private firms would in any sector;[904] therefore, the greatest number of and most

[900] Enthoven, *Reflections of the management of the NHS.* London: (Nuffield & Provincial Hospitals Trust 1985); Hunter, Change of government: one more big bang health care reform in England's National Health Service, (2011) 41 IJHS; May, et al 'Postcode lotteries in public health – the NHS health check programme in north west london' (2011) 11 *BMC Public Health* 738; Nicholas, et al 'Variations in the organization and delivery of the 'NHS health check' in primary care' (2013) 35 *JPH* 85; Peedell, 'NHS Reforms: Further Privatisation is inevitable' (2011) 342 *BMJ* 1112; Pollock, *NHS Plc: The Privatisation of Our Health Care* (Verso 2005)

[901] Bovbjerg, et al 'Privatisation and bidding in the health-care sector' (1987) 6 *JPAM* 648; Buchanan, 'Privatistaion and just healthcare' (1995) 9 *Bioethics* 220; Civaner, 'Transforming our health by privatistaion' (2011) 342 *BMJ* 723; Dixon-Warren, 'Privatisation of health care', (2009) 180 CMAJ 429

[902] Blendon et al. 'Spain's citizens assess their health care system' (1991) 10 *Health Affairs* 216; European Observatory on Health Systems . Health Care Systems in Transition: Spain. (WHO 2000); OECD Health Statistics 2014, How does Spain compare? (OECD 2014)

[903] ibid; Anderson, et al 'Culturally competent healthcare systems' (2003) 24 *AJPM* 68; WHO 'The World Health Report 2003: Shaping the Future' (2003); WHO 'Universal Healthcare Coverage (UHC)' Factsheet updated December 2016

[904] Falkenberg, 'How privatisation and corporatization affect healthcare employee's work climate, work attitudes and ill-health' (Thesis, Stockholm University 2010); Geyman, 'The corporate transformation of Medicine and its impact on costs and access to care' (2003) 16 *J Am Board Fam Med* 443; Hellander, et al. *Bleeding the patient: the consequences of corporate health care.* (Common Courage Press 2001); Wynne, 'Hazards in corporatization of healthcare' (2004) 80 *New Doctor* 2

skilled employees will be in the highest paying hospitals.[905] I argue that the differences in staff availability could affect the availability for patients at lower paying hospitals.[906] Consequently, the already existing urban-rural imbalance of healthcare services in Saudi Arabia would be further enhanced, as discussed by Almalki, Khaliq, Albejaidi, and Al-Borie,[907] resulting in less available healthcare in rural areas than urban areas, which is in contradiction to Sharia.[908] I argue that accountability and regulation by the government is essential to combat the urban-migration, as seen in the Spanish example.[909]

Corporations also generate some of their finances, and therefore are at risk of becoming somewhat profit-driven and forming a competitive market amongst them.[910] Although competition is one of the main arguments of those in favour of privatisation, it can be harmful if not contained and monitored, as mentioned previously in this chapter.[911] An example of this was seen in the UK, when acute hospital care services were privatised, leading to an initial increase in the

[905] ibid
[906] ibid
[907] Albejaidi, F. "Healthcare system in Saudi Arabia: An analysis of structure, total quality management and future challenges." (2010) 2 *Journal of Alternative Perspectives in the Social Sciences* 794; AlBorie et al 'A 'DIRE' needs orientation to Saudi health services leadership' (2013) 26 *Leadersh Health Serv*; Almalki et al. 'The healthcare system in Saudi Arabia: An overview' (2011) 7 *East Mediterr Health J* 784; Khaliq A., 'The Saudi Healthcare System: A View from the Minaret' (2012) 13 *World Health & Population* 52
[908] Jannadi, B., et al. "Current structure and future challenges for the healthcare system in Saudi Arabia." (2008) 3 *APJHM* 43; Jone, 'Challange to Saudi Arabian Hospitals?' (1984) 5 SMJ 1; Milaat, "Public health in the saudi health system: A search for new guardian." (2014) 2 SJMMS 77
[908] Allan, et al., 'Exploring the influence of income and geography on access to services for older adults in British Columbia: A multivariate analysis using the Canadian Community Health Survey (Cycle 3.1)' (2011) 30 *Canadian Journal on Aging* 69; Lamarche, et al., 'The experience of primary health care users: a rural-urban paradox' (2010) 15 *Canadian Journal Of Rural Medicine* 61; Manga, P. Privatization of health care services in Canada: Reform or regress? (1987) 10 Journal of Consumer Policy; Sibley, et al., 'An evaluation of access to health care services along the rural-urban continuum in Canada' (2011) 11 *BMC Health Serv Res* 20
[909] Blendon et al. 'Spain's citizens assess their health care system' (1991) 10 *Health Affairs* 216; European Observatory on Health Systems . Health Care Systems in Transition: Spain. (WHO 2000); OECD Health Statistics 2014, How does Spain compare? (OECD 2014)
[910] Bovbjerg, et al 'Privatisation and bidding in the health-care sector' (1987) 6 *JPAM* 648; Buchanan, 'Privatistaion and just healthcare' (1995) 9 *Bioethics* 220; Civaner, 'Transforming our health by privatistaion' (2011) 342 *BMJ* 723; Dixon-Warren, 'Privatisation of health care', (2009) 180 CMAJ 429
[911] Fielding, et al, Can managed competition solve the problems of market failure? (1993) *HA* 216; Goodman, et al. *The economics of health and health care* (Prentice-Hall, 2001); OECD, *OECD Economic Surveys: Luxembourg 2008* (OECD 2008)

resources and availability of the services;[912] however, the high competition between providers later led to closure of some units. [913] I argue that the closure of units affects the availability of services, which is in contradiction to Sharia.

B. Quality

To maintain trust status and continue as corporates, hospitals in the UK are required to maintain a level of high quality services, which in theory would mean that the quality of services provided would be enhanced.[914] However, the effect of corporatisation on the quality of services provided is dependent on the financial ability of the corporate entity and the budget allocated to it by the government.[915] Moreover, corporatisation has led UK hospitals to compete in the quality and types of treatments provided, a situation that was not present prior to corporatisation, when services were standardised by the NHS.[916] The competition was widely criticised when it became evident that some hospitals were offering free aesthetic treatments to their distressed patients while other hospitals in neighbouring areas were not.[917] The variation in services can be argued to be a tactic to increase the number of patients treated at a hospital or to allow the trust to demand a higher block allocation of funding from the

[912] Enthoven, *Reflections of the management of the NHS.* London: (Nuffield Trust 1985); Falkenberg, 'How privatisation and corporatization affect healthcare employee's work climate, work attitudes and ill-health' (Thesis, Stockholm University 2010); Hunter, 'The Slow, lingering death of the english NHS' (2016) 5 IJHPM 55; Wynne, 'Hazards in corporatization of healthcare' (2004) 80 *ND* 2
[913] ibid
[914] ibid
[915] ibid; Falkenberg, 'How privatisation and corporatization affect healthcare employee's work climate, work attitudes and ill-health' (Thesis, Stockholm University 2010); Smith, et al. 'Political and economic aspects of the transition to universal health coverage' (2012) 380 *Lancet* 924; Yasin, et al. 'Universal Coverage in an era of privatisation: can we guarantee health for all?' (2012) 12 BMC Public Health
[916] ibid
[917] Henderson, 'The plastic surgery postcode lottery in England' (2009) 7 *IJS* 550; May, et al 'Postcode lotteries in public health – the NHS health check programme in north west london' (2011) 11 *BMC Public Health* 738

NHS.[918] Furthermore, an increase in patient numbers and patient satisfaction allows a hospital to declare trust status, which gives the hospital further liberty in their finances, along with the liberties provided by corporatisation.[919]

This competition explains why the privatisation experience was more successful in Spain than in the UK, since Spain's central government eliminated the formation of the postcode lottery and differences in availability by determining the provision of healthcare services across the country. [920] However, it is essential to note that not all competition is harmful in privatisation. A beneficial competition between providers formed to attract patients is possible through lowering prices, which could benefit both the patients and government.[921] Better quality of services and increased financial availability are both requirements of healthcare in Sharia.

The privatisation experience in the UK has not been entirely a negative experience; one benefit of the corporatisation is the separation of powers.[922] As of April 2013, a new structure was established:[923] the Department of Health is now responsible for both the health and social care systems, and NHS England

---

[918] ibid

[919] Lyon, et al 'Surviving Out of Hospital Cardiac Arrest at Home: a Postcode Lottery?' (2004) 21 *EMJ* 619; May, et al 'Postcode lotteries in public health the NHS health check programme in north west london' (2011) 11 *BMC* 738; Nicholas, et al 'Variations in the organization and delivery of the 'NHS health check' in primary care' (2013) 35 *JPH* 85; Shapps, 'All your eggs in one basket. A comprehensive study into the continuing postcode lottery in IVF provision through the NHS' 6 August 2009

[920] ibid; Fielding, et al. 'Can managed competition solve the problems of market failure?' (1993) *HA* 216; Karlaftis, 'Privatisation, regulation and competition: A thirty-year retrospective on transit efficiency' (2008) *ITF* 67; Vargas, et al., 'Barriers of access to care in a managed competition model: lessons from Colombia' (2010) 10 *BMC* 297; Zigante, 'Consumer choice, competition and privatisation in European health and long term care systems: Subjective well being effects and equity implications' (PhD Thesis, The London School of Economics and Political Science 2013)

[921] ibid

[922] Daily Telegraph, Biggest Revolution in the NHS for 60 years, 9 July 2010; Francis R. Robert Francis inquiry report into Mid-Staffordshire NHS Foundation Trust; Hunter, 'Change of government: one more big bang health care reform in England's National Health Service' (2011) 41 IJHS 159; Peedell, 'NHS Reforms: Further Privatisation is inevitable' (2011) 342 *BMJ* 1112

[923] ibid

is now a separate independent body whose main role is improving the quality of care and health outcomes of patients.[924] The NHS aims to achieve this through allocating resources, commissioning services, and overseeing its inferior establishments, such as Clinical Commissioning Groups.[925] The guidelines of treatment and data are both provided by the National Institute for Health and Clinical Excellence (NICE) and the Care Quality Commission (CQC), respectively.[926] These new institutes work to eliminate the differences in quality between corporate hospitals.[927] I argue that in theory, the separation of powers appears to serve its purpose of improving efficiency and ensuring quality and availability of healthcare. All these theoretical outcomes are in accordance to the Sharia healthcare requirements.

5.3.4 Outsourcing

The private sector in Great Britain is seen by the government as supplementing, rather than supplanting, the NHS for both technical and political reasons.[928] Private organisations are increasingly performing public health functions, such as medical imaging and primary care services, since public healthcare agencies are entering into partnerships or are contracting out certain services to balance the services they can provide to the public.[929] The outsourcing of service

[924] ibid
[925] ibid
[926] ibid; Kelley, et al. "Health care quality indicators project." *OECD Health Working Papers*, No. 23 (OECD Publishing 2006); OECD Health Care Quality Framework, OECD Health Working Paper No. 23, March 2006
[927] ibid
[928] Mohan, J. 'Rolling back the state?: Privatization of health services under the Thatcher governments' in Scarpaci, *Health Services Privatization in Industrial Societies* (Rutgers University Press 1989); Peedell, 'NHS Reforms: Further Privatisation is inevitable' (2011) 342 *BMJ* 1112
[929] ibid

provision within the NHS in the UK continues to include diagnostic services, blood transfusion services, and out-of-hours GP services.[930]

A. Availability

An analysis of the available literature discussing the outsourcing of these services in the UK demonstrates that the outsourced services are available to all.[931] I argue that increasing providers by outsourcing also allows services to be readily delivered and reduces waiting times, which further enhances the availability of healthcare for individuals and is in the patients' best interest. The availability of providers and services are all part of the healthcare requirements in Sharia and contribute to the protection of *Maqasid AlSharia* and *Maslahah*. Nonetheless, it is important to be aware that available healthcare does not necessarily ensure it is of quality.

B. Quality

A study by Keane found that 73% of 347 local health departments had contracted out at least one public health service to a private organisation between 1998 and 1999.[932] Recent figures also show a similar trend and greater competition between private providers.[933] According to the Department of

[930] ibid; Nicholas, et al 'Variations in the organization and delivery of the 'NHS health check' in primary care' (2013) 35 *JPH* 85; Peedell, 'NHS Reforms: Further Privatisation is inevitable' (2011) 342 *BMJ* 1112; Pollock, *NHS Plc: The Privatisation of Our Health Care* (Verso 2005)
[931] ibid; Johns, et al 'Selective contracting in California: Experience in the second year' (1985) 22 Inquiry 335; Mills, 'To contract or not to contract? Issues for low and middle-income countries' (1998) 13 *HPP* 32; Rohrer, Performance contracting for public health: the potential and the implications. (2004) 10 *JPHMP* 23; Schmidt, 'The costs and benefits of privatisation: an incomplete contracts approach' (1996) 12 *JLEO* 1
[932] Keane, et al. 'Privatisation and the scope of public health: a national survey of local health department directors' (2001) 91 *AJPH* 611
[933] Joha et al., 'Public-private partnerships, outsourcing or shared service centres?: Motives and intents for selecting sourcing configurations' (2010) 4 *Transforming Government: People, Process and Policy* 232; Zain, et al. "Isnt it now a crucial time for Saudi Arabian firms to be more innovative and competitive?' (2017) 21

Health, the proportion of the overall NHS budget spent on private healthcare providers tripled to 6.1% in 2013–2014.[934] In doing so, local health departments focused on technical factors and increased capacity and expertise due to high accountability and regulation to the NHS.[935] I argue that increasing expertise through outsourcing allows hospitals to provide services of better quality, which is in favour of the protection of *Maqasid AlSharia* and *Maslahah*.

As part of my analysis of Islamic history, as mentioned in Chapter Four,[936] I have come across transfers of service provision that resemble outsourcing,[937] such as when the prophet transferred the provision of services from the state to Rufaidah AlAslamiyah, the first female Muslim nurse and surgeon.[938] I argue that outsourcing the provision of health services to Rufaidah enhanced the availability of services and quality.[939] As mentioned in the previous chapter, by adopting *Qiyas*, the outsourcing of healthcare services is compliant with Sharia.

Nonetheless, the transfer from the public to the private sector in healthcare is subject to several challenges.[940] In the case of privatisation due to lack of

---

International Journal of Innovation Management 1750021; Zigante, 'Consumer choice, competition and privatisation in European health and long term care systems: Subjective well being effects and equity implications' (PhD Thesis, The London School of Economics and Political Science 2013)

[934] House of Commons. Health services: private sector: written question—21844. 2014.; House of Commons. NHS: private sector health. 2011; Naylor ,et al. Briefing: Independent sector treatment centres. King's Fund 2009

[935] Enthoven, *Reflections o f the management of the NHS.* London: (Nuffield Trust 1985); Keane, et al. 'Services privatized in local health departments: a national survey of practices and perspectives' (2002) 92 *AJPH* 1250; Peedell, 'NHS Reforms: Further Privatisation is inevitable' (2011) 342 *BMJ* 1112; Pollock, *NHS Plc: The Privatisation of Our Health Care* (Verso 2005)

[936] Chapter Four Section 4.2.1.2

[937] AlKatani, *The Prophetic Government: Administrative Formalities* (AlArqam 2008) [In Arabic]; Ferngren, *Medicine and Religion: A Historical Introduction* (JHUP 2014); Hamidullah, *The Prophet's establishing a state and his succession,* (NHC 1988); Watt, *Muhammad at Medina* (OUP 1956)

[938] ibid

[939] ibid

[940] Akinci, 'Privatisation in Healthcare: Theoretical Considerations and Real Outcomes' (2002) 3 *JEER* 62; Avery, 'Outsourcing Public Health Laboratory Services: A Blueprint for determining whether to provatise and how' (2002) 60 *PAR;* Johaet al., 'Public-private partnerships, outsourcing or shared service centres?:

finances, the transaction costs of contracting out services may outweigh and exceed potential gains.[941] Furthermore, shared arrangements may be difficult to operate in practice in the case of privatisation due to lack of capacity and expertise, which will further effect the ability to deliver services.[942] Therefore, when privatising healthcare, it is essential to identify the reason for privatisation and its potential gain to ensure that healthcare services are non-diminishable and non-excludable, as required.

5.4 Expansion of Cooperative Health Insurance in Saudi Arabia

As mentioned in Chapter One,[943] the Cooperative Health Insurance Act (CHI Act) passed by the Saudi government was initially aimed at non-Saudi residents.[944] Due to its perceived success, CHIS was expanded in 2002 to include Saudis working in the private sector and ensure availability to all residents.[945] The act made health insurance compulsory for non-Saudi residents and Saudis working in the private sector, where the employer is obliged to pay the premium on behalf of the employee.[946]

The act was in response to the rise in the number of expatriates in Saudi Arabia who the MOH was no longer able to accommodate and provide free healthcare

Motives and intents for selecting sourcing configurations' (2010) 4 *TGPPP* 232; Keane, Perceived outcomes of public health privatisation: a national survey of local health department directors. (2001) 79 *Milbank Q* 115; WHO, Everybody's business. Strengthening health systems to improve health outcomes: WHO's framework for action, 2007

[941] ibid

[942] ibid

[943] Chapter One Section 1.10.9

[944] Implementing Regulations of the Cooperative Health Insurance Law in the Kingdom of Saudi Arabia (Amended) Cooperative Council for Health Insurance, Session 73 Ministerial Decision DH/1/30/6131 (2009) ; Rules of Implementation of Cooperative Health Insurance System & Cooperative Health Policy, Ministry of Health Resolution 460/23/DH (2002)

[945] ibid

[946] ibid

for, as was initially intended by the Saudi government.[947] Its expansion to include Saudis was because healthcare in Saudi Arabia was still not available to all.[948] Saudis working in the private sector at the time were not affiliated with an employer hospital like Saudis working in the public sector and Aramco, who sought free healthcare at their employers' hospitals, such as the National Guard and Aramco hospitals.[949] To fulfil the Sharia obligation upon the government to supervise, the CHI Act also established the Cooperative Council for Health Insurance to oversee the implementation of the Act, and assigned supervision of the insurance law implementation to both the MOH, to monitor services provided, and the Saudi Arabian Monetary Agency (SAMA), to guarantee insurance companies satisfied the conditions and rules.[950]

After understanding the models of privatisation in healthcare and determining which models are compliant with Sharia, I argue that similarities can be drawn to Islamic insurance (*Takaful)*. Based on the findings of this thesis thus far, I argue that *Takaful*, as envisaged in the Saudi Cooperative Insurance Act, strongly resembles healthcare financial privatisation. Both systems consist of a healthcare finance transfer from the public sector and rely on premium

[947]AbdulGhafour, 'CCHI Set to Extend Health Insurance to Aged' Arab News, 23 February 2007; AlMobarak, 'Beneficiaries' Satisfaction with the Cooperative Health Insurance System (CHIS) in the Kingdom of Saudi Arabia: A Case Study of Riyadh City' (PhD Thesis, University of Hull 2010); Cooperative Health Insurance System Booklet (CHISB) (1999) Riyadh, Saudi Arabia: The council of Cooperative Health Insurance; Country cooperation strategy for WHO and Saudi Arabia 2006–32. 2011. Cairo, World Health Organization Regional Office for the Eastern Mediterranean, 2007

[948] ibid

[949] ibid; Rules of Implementation of Cooperative Health Insurance System & Cooperative Health Policy, Ministry of Health Resolution 460/23/DH (2002)

[950] ibid; Implementing Regulations of the Cooperative Health Insurance Law in the Kingdom of Saudi Arabia (Amended) Cooperative Council for Health Insurance, Session 73 Ministerial Decision DH/1/30/6131 (2009); Ram, "Management of Healthcare in the Gulf Cooperation Council countries with special reference to Saudi Arabia." (2014) 4 *IJARBSS* 24; Rules of Implementation of Cooperative Health Insurance System & Cooperative Health Policy, Ministry of Health Resolution 460/23/DH (2002)

payments.[951] The difference is that conventional insurance is adopted in financial healthcare privatisation, while *Takaful* is applied in the cooperative healthcare system. I argue that both systems allow governments to cut costs and are supervised by a separate body to ensure availability, quality, accessibility, and affordability of healthcare services. Furthermore, both systems are compliant with Sharia healthcare requirements.[952]

5.5 Conclusion

The concerns of implementing forms of privatisation in the healthcare sector relate to ensuring Sharia healthcare requirements of accessibility, availability, affordability, and quality of healthcare services. In this chapter, I have identified models of healthcare privatisation that can be considered Sharia compliant. The chapter's findings are based on evidence from non-Sharia bodies of literature that discuss the problems with privatisation in healthcare and I have then analysed these effects on the Sharia healthcare requirements. I argue that models that, according to non-Sharia literature, do not adversely affect the availability, accessibility, affordability, and quality of healthcare are compliant with Sharia.

Based on the evidence, healthcare in full privatisations and financial privatisations only meets the four Sharia requirements for paying and insured

[951] AbdulAziz, 'Fulfillment of Maqasid al-Shari'ah via Takaful' (2013) 1 *IPR*; Abdullah, 'Risk Management via Takaful from a Perspective of Maqasid of Shari'ah' (2012) 65 *SBS* 535; Akinci, 'Privatisation in Healthcare: Theoretical Considerations and Real Outcomes' (2002) 3 *JEER* 62; Akinci, 'The Role of Privatisation in Healthcare Services' (2000) 3 *AEEE* 14; AlKhamis, Privatisation of health services: a necessity or a luxury? AlEqtisadiah, 21 July 2015 [In Arabic]; Syahida, 'Risk Management via Takaful from a perspective of Maqasid Alshariah' (2012) 65 *SBS* 535

[952] ibid

patients, leaving the less fortunate at risk. Consequently, I have concluded that both healthcare finance privatisation and full privatisation of healthcare are not compliant with Sharia. However, to eliminate this discrimination, I argue that the state may safeguard the right to available and accessible healthcare for the financially unfortunate by offering them free or subsidised healthcare, similar to the German government's sick funds,[953] and expansion of the Saudi CHIS to include Saudis working in the private sector.[954] The financing scheme must be Sharia compliant or from within Sharia, such as *Zakat* or *Takaful,* and be subject to supervision by the public sector and high accountability to the government to avoid failures, which is a Sharia obligation upon the state. Subsequently, I argue that both healthcare finance privatisation and the full privatisation of healthcare are compliant with Sharia when coupled with 'sick funds' from the government and regulation. It is essential to highlight that the second step of the 2030VFH is a full privatisation with an NHI system to provide financial support for individuals who are in need of it. Accordingly if the NHI system is arranged in a Sharia compliant manner and the Saudi government is able to efficiently monitor the services, the 2030VFH will be Sharia compliant. An important factor for Sharia compliance of the NHI is that premiums are based on the ability of the patient to pay.

By drawing upon the findings of this chapter and the previous one, as well as the understanding of *Takaful*, I was able to draw the following similarities

[953] Clarke et al. *Healthcare Systems: Germany* (Civitas 2013); Müller et al, *Understanding the German Health care system,* (Mannheim Institute 2013)
[954] Implementing Regulations of the Cooperative Health Insurance Law in the Kingdom of Saudi Arabia (Amended) Cooperative Council for Health Insurance, Session 73 Ministerial Decision DH/1/30/6131 (2009) ; Rules of Implementation of Cooperative Health Insurance System & Cooperative Health Policy, Ministry of Health Resolution 460/23/DH (2002)

between financial privatisation and cooperative health insurance. Both systems allow governments to cut costs by transferring healthcare finance to premium payments. As conventional insurance is considered by some to be against Sharia, *Takaful* substitutes insurance premiums found in financial privatisation. Moreover, both systems are supervised by separate bodies to ensure the availability, quality, accessibility, and affordability of healthcare services.

As for corporatisation, according to non-Sharia literature, healthcare availability was affected as a result of uncontrolled competition between corporate hospitals. Fulfilling the government's Sharia obligation to regulate the private sector is essential for controlling competition between entities and ensuring healthcare availability. Therefore, I argue that healthcare corporatisation is compliant with Sharia in theory, if the regulation is efficiently fulfilled and the accessibility and availability of essential services to all is ensured. Accordingly, the first step of the 2030VFH will be Sharia compliant.

With regard to outsourcing, the literature demonstrates that the availability and accessibility of services is enhanced. Moreover, when coupled with regulated competition and high accountability to the government, outsourcing can allow hospitals to better the quality of the services they provide and also those by contracted private organisations. Therefore, I argue that outsourcing has increased the availability, accessibility, and quality of services and is compliant with Sharia.

It is evident from the findings of this chapter that governments can have a role

in improving market efficiency in cases where competitive markets tend to fail. Therefore, government intervention in the healthcare industry is generally justified on the basis of some form of market failure. Regulated competition ensures results in favour of both the patient and the government, such as lower service prices and better quality services. Many scholars, such as Young, encourage countries to develop health policies that favour maintaining an appropriate mix between competition and regulation.[955] This combination allows lower prices and better quality service through a mixture of less radical forms of privatisation, rather than moving toward a completely unregulated healthcare system by implementing denationalisation.[956] In short, it is the public-private partnership, rather than the total elimination of the government's role, that has the greatest potential amongst privatisation models to achieve the aims of cost cutting and improve services in the healthcare system. Since each country has a unique set of resources to support health services as well as organisation and delivery systems to provide care, each country must design and manage its own partnership between the public and the private sector, such as following a financial privatisation model. It is essential to note that there are other policies that are more ethical and could present better solutions, however in this thesis the focus is privatisation during financial crisis when these other solutions are not possible.

[955] Kahn, et al., *Privatisation and the welfare state* (Princeton University Press 2014);Young et al, *Guidance for Good Governance: Explorations in Qur'anic, Scientific and Cross-cultural Approaches* (IIUM Press 2008); Young, 'Privatizing health care' (1990) 5 *International Journal of Health Planning and Management* 237

[956] Manga, 'Privatisation of health care services in Canada: Reform or regress?' (1987) 10 *JCP* 1; Sibley, et al., 'An evaluation of access to health care services along the rural-urban continuum in Canada' (2011) 11 *BMC HSR* 20; Smith, *Decentralization: the territorial dimension of the state* (Allen 1985); Wolman, 'Decentralization: what it is and why we should care' in Bennett, *Decentralization, local governments, and markets: towards a post-welfare agenda* (Clarendon 1990)

In this chapter, I critiqued some of the proposed methods of financing in Sharia scholarship and argued against the practicality of financing healthcare systems through *Sadaqah* and *Zakat* alone. I argued that prevention of harm is of dynamic importance in Sharia law and is part of the obligation of protection of *Maqasid AlSharia*. So, I argued that the basic concept of prevention of harm in insurance is acceptable in Sharia. Nonetheless, the method of insurance's implementation is still a matter of concern, as conventional insurance contains elements of *Riba, Gharar* and *Qimar*, which are not compliant with Sharia regulations. I concluded that *Takaful* provides a way to manage risks according to Sharia principles and, unlike conventional insurance, does not contain elements contrary to Sharia. Finally, based on the understanding that Sharia law allows a form of Islamic insurance through *Takaful*, as envisaged in the Saudi CHIS, I anticipate that some models of privatisation could be arranged and adopted in a Sharia compliant manner. This view will be discussed further in the next chapter.

Chapter Six Conclusion

6.1 Introduction

The main aim of this thesis has been to assess if healthcare can be privatised while maintaining compliance with Sharia. The assessment was essential due to the announcement of 2030VFH and scholars' persistent calls for privatisation in light of the stated need to cut costs.[957] This thesis has found that some models of privatisation were not compliant with both Sharia and Saudi law, while other models of privatisation allowed governments to fulfil their obligations in the context of healthcare provision.

Several themes have emerged from the main analysis. As the thesis was focused on privatisation in healthcare, there was a need to discover what healthcare provision means in Sharia and Saudi law. Furthermore, as Sharia scholars argued that privatisation prevented governments from fulfilling their obligations enshrined in Sharia,[958] it was essential to identify governmental obligations within the context of healthcare. Moreover, as it was concluded that Sharia imposed obligations and requirements on governments in the context of healthcare provision, it was vital to assess if Sharia scholars were correct in their opinion against privatisation according to their definition or if that model can be considered Sharia compliant. Additionally, as there are different forms of

[957] 'Transforming Saudi Arabia: National Transformation Program 2020 Approve' Shearman and Sterling, 14 June 2016; Almashabi, et al., 'Saudi Arabia's Deputy Crown Prince Outlines Plans: Transcript.' Bloomberg, 4 April 2016; Jadwa, Saudi Vision 2030, May 2016; Reed, Saudi Vision 2030: Winners and Losers (Canergie 2016); Saudi Gazette, Full text of Saudi Arabia's Vision 2030, April 2016

[958] Ali, Privatisation (AlAhram 1996) [in Arabic]; Eissa, Privatisation and a Diversified Economy (AlMuntalaq 1996) [In Arabic]; Saba, Privatisation and a Weak and Absent Public Sector (AlMawqif 1994) [In Arabic]

privatisation in healthcare,[959] it was vital to explore whether the Sharia scholars' opinions against privatisation could be considered as being against all forms of privatisation in healthcare or specific to the model identified in their definition. Finally, as the thesis is focused on 2030VFH and Saudi healthcare, it was essential to focus on the models of privatisation which fulfilled the aim of 2030VFH, and to identify existing problems with Saudi healthcare that could be exacerbated with the plan to privatise.

6.2 Summary of Research Findings

The assessment presented in this thesis has resulted in several findings, the first being that the Sharia scholarship was limited and based on a misinterpretation of privatisation. Unfortunately, Sharia scholars depended on their personal translations of the definition of privatisation, and accordingly their analysis was fixated on one translation. This thesis found the translation to be incorrect in comparison to non-Sharia literature definitions which specify the private sector,[960] while Sharia scholars such as Eissa and Saba specified a transfer to the private personal possession which is different from the private sector in Sharia and consequently is a definition of deregulation rather than privatisation.[961] Accordingly, the Sharia scholars are justified in their opinion

[959] Hemming, et al. Privatisation and Public Enterprises (IMF 1988); Kemp, Privatisation: The Provision of Public services by the Private Sector (McFarland 2007); Saal, et al. International Handbook on Privatisation (Elgar 2003)

[960] Béchamps et al. *Privatization and public health: a report of initiatives and early lessons learned.* (Public Health Foundation 1999); Berer, 'Privatisation in health system in developing countries: whats in a name?' (2011) 19 *Reproductive Health Matters* 4; Bienen, et al. 'The political economy of privatisation in developing countries' (1989) 17 *World Development* 617

[961] AlObaidi, *The Three Ownerships: A study about Private public ownership, Private personal ownership, and Governmental public ownership in the Islamic Economical Syste*] (Islamic Affairs 2009); Eissa, *Privatisation and a Diversified Economy* (AlMuntalaq 1996) [In Arabic]; Saba, *Privatization and a Weak and Absent Public Sector* (AlMawqif 1994) [In Arabic]

against the model identified in their definition due to ownership laws in Sharia,[962] as the government would not be able to monitor the privatised entity and ensure *Maslahah* is maintained and *Maqasid AlSharia* is protected as required in Sharia. However, as a result of the Sharia scholars' misinterpretation, several decades have passed without any scholars revisiting the Sharia opinion of privatisation or including a wider selection of resources and practical evidence of the implementation of models of privatisation.

Second, this thesis concluded that government obligations can be derived by adopting the three-stage method developed in this thesis, *Maslahah, Maqasid AlSharia,* and *Huquq,* as the traditional method has proven to be insufficient. In the case of healthcare, I have concluded that healthcare provision is an obligation on the government in both Sharia and Saudi law and is required to be available, acceptable, accessible and of quality to all. Determining the requirements of the obligation allowed this thesis to assess for their fulfilment, which is a direct indication of the Sharia compliance of healthcare provision. Accordingly, these requirements were utilised as a benchmark when assessing the Saudi healthcare system and models of privatisation for Sharia compliance.

Third, based on the scholarship discussing the state of healthcare in Saudi Arabia today,[963] it was concluded that Saudi healthcare is not compliant with

[962] AlMaamiry *Private Personal Ownership and its limitations in Islam* (Lancer Books 1987); AlObaidi, The Three Ownerships: A study about Private public ownership, Private personal ownership, and Governmental public ownership in the Islamic Economical System (Islamic Affairs 2009); Taleqani, *Islam and Ownership* (Lexington 1983)

[963] Khaliq A., 'The Saudi Healthcare System: A View from the Minaret' (2012) 13 *World Health & Population* 52; Milaat, "Public health in the saudi health system: A search for new guardian." (2014) 2 Saudi Journal of Medicine and Medical Sciences 77; Ram, P. "New Strategic Initiatives-A Case Study of the Saudi Health Ministry" (2014) 3 *International Journal of Academic Research in Economics and Management Sciences* 236

the Sharia healthcare provision requirements or Saudi law, and does not adhere to the healthcare related international conventions that Saudi Arabia has signed and ratified. Due to the high demand on healthcare and the noncompliance of healthcare provision to Sharia and Saudi laws, it was concluded that the state of healthcare provision in Saudi Arabia demonstrates a state of need according to Sharia which constitutes a necessity for change and remedy. The main factors that led to the noncompliance of Saudi healthcare provision to Sharia are the existing discriminations due to the geographical distribution of healthcare workers, and shortage of staff.[964] The necessity for improvement stems from the fact that the reasons for incompliance may continue or be amplified when healthcare is privatised. Therefore, it is essential to ensure that the policies implemented are effectively encompassing both the aim of cost cutting and the legal requirement of ensuring equity and quality of the services provided. Understanding that these problems compromise healthcare provision and yet noting the MOH has not corrected them, illuminates the need for recommendations to overcome them and effective monitoring mechanisms which are essential with the upcoming privatisations.

Fourth, by reflecting on the examples in Islamic history literature this thesis was able to identify examples of transfers of provision and finance.[965] In light of

[964] Albejaidi, F. "Healthcare system in Saudi Arabia: An analysis of structure, total quality management and future challenges." (2010) 2 *Journal of Alternative Perspectives in the Social Sciences* 794; AlFaqeeh, 'Acess and utilization of primary health care services in Riyadh province, Kingdom of Saudi Arabia' (University of Bedfordshire PhD Thesis 2015); Aljuaid, et al. "Quality of care in university hospitals in Saudi Arabia: a systematic review." (2016) 6 *BMJ open* e008988; Walker, "The Right to Health and Access to Health Care in Saudi Arabia with a Particular Focus on the Women and Migrants" in Toebes, et al. *The Right to Health: a multi-country study of law, policy and practice* (Asser Press 2014); Yusuf, N. "Private and public healthcare in Saudi Arabia: future challenges." (2014).2 *International Journal of Business and Economic Development*

[965] Ahmad, 'Economic Development in Islamic Perspective Revisited' (2000) 9 *RIE* 83; Ahmad, *Studies in Islamic Economics* (TIF 1980); AlKatani, *The Prophetic Government: Administrative Formalities* (Dar AlArqam 2008) [In Arabic]; Ferngren, *Medicine and Religion: A Historical Introduction* (JHUP 2014);

the lack of laws that explicitly forbid transfers of provision and finance in Sharia and Saudi law, it was concluded that transfers of finance or provision through some forms of privatisation and *Takaful* are lawful in Sharia and Saudi law. Accordingly, and by adopting the typology that this thesis has developed, I have concluded that the forms of healthcare privatisation compliant with Sharia healthcare requirements and Saudi law are outsourcing, decentralisation, financial privatisation and corporatisation. However, government supervision is essential to ensure continued compliance. Furthermore, full privatisations can become Sharia compliant if they are coupled with vigorous governmental supervision to eliminate any discrimination or quality and a form of finance to include all demographics of the society regardless of their financial ability. Although governmental supervision is a Sharia obligation of governments, government adherence is uncertain especially with the examples of urban migrations and differences in healthcare provision between regions. [966] Therefore, the compliance of privatisation with Sharia and Saudi law is at risk and it is essential for the government to establish a network of governmental and independent bodies to monitor and regulate the healthcare sector to ensure its compliance with the law especially with the planned privatisation in light of the announcement of 2030VFH.

Hamidullah, *The Prophet's establishing a state and his succession,* (NHC 1988); Mahmood, The Reference of The Arab Islamic Civilisation (AlSalasil 1984) [In Arabic]; Ragab, 'Islam and Development' (2002) 8 *JWD* 513; Watt, *Muhammad at Medina* (OUP 1956)

[966] AlKatani, The Prophetic Government: Administrative Formalities (Dar AlArqam 2008) [In Arabic]; Asad, *The Principles of State and Government in Islam,* (Berkeley 1961); Crone, *God's Rule: Government and Islam,* (CUP 2005); Kamali, '*Siyāsah shar'īyah* or the Policies of Islamic Government' (1989) 6 *The American Journal of Islamic Social Sciences* 60

The fifth finding is that although Sharia scholars such as AlFadhil are against insurance,[967] this thesis found that the objectives of insurance are beneficial and encouraged in Sharia. Nonetheless, Sharia scholars have not revisited insurance since the First International Conference on Islamic Economics in 1976.[968] Through showcasing the resemblance between the objectives of *Takaful* and conventional insurance, this thesis highlighted the fact that resemblance can be found between Sharia products and products of modern life. The resemblance led this thesis to propose implementing *Takaful* based insurance, similar to CHIS, to compliment the implementation of financial privatisation as opposed to conventional insurance.

The sixth finding is that the 2030VFH is Sharia compliant if it is accompanied by vigorous regulation by governmental and independent bodies to ensure the requirements are fulfilled and the whole population has available, accessible, affordable healthcare of quality with no discrimination. However, the 2030VFH does not state detailed steps that will be taken to execute the plan to privatise in accordance to NTP2020 and 2030VFH.[969] Therefore, more transparency and clarity is required to effectively assess the plans and ensure they will enhance the availability, accessibility, affordability and quality of healthcare as required by Sharia, Saudi law, and international conventions ratified and signed by Saudi Arabia. Moreover, the 2030VFH does not address the current problems facing

[967] AlFadhil, *Healthcare Insurance in Sharia and Law* (Masters Thesis, Islamic University of Madinah 2012) [In Arabic]
[968] The first International Conference on Islamic Economics held in Makkah, Saudi Arabia February 21-26, 1976
[969] 'Transforming Saudi Arabia: National Transofrmation Program 2020 Approve' Shearman and Sterling, 14 June 2016; AlDakheel, 'An opinion on the 2030 Vision: A Critical Analytical Reading' *Riyadh* 2016 [in Arabic]; Almashabi, et al., 'Saudi Arabia's Deputy Crown Prince Outlines Plans: Transcript.' *Bloomberg*, 4 April 2016

the Saudi healthcare system or set plans to overcome them.[970] Accordingly, this thesis has found that to achieve compliance with the Sharia and Saudi healthcare provision requirements it is essential for the Saudi government to first attend to the existing problem of urban-migration which is currently compromising the availability and accessibility of healthcare.

6.3 Relationship with Previous Research

This thesis combines different topics and distinctive bodies of literature, namely Sharia, Islamic history, Saudi law, Saudi healthcare, healthcare in Sharia and healthcare privatisation scholarship. In this thesis, I have built upon previous research, challenged arguments and scholars' opinions, drawn analogies and formed links between these distinct fields. In this section, I discuss how this thesis relates to previous research.

As a starting point, it was essential to identify the Sharia obligations of the government in the context of healthcare. Accordingly, this thesis has built upon information within Sharia healthcare, and Sharia and Islamic History literature. I have concluded that direct orders and statements related to healthcare made by the Prophet in the Hadeeth, such as 'Seek cure',[971] could only be fulfilled if the means of seeking cure were made available and accessible to all individuals with no discrimination. Furthermore, I have concluded that the inclusiveness of

[970] *'Boxed In: Women and Saudi Arabia's Male Guardianship System'* (Human Rights Watch 2016); Abu Aisha, 'Women in Saudi Arabia: do they have the right to give their own consent for medical procedures?' (1985) 6 *Saudi medical journal* 74; Mughal, et al., 'Urban growth management-the Saudi experience' (2004) 28 *Habitat International* 609; Safi, "The Challenges For Saudi Arabia Health Care System." (2016) 6 *Indian Journal of Applied Research*

[971] Sahih Bukhari 1:149

all individuals is essential to ensure the effectiveness of the healthcare provided, especially with regards to the effectiveness of vaccinations and controlling contagious diseases.[972] It is important to note that the inclusiveness with no discrimination was also demonstrated by the Prophet and was followed by his successors as stated in Islamic History literature namely the work of AlGhazali, Deuraseh, and Rahman.[973] The examples presented by these scholars allowed me to deduce the practice Sharia obliges states to adhere to. For example, I have concluded that Sharia obliges states to ensure healthcare is provided by skilful knowledgeable individuals. This conclusion can also be reached by acknowledging that the basis of healthcare provision in Sharia is the protection of life,[974] which is one of the *Maqasid* AlSharia and can only be achieved through healthcare that is of quality, and is available, affordable, and accessible by all with no discrimination. Accordingly, by drawing conclusions from these bodies of literature, this thesis was able to add to the existing literature and identify the benchmark for Sharia compliance of healthcare provision against which models of privatisation were checklisted.

Consequently, this thesis argues that the term Sharia compliance is not specific to finance. Traditionally, finance scholars such as Azmat defined Sharia compliance strictly from a finance perspective.[975] The misconception was enhanced given the fact that Sharia literature has focused for many years on

[972] Ferngren, *Medicine and Religion: A Historical Introduction* (JHUP 2014); Kamali, *Equity and Fairness in Islam* (ITS 2005); Kamali, *Right to Education, Work and Welfare in Islam* (ITS 2010); Nagamia, 'Islamic Medicine History and Current Practice' (2003) 2 *JISHIM* 19

[973] Deuraseh, 'Health and Medicine in the Islamic Tradition based on the Book of Medicine (Kitab AlTibb) of Sahih Bukhari' (2006) 5 *JISHIM* 2; Rahman, *Health and Medicine in the Islamic Tradition* (ABC 1998) ; Zayd, AlGhazali on Divine Predicates and their Properties (Ashraf 1970) [in Arabic]

[974] ibid

[975] Azmat et al., 'The Sharia Compliance Challenge in Islamic Bond Markets' (2014) 28 PBFJ 47; Ibrahim, 'Issues in Islamic banning and finance: Islamic banks, Sharia compliant investment and sukuk' (2015) 34 PBFJ 185

Islamic finance, unlike other topics in Sharia. Therefore, compliance was dubbed a finance term due to its wide use despite the fact that it applies to all matters that would need to undergo a Sharia compliance test to ensure adherence to Sharia requirements.[976] Accordingly, by adopting a method to assess Sharia compliance of healthcare provision, this thesis offers an innovative approach to Sharia interpretation. Furthermore, this thesis demonstrates to researchers in Sharia that the compliance with Sharia laws and requirements can be practically assessed through determining the associated requirements and laws.

In relation to the Sharia scholars' strong opinions against privatisation, the work of Sharia scholars such as Ali and AlSaqa has had an impact on subsequent research, resulting in a scarcity of Sharia resources discussing privatisation.[977] As a result there was a lack of Sharia resources discussing the different models of privatisation and the implementation of privatisation in different sectors. Consequently, this thesis was able to contribute to this body of literature by analysing privatisation in healthcare from a Sharia perspective based on the checklist it identified along with evidence of the failure and success of privatisation in healthcare found in non-Sharia literature. Accordingly, this thesis was able to add to the body of literature, correct a misinterpretation of privatisation by highlighting two important findings. First, that the definition in Sharia literature is a definition of deregulation rather than privatisation.

[976] AlalSheikh, Fatwas between Sharia Compliance and Following Desire (Jareer 2013) [In Arabic]; AlMaududi, On the Application of Sharia in the Present Era (AlRushd 2012) [In Arabic]; Esposito, What Everyone Needs to Know about Islam (OUP 2002)
[977] Ali, *Education and Privatization* (AlAhram 1996) [In Arabic]; Alsaqa, *The Experience of Privatisation in the U.K* (AlMujalad Kuwait University 1997) [In Arabic]

Second, that there are multiple understandings and models of privatisation that do not compromise the government's ability to fulfil its obligations, for example outsourcing in healthcare with regulation by governmental and independent bodies.

Furthermore, this thesis has found that the vigorous regulation and monitoring is essential for the continuation of the compliance of healthcare provision with Saudi and Sharia law. By drawing examples from non-Sharia literature which portray the importance of monitoring to form a competitive market, such as the example of the privatisation of water and sanitation companies in England and Wales, [978] this thesis highlights the importance of government licensing in relation to the success of privatisation. In this example, providers are required to maintain standards and achieve goals set by the government or risk having their licences evoked. Accordingly, this thesis sheds light on methods of government regulation which can be applied to Saudi hospitals when healthcare is privatised to ensure the services provided are compliant with Saudi law.

In Sharia literature, scholars such as Saleh, Lutfi, Maysami and AbdulAziz have recommended Sharia economic systems to finance healthcare as an alternative to privatisation.[979] However, these recommendations were not assessed for

[978] Haskel, et al. 'Privatisation, Liberalization, Wages and Employment: Theory and Evidence for the UK' (1993) 60 *Economics* 161; Karlaftis, 'Privatisation, regulation and competition: A thirty-year retrospective on transit efficiency' (2008) *ITF* 67; Laffont, et al. 'Privatisation and incentives' in Laffont, *A theory of incentives in procurement and regulation* (MIT 1993) Rondinelli, *Decentralization in developing countries*, Staff Working Paper 581 (WB 1983); World Bank (PPPIRC), 'Privatisation' (2016)
[979] AbdulAziz, 'Fulfillment of Maqasid alSharia via Takaful' (2013) 1 IPR; Lutfi, et al, 'Sadaqah-based crowdfunding model for healthcare' (NUM 2016); Maysami, 'An analysis of Islamic Takaful Insurance: A

compliance with Sharia requirements which resulted in an incomplete argument and a mere claim that was not sustained by evidence, rather than presenting an academic and measured conclusion as the Sharia scholars portrayed. Therefore, this thesis explored these arguments more thoroughly by assessing these recommendations and presented results contrary to the Sharia scholars' opinions on *Sadaqah* and *Zakat,* as it found these to be impractical recommendations that would be problematic to adopt and insufficient to finance a healthcare system. Meanwhile, the thesis findings concurred with the Sharia scholars' opinions on *Takaful,* however government supervision is compulsory to ensure continued compliance. Accordingly, this thesis has added a new dimension to Sharia scholars' analysis of healthcare finance by adding the elements of Sharia compliance and practicality of implementation that were previously lacking.

Moreover, I have assessed the objectives of both *Takaful* and conventional insurance. Sharia scholars such as Murtaza and Siddiqi have been against conventional insurance and follow the opinion of the scholars who attended the 1976 First International Conference on Islamic Economics.[980] I do not agree with this school of thought as demonstrated in this thesis however focusing on challenging the Sharia scholars argument against conventional insurance is out of the scope of this thesis as Saudi law only allows *Takaful* based insurance.[981]

Cooperative Insurance Mechanism' (1999) 18 JIR 109; Saleh, The role of Zakat in Financial and Social Development (AlBayan 2011) [In Arabic]

[980] Murtuza, *Insurance in Islam, Some Aspects of Islamic Insurance* (Islamic Economics Research and Bureau 1991); Siddiqi, M. *Insurance in an Islamic Economy* (The Islamic Foundation 1985); The first International Conference on Islamic Economics held in Makkah, Saudi Arabia February 21-26, 1976

[981] Abdul Ghafour, "Saudi Insurance Market to Reach S.R 30bn: Analysts"*Arab News* 14 February 2007; Al-Otaibi, Adel 'Assessment of the Health Insurance in the Kingdom of Saudi Arabia' (Master thesis, Maastricht University 2005); AlTassan, 'The Emergence of Health Insurance in the Kingdom of Saudi

Nonetheless I drew on the objectives and possible benefits of insurance in the context of healthcare in non-Sharia literature presented by scholars such as Banoob, Bennett and Churchill.[982] The arguments for insurance these scholars presented were similar, if not identical, to those presented by Sharia scholars calling for the implementation of *Takaful* and warning against the risks of conventional insurance.[983] By drawing parallels between the objectives of conventional insurance and *Takaful,* and drawing on the successes of the Saudi CHIS,[984] this thesis was able to recommend the implementation of a *Takaful* based insurance scheme, instead of conventional insurance, with models of privatisation such as financial privatisation of healthcare. Implementing such a system will increase the availability and accessibility of healthcare. In doing so, this thesis demonstrates the need for updated Sharia research, which brings Sharia literature to the current era. Moreover, I argue that this finding serves as a testament that conformity can be achieved between Sharia and requirements of modern life such as health insurance.

Arabia' (PhD Manchester Metropolitan University, 2003); Ansari, Analysis of the impact of reforms on insurance industry of Saudi Arabia (2011) 1 *Interdisciplinary Journal of Research in Business* 28

[982] Banoob, "Global directions for reforming health systems and expanding insurance. What is suitable for the Arab Gulf countries?" (2001) 22 *Saudi Medical Journal* 743; Bennett, et al. *Health insurance schemes for people outside formal sector employment* (The WHO 1998); Churchill, 'What is insurance for the poor' in Churchill, *Protecting the Poor: A Microinsurance Compendium* (ILO 2006) 12

[983] Abdul Aziz, 'Fulfillment of Maqasid al-Shari'ah via Takaful' (2013) 1 *International Policy Review*; Abdullah, 'Risk Management via Takaful from a Perspective of Maqasid of Shari'ah' (2012) 65 *Social and Behavioral Sciences* 535; Al-Amri 'A survey of the Islamic insurance literature – takaful' . (2015) 6 *Insurance Markets and Companies;* AlFadhil, *Healthcare Insurance in Sharia and Law* (Masters Thesis, Islamic University of Madinah 2012) [In Arabic]; AlUlfi, *Health Insurance: An Emprical Study AlHIkmah* (Riyadh 2006); Ismail, et al., *Essential Guide to Takaful (Islamic Insurance)* (CERT Publications 2008); Syahida, 'Risk Management via Takaful from a perspective of Maqasid AlSharia' (2012) 65 *Social and Behavioral Sciences* 535

[984] Alosaimi et al. *The equity in access to health services in cooperative health insurance system, Jeddah, 2008-2009.* (Arab Board in Community Medicine 2009); AlSheikhi, 'The Success of Health Insurance for Saudi Citizens: Hospital Privatisation in Saudi Arabia' (2016) 8 *European Journal of Business Management* 183; Barakah, 'The Cooperative Insurance in Saudi Arabia: a Nucleus to Health Reform Policy' (2011) 21 *IPEDR* 6

Furthermore, this thesis has linked Saudi healthcare laws and non-Sharia literature discussing privatisation in healthcare. After forming an understanding of the different arrangements and transfers that constitute a privatisation, I have identified gaps in Saudi healthcare laws. For example, Saudi law states that essential lifesaving services are to be provided by the government within the government's available resources.[985] Accordingly, this thesis has concluded that finance and provision can be transferred from the government. Consequently, this thesis has been able to draw conclusions from these distinct bodies of literature and identify models of privatisation that could be said to be lawful in Saudi Arabia. Although I initially intended to challenge the Sharia scholarly opinions against the arrangement in their definition of privatisation, it has concurred with it in some respects and added a necessary corrective to the out-dated body of Sharia literature discussing privatisation.

Additionally, in this thesis I have highlighted the effect of the urban-migration, which has been discussed by many scholars before such as Jannadi and Garba,[986] on the availability, accessibility and quality of healthcare. In doing so I have assessed the impact of the urban-migration on the compliance of Saudi healthcare provision with Saudi and Sharia law which was previously lacking from the literature. Accordingly, this thesis has added a new dimension to the current discussion and has further emphasised the importance of tackling this problem before the implementation of the upcoming privatisations. Moreover,

[985] The Saudi Health Law, Royal Decree No. M/11, 4th June 2002
[986] Colliers International, 'Kingdom Of Saudi Arabia Healthcare Overview' (2012) Q1; El Bcheraoui, et al. "Access and barriers to healthcare in the Kingdom of Saudi Arabia, 2013: findings from a national multistage survey." (2015) 5 *BMJ*; Garba, 'Managing urban growth and development in the Riyadh metropolitan area, Saudi Arabia' (2004) 28 *HI* 593; Jannadi, B., et al. "Current structure and future challenges for the healthcare system in Saudi Arabia." (2008) 3 *APJHM* 43

by assessing the impact on the availability, accessibility and quality individually, this thesis provides insight into the importance of equal distribution of healthcare workers and services across the 13 regions of Saudi Arabia which will aide the MOH in balancing the workforce and workload between hospitals and therefore ensuring a higher probability of achieving a healthy competitive market when privatised.

Finally, as the accounts discussing gender inequity in the healthcare sector in Saudi Arabia were scarce they were insufficient to draw academic conclusions on. Nonetheless, due to the importance of the protection of health in Saudi law, Sharia, and international conventions that Saudi Arabia has signed and ratified, and due to the upcoming privatisations in Saudi Arabia it was essential to explore the possible effect of these fairly new claims. By assessing the impact of these reported inequities on the compliance of healthcare provision with Sharia and Saudi law, this thesis was able to add to this body of literature and shed light on an important area which was neglected in the 2030VFH and in the scholarly discussions about privatisation of healthcare in Saudi Arabia.

6.4 Limitations and Contributions of Research

A major limitation of this thesis has been the lack of information on the effects of implementing compliant models of privatisation identified in this thesis. The thesis findings are solely based on examples of evidence of privatisation in non-Sharia literature and related material in Sharia literature. Although the evidence in non-Sharia literature is derived from the application of these models of privatisation, these examples were nevertheless applied in non-

Sharia adherent jurisdictions with different requirements and circumstances. Accordingly, the compliant models would need to be implemented to test the effects of fulfilling Sharia or Saudi healthcare requirements. Whilst this study did not test the compliance empirically, it did substantiate the compliance according to Saudi and Sharia healthcare laws and requirements in theory.

Moreover, the study's findings are limited by the possibility of governments' non-fulfilment of the requirement to supervise. The compliance of the stated models of privatisation is directly linked and thus dependent on government supervision, as concluded in this thesis. If government supervision is lacking, there is a risk that the healthcare requirements may not be fulfilled, which undermines their compliance with Sharia and Saudi law. There are no means to ensure government adherence to this requirement, and I emphasise that I have intentionally not discussed government supervision strategies and systems as these are out of the scope of this thesis. However, to ensure compliance of privatisation models, it is essential to initially form an executive division, separate from those currently monitoring the CHIS, that is responsible and legally bound to monitor healthcare requirements and regulate healthcare services and providers. Notwithstanding this limitation, this thesis offers valuable insights into privatisation that can serve as a road map for future applications of privatisation and a checklist for government supervision markers.

This thesis was also limited by the scarcity and obsolescence of the Sharia literature discussing privatisation. The majority of the available literature was

from the 1980s-90s and lacked Sharia compliance assessment. This resulted in a dependence on the secondary sources of *Ijtihad* and *Qiyas,* and the adaptation of the methodology of *Usul AlFiqh,* to derive Sharia opinions rather than depending on existing established laws. The scarcity of resources can be blamed on the stern opinion against privatisation in Sharia literature, which can be said to have steered Sharia scholars away from pursuing further investigation of privatisation. Despite this limitation, the study certainly adds to the understanding of the Sharia viewpoint on privatisation and clarifies the misconceptions of the Sharia scholars' definition and analysis.

Transfers of healthcare finance in Sharia have also posed a limitation to this study. This thesis concludes that healthcare finance is not an obligation upon governments due to the absence of a clear and explicit law that states otherwise. Nonetheless, the Hadeeth narrates that the Prophet treated the ill at his own expense during his time,[987] which could be interpreted as an obligation for rulers to provide healthcare finance. However, the Prophet did not order rulers to follow in his footsteps and finance healthcare. Moreover, as mentioned in Chapter One, some Hadeeths may be fabricated,[988] which has left room to question, and therefore disregard, finance as an obligation. The thesis findings conclude that healthcare is required to be available and accessible to all under Sharia law. Accordingly, it can be argued that affordability of healthcare is essential to ensure its availability and accessibility. Therefore, the lack of a clear law in the Quran or Hadeeth stating healthcare finance as a government

[987] AlAli, The Prophet's state in Medinah: A study of its establishment and organization (AlMatbuat 2001); AlKatani, The Prophetic Government: Administrative Formalities (Dar AlArqam 2008) [In Arabic]; AlShayaa, The Concise Life story of The Prophet (AlRayyan 2003) [In Arabic]
[988] Schacht et al, The Origins of Muhammadan Jurisprudence (OUP 1950)

obligation may not be considered a sufficient reason to relieve the government of healthcare finance provision or to consider transferring healthcare finance to be compliant with Sharia. Whilst this study did not confirm that healthcare finance is an obligation of the government, it did partially substantiate that governments are obliged to ensure healthcare provision is available and accessible to all, and of quality.

Although I have assessed healthcare privatisation models in accordance to Sharia law, it is essential to note that I have focused on the law in accordance with the *Hanbali* school of thought. Therefore, the findings of this thesis cannot be generalised with other schools of Sharia. Moreover, there may be differences in findings when addressing the study in accordance with another school of thought or sect. As mentioned in the introduction and Chapter Two, each school of thought and sect applies different methodologies, depends upon different resources and follows different teachings. [989] Therefore, variations are inevitable, however this does not belittle the significance of the findings in this thesis. My choice of the *Hanbali* school of thought is of great advantage to this thesis as it is the primary school adopted in Saudi law, allows the use of Sharia Law Maxims, *Ijtihad* and *Qiyas,* and therefore is the most accommodating to new developments and changing circumstances in comparison to other schools of Sharia thought. [990] As such, the focus of this thesis on the *Hanbali* school of thought offers valuable insight into how the Sharia compliance of healthcare

[989] Alluhaidan, Ijtihad of Judges in Sharia and its applications in Saudi Arabia (Master thesis, NAU 2004)[in Arabic]; AlZahm, The role of Experience, Islamic law and the Saudi regime (Master thesis, IUM 2011) [in Arabic]

[990] Hosen, Modern Perspective on Islamic Law (Elgar 2013); Janin, Islamic Law: The Sharia from Muhammad's Time to the Present (McFarland 2007); Mottahedeh, Lessons in Islamic Jurisprudence (Oneworld 2014); Mumisa, Islamic Law: Theory and Interpretation (Amana 2002); Vogel, The Islamic School of Law: Evolution, Devolution and Progress (HUP 2005)

privatisation can be assessed. This methodology can be adapted to different schools of thought.

Moreover, I should stress that my study has also focused on Saudi law. Accordingly, the findings in this thesis cannot be generalised, nor easily be applied to other countries whose laws are partially derived from Sharia, such as Malaysia and the Gulf Corporation Countries (GCC). Notwithstanding this limitation, this thesis has served as a road map to the assessment of compliance with healthcare laws and this methodology can be adapted to other jurisdictions. Although this thesis focuses on Saudi law, other countries have their own laws and constitutions; therefore, to assess the compliance of healthcare privatisation to their laws, privatisation would need to be checklisted against their healthcare laws and requirements in a methodology identical to the one applied in this thesis. Nonetheless, regardless of the local laws, the findings of this thesis will be of advantage of authorities that would like to undergo privatisation and ensure healthcare is available, accessible, affordable and of quality.

My analysis has focused on the compliance of privatisation in healthcare to Sharia and Saudi law and lacks engagement with other methods of financing healthcare, such as taxation. Therefore, the findings of my thesis should not be taken as the only methods for approaching finance healthcare and cutting costs. As mentioned in Chapter One, I fully acknowledge that there are other methods to finance healthcare, however I have intentionally left these out of the discussion as they are out of the scope of this thesis. Although this may be seen

as a restriction, eliminating other forms of finance from the analysis has allowed this thesis to wholly engage in and focus on its scope, and enabled it to derive valuable insights into the privatisation of healthcare in accordance to Sharia and Saudi law.

6.5 Implications of the Research and Future Directions

The findings of this study suggest that, in general, healthcare can be privatised according to Sharia and Saudi law. The results of this thesis also highlight the importance of governmental monitoring of governmental divisions and the private sector to maintain *Maslahah* and ensure the protection of *Maqasid AlSharia.* This suggests that government supervision is a vital factor in ensuring the compliance of any adopted policies.

A natural progression of this work has been to assess the level of compliance of the government's obligation to supervise the healthcare system and how to improve it. This assessment is extremely beneficial considering that the thesis has demonstrated how certain problems exist in the Saudi healthcare system, and have gone undetected despite the negative affect they have on healthcare provision. For example, the existing misdistribution of healthcare employees and differences in quality which resulted in an urban-migration. Such an assessment would help to determine if privatisation models would be compliant once adopted.

Furthermore, this study has allowed consideration of areas that may need improvements to ensure adherence to this obligation to monitor the healthcare sector and the consequent compliance of the privatisation models that will be implemented. With regards to quality and monitoring lessons can be learnt from the privatisation of Saudi Telecom Company (STC) and Saudi Airlines. Their privatisation and monitoring by a separate body led to better quality and higher standards.[991] Competition developed between the companies and investors, which benefitted both the consumers and economy.[992] Further investigation of these privatisations will provide insight into the privatisation of services and highlight areas that may require attention.

Moreover, it is essential to investigate the effect of having separate bodies monitoring services with regards to the adherence to the law and the competitive market between providers. Lessons can be learnt from the Cooperative Council for Health Insurance (CCHI) and how it oversees the implementation of the CHIS Act and delegated supervision of the implementation to the MOH and SAMA.[993] The evaluation of the CCHl will provide clear insight into supervision strategies and what mistakes to avoid which will can beneficial when the NHI is implemented.

---

[991] Privatisation of STC introduced new telecom companies to the market which are supervised by the Saudi Communications and Technology Commision. Likewise, Saudi Airlines privatisation allowed new airline companies to be introduced to the market, while the General Authority of Civil Aviation monitors their services.

[992] Alsumairi, et al. 'A case study: The impact of low-cost carriers on inbound tourism of Saudi Arabia' (2017) 62 *JATM* 129; Alyagout, et al. "Public Sector Transformation: Privatization in Saudi Arabia." in *Public Sector Transformation Processes and Internet Public Procurement: Decision Support Systems: Decision Support Systems* (IGI Global 2012); Askari, *Saudi Arabia's Economy: Oil and the Search for Economic Development*, (Jai 1990); Choudhury, et al. "Oil and non-oil sectors in the Saudi Arabian economy." (2000) 24 *OPECER* 235

[993] ibid; Implementing Regulations of the Cooperative Health Insurance Law in the Kingdom of Saudi Arabia (Amended) Cooperative Council for Health Insurance, Session 73 Ministerial Decision DH/1/30/6131 (2009); Ram, "Management of Healthcare in the Gulf Cooperation Council countries with special reference to Saudi Arabia." (2014) 4 *IJARBSS* 24; Rules of Implementation of Cooperative Health Insurance System & Cooperative Health Policy, Ministry of Health Resolution 460/23/DH (2002)

Another area that requires attention in Saudi healthcare is the possible bias against women in the healthcare sector. Despite the Royal Decree that is against gender bias in services,[994] and the Saudi MOH official statement that clarifies females' autonomy,[995] new evidence is emerging of the inequity and differences between women and men in the context of healthcare provision in Saudi Arabia. Unfortunately gender bias has not yet been efficiently investigated and the reliable research on this topic is scarce and new. If proven to be true, both the availability and accessibility of women's healthcare would be greatly restricted which is against Sharia, Saudi law and international conventions as demonstrated in this thesis. These claimed practices, if accurate, are of huge impact especially as 49.07% of the Saudi population are female according to the latest official figures by the General Authority for Statistics.[996] Due to its importance, gender inequity in the Saudi healthcare sector specifically and in Saudi Arabia in general should be investigated in depth to help tackle any factors causing discrimination. As part of this future research, it is essential to investigate the Patients' Rights bills of the different main healthcare providers in Saudi Arabia, such as the National Guard Hospital and Aramco, to ensure they are in accordance with the Sharia and Saudi law healthcare requirements and do not contribute to the claimed gender bias. For example, by using gender

[994] A Royal Decree 33322 was passed in 2017 that stated women did not need a male guardian's approval to obtain public services, yet this was not adhered to and females were asked for male guardian consent regeardless. The 2019 Royal Decree was restating the 2017 law and making it illegal to ask for guardian consent.
[995] AlKhabrani, 'MOH: Female patients are allowed to give consent without guardian signature' *Sabq* 16 January 2019; Royal Decree 33322 7 March 2017
[996] Population by Gender, Age Groups and Nationality 2018 available on www.stats.gov.sa accessed on 2 December 2018

neutral terminology, or clearly stating that the laws and rights apply to all males and females as the Basic Law of Governance does. [997]

Another area that requires attention is ensuring that there is no discrimination between the services and expertise available in all 13 regions of Saudi Arabia. Further research is required to estimate the degree of differences between regions and effectively tackle this problem and eliminate the urban-rural healthcare migration in Saudi Arabia. One method would be by setting a package of essential treatments that will be provided, similar to the standardised treatments provided under the CHIS. Furthermore, future research is required to determine which treatments and procedures are considered essential and are to be included under the NHI before its implementation in 2030. Lessons can be learnt from the treatment plan and available add-on's under the CHIS, which will help when establishing the NHI system while limiting differences between the different regions of Saudi Arabia. With the plan to privatise, and as part of ensuring a healthy competitive market, this research is essential, as strict rules should be enforced to ensure all hospitals across Saudi Arabia provide the same essential services.

Moreover, in light of the findings of this thesis with regards to the different meanings of privatisation some of which will be implemented in Saudi Arabia, it is essential to assess, in light of this thesis' findings, how the related Saudi healthcare laws can be reviewed and amended to accommodate for the planned

[997] The Basic Law of Governance, Royal Decree No. A/90, 31st of January 1992

privatisations under the 2030VFH without compromising the availability, accessibility, affordability and quality of healthcare to all without discrimination. For example, the Basic Law of Governance currently states, *'The State shall protect public health and provide healthcare to every citizen'*.[998] However, this law is in clear contradiction to the 2030VFH, as with the plan to privatise as envisaged in the 2030VFH, the state will no longer be providing or financing healthcare.

Furthermore, this thesis demonstrates that Sharia accepts non-Sharia policies, and accordingly supports the argument for a change in how modern and foreign concepts are addressed and highlights the need to revisit out-dated academic discussions to enrich the scholarship with updated findings. This is exceptionally important as Sharia scholars claim that Sharia is ever-evolving, yet privatisation resources were predominantly from the 1980s. Moreover, this thesis is supportive of the importance of utilising the progressive tools from within Sharia to accommodate new advances and circumstances as they arise, such as *Ijtihad, Qiyas* and Sharia Law Maxims which are highly utilised in the *Hanbali* school of thought. Furthermore, future research can also assess the possibility of the inclusion of these secondary sources and maxims to other schools of thought of Sharia law which currently do not utilise them by demonstrating how these sources and maxims have been beneficial and enabled Sharia law to be applied in a modern context while maintaining *Maqasid AlSharia* and *Maslahah* as required by Sharia. Accordingly, the rulings by the various schools of thought in Sharia will be more readily modernised.

[998] The Basic Law of Governance Article 31

This thesis provides insight as to how Sharia obligations can be easily detected by utilising the three-stage method developed in this thesis. Although this thesis focuses on healthcare provision obligations and requirements, the method itself can be applied in other sectors. For example, the method can be applied to derive obligations on states in relation to human rights, such as women's right to autonomy. Adopting the three-stage method may result in an obligation on the state to protect women's autonomy by establishing laws that protect it, and criminalise actions that compromise it. The value and benefit of this method extends beyond the Saudi society and Saudi healthcare, and can include all jurisdictions that include some aspects of Sharia, such as in Indonesia, Algeria and the GCC, all of which have legal systems that are a mix between Western laws and elements of Sharia.

Furthermore, it is important for Sharia research to end its full dependence on theory only, such as in the recommendation of *Sadaqah* to finance the healthcare sector,[999] and include practical evidence from other bodies of literature or conduct empirical research which will serve as proof and strengthen arguments made by Sharia scholars. The effect and benefit of this will extend and include all Muslims who consider religion a way of life and are affected by the rulings of Sharia scholars whom they look to for guidance. Another method to end the isolation of Sharia literature is through finding resemblance between Sharia and products of modern life. In this thesis, I found the objectives of *Takaful* to be similar to those of conventional insurance which

[999] Lutfi, et al, 'Sadaqah-based crowdfunding model for healthcare' (NUM 2016

Sharia scholars are against. The opinion was reached in 1976 however Sharia literature discussing insurance has not evolved since.[1000] The evolvement of Sharia literature will also lead to the incorporation of Muslims into modern societies more effectively due to its effect on them on a daily basis as a result of their belief that religion is a way of life. Collectively, these will contribute to the growth of this body of literature and to the education of Muslims in a modern manner as opposed to the out-of-date misconceptions which are isolating and holding back some Muslim communities.

Additionally, by shedding light on *Takaful* and the success of its implementation today in Saudi Arabia, this thesis draws attention to the need for further research on the effect and possibility of expanding the CHIS to include all of Saudi Arabia, and adopting a similar system in countries with jurisdictions that have aspects of Sharia law, such as the GCC whose legal systems are a mix between British law due to colonisation and some elements of Sharia. Nonetheless, it is essential to test healthcare *Takaful* for compliance with their local jurisdictions beforehand. The method of assessment implemented in this thesis can serve as guidance however instead of deriving obligations from Sharia, obligations and requirements can be derived directly from their existing laws. Moreover the Sharia healthcare requirements can serve as markers when assessing the effect of the expansion of the CHIS as part of the implementation of privatisation in Saudi Arabia to gradually include the whole of Saudi Arabia, in a similar manner to how CHIS started in Riyadh for foreigners and was

[1000] The first International Conference on Islamic Economics held in Makkah, Saudi Arabia February 21-26, 1976

gradually expanded to now include Saudi and non-Saudi private sector employees across Saudi Arabia.

It is important to note that the 2030 Vision was announced as part of a governmental response to the drop in oil prices as mentioned in Chapter One.[1001] As Saudi Arabia depends on oil revenue, the Saudi government announced the 2030 Vision to overcome the financial crisis and cut costs. Nonetheless, as mentioned in this thesis the latest budget is the highest budget yet for Saudi Arabia.[1002] Despite this landmark budget, the Saudi government has not considered alternative methods to finance the healthcare sector besides privatisation. Nonetheless, I argue that the financial crisis has lessened if not disappeared, considering the improvement in the national budget. Moreover, I argue that two new main goals emerged given this landmark budget. First, to correctly invest the available resources and nourish the economy further, which are part of the obligation of *Maslahah* on the government as mentioned in Chapter Two.[1003] Second, to work towards improving the state of the healthcare of the population as opposed to fixating on how to end the governments financing of healthcare. However there is no data for the period between 2017 and 2019 from the Ministry of Health, therefore, it is unclear what the expenditure per capita is for this year or how it has improved since 2016. Moreover, I argue that less radical policies may be beneficial now and I call for further research to consider more ethical solutions to cut costs and finance the

[1001] AlDakheel, 'An opinion on the 2030 Vision: A Critical Analytical Reading' (Riyadh 2016); Almashabi, et al., 'Saudi Arabia's Deputy Crown Prince Outlines Plans: Transcript.' Bloomberg, 4 April 2016; Ramady Saudi Aramco 2030: Post IPO challenges (Springer 2017)
[1002] Saudi Arabia 2019 Budget Report available on Ministry of Finance Website www.mof.gove.sa accessed 20 January 2019
[1003] Chapter Two Section 2.5.1.1 A

healthcare sector. This further research is exceptionally important given the fact that the Sharia compliance of identified models in this thesis is dependent on the government's adherence to supervision of the private sector. If government monitoring is lacking, the compliance of these models is undermined. Given the findings of the thesis, governmental supervision requires further effort and adherence by the Saudi government. Accordingly, alternative methods of finance should be found to ensure healthcare is provided to citizens according to the healthcare provision requirements in Sharia and Saudi law.

Moreover, as mentioned there is no estimation of how much the healthcare expenditure per capita will be for 2019, and similarly no details were given for 2018. As of March 2019, the Saudi MOH website only contains expenses and financial plans up to 2017, with no information as to when those for 2018 and 2019 will be available to the public.[1004] The lack of transparency regarding MOH finances and expenditure since the announcement of the 2030VFH is alarming and problematic as Saudi Arabia is destined to undergo a drastic policy change and embark on the widely unfavourable road to privatisation, which advocates in non-Sharia literature argue requires transparency and public monitoring to ensure its success.[1005] Therefore, it is essential that the Saudi government is clear and transparent as to how much revenue these changes have so far made,

[1004] Saudi Ministry of Health Archive available on Saudi Ministry of Health website www.moh.gov.sa accessed on 24 February 2019

[1005] ibid; 'Transforming Saudi Arabia: National Transofrmation Program 2020 Approve' Shearman and Sterling, 14 June 2016; Banafea, et al 'Assessment of economic diversification in Saudi Arabia through nine development plan' (2018) 42 *OPECER* 42; Presley, et al. *A guide to the Saudi Arabian economy* (Springer 2017); WHO (Task Force on Health Economics) 'Privatisation in Health' (1995); Yasin, et al. 'Universal Coverage in an era of privatisation: can we guarantee health for all?' (2012) 12 BMC Public Health; Young, 'Privatizing health care' (1990) 5 *International Journal of Health Planning and Management* 237

and how the revenue will be spent. Moreover, governmental sectors, such as the MOH, and the MOF should return to the state of full disclosure and providing detailed Yearbooks as they have prior to the announcement of the 2030 Vision.

Nonetheless, if the Saudi government continues with the plan to privatise despite the landmark budget I suggest as further research to investigate a practical and efficient method to collect premium payments before implementing the NHI system. For example, lessons can be learnt from the implementation of the collection of *Zakat* payments from companies by the GAZT as mentioned in this thesis.[1006] Understanding the obstacles that arise for the GAZT and companies alike, and lessons learnt from both parties, alongside with evidence of the CHIS premium payments by employers will provide great insight into how the NHI payments collections can be executed on a nationwide scale when 2030VFH is adopted. Such research is essential to ensure healthcare is available and accessible to all when privatised.

Similarly, lessons on privatisation can be learnt from the privatisation of Aramco which will commence this year.[1007] Aramco will undergo a full privatisation, and will provide insight into the problems and challenges that may arise when adopting a full privatisation. Future research into the privatisation of Aramco will also highlight effective methods for attracting successful international investments which will benefit the healthcare sector.

[1006] www.gazt.gov.sa accessed 30 January 2019
[1007] Almashabi, et al., 'Saudi Arabia's Deputy Crown Prince Outlines Plans: Transcript.' *Bloomberg*, 4 April 2016; Banafea, et al 'Assessment of economic diversification in Saudi Arabia through nine development plan' (2018) 42 *OPECER* 42; Presley, et al. *A guide to the Saudi Arabian economy* (Springer 2017); Ramady *Saudi Aramco 2030: Post IPO challenges* (Springer 2017)

More importantly, it is essential for further research to consider methods of government regulation and licensing for both providers and investors, such as that present in the privatisation of water and electricity in the UK as mentioned in the thesis.[1008] Setting regulations will allow a healthy competitive market to form which is beneficial for the consumer and economy rather than risking the development of crony capitalism such as that evident in the Mubarak example given in this thesis.[1009]

For further research, I suggest investigating the similarities between *Takaful* and financial privatisation. This thesis has found that *Takaful* and privatisation both facilitate transfers of finance. The concept of *Takaful* could resemble finance privatisation; however, further investigation is required to reach this conclusion. If *Takaful* is found to resemble privatisation, this would add to the argument presented in this thesis that some models of privatisation are in accordance to Sharia and Saudi law.

Another fruitful area for further work is in determining the link between Sharia healthcare requirements and modern day WHO requirements.[1010] Both Sharia and the WHO require healthcare to be available, accessible and of quality, which

[1008] Haskel, et al. 'Privatisation, Liberalization, Wages and Employment: Theory and Evidence for the UK' (1993) 60 *Economics* 161; Karlaftis, 'Privatisation, regulation and competition: A thirty-year retrospective on transit efficiency' (2008) *ITF* 67; Laffont, et al. 'Privatisation and incentives' in Laffont, *A theory of incentives in procurement and regulation* (MIT 1993) Rondinelli, *Decentralization in developing countries*, Staff Working Paper 581 (WB 1983); World Bank (PPPIRC), 'Privatisation' (2016)

[1009] Akhmetova, 'The Arab Spring, Good Governance and Citizens' Rights' (2014) 5 *Islam and Civilisational Renewal* 334; Rutherford, *Egypt after Mubarak: Liberalism, Islam, and Democracy in the Arab World* (PUP 2013)

[1010] WHO 'A WHO Framework for Health System Performance Assessment' (1999); WHO 'Universal Healthcare Coverage (UHC)' Factsheet updated December 2016

is known as universal healthcare according to the WHO,[1011] however similarities have not yet been drawn between the two.[1012] The study could produce interesting findings and could also identify similarities between the Sharia compliance assessment and the WHO AAAQ test.[1013] The AAAQ is a framework developed by the WHO to assess adherence to the Right to Health enshrined in international conventions and ratified by many countries, including Saudi Arabia.[1014] It is argued to be the most accurate and most commonly used framework in international documentation to evaluate health systems.[1015] The success of the AAAQ framework is argued to be due to its focus on healthcare performance and quality, unlike other evaluation methods that include non-healthcare determinants of health, such as genetics and diet.[1016]

[1011] ibid; WHO 'Health Systems Financing: The Path to Universal Health Coverage' (2010)

[1012] ibid; Neuhauser, D. (2004) Assessing health quality: the case for tracers, Journal of Health Services Research and Policy, 9(4): 246–7; Nolte, et al, 'Assessing quality in cross-country comparisons of health systems and policies: Towards a set of generic quality criteria' (2013) 112 *Health Policy* 156-162; Nolte, et. al 'Population health' in P.C. Smith et al. *Performance measurement for health system improvement: experiences, challenges and prospects.* (Cambridge University Press 2009); Papanicolas et al, 'Health System Performance Comparison' (McGraw-Hill Education 2013); Panzer, et al. "Increasing demands for quality measurement." (2013) 310 *Jama* 1971-1980

[1013] ibid; WHO 'A WHO Framework for Health System Performance Assessment' (1999); WHO, Everybody's business. Strengthening health systems to improve health outcomes: WHO's framework for action, 2007; WHO Factsheet 323, 2007; WHO [World Health Organization]. The world health report 2000: health systems; improving performance. Geneva: World Health Organization; 2000

[1014] Kessner, et al, (1973) Assessing health quality – the case for tracers, New England Journal of Medicine, 288(4): 189–94; League of Arab States, *Arab Charter on Human Rights*, 15 September 1994; Loeb, "The current state of performance measurement in health care." (2004) 16 *International journal for quality in health care* i5-i9; Mays et al., Assessing quality in cross-country comparisons of health systems and policies: Towards a set of generic quality criteria, Health Policy 112 (2013) 156– 162; McGlynn,"Six challenges in measuring the quality of health care." (1997) 16 *Health Affairs* 7-21; Organization of the Islamic Conference (OIC), *Cairo Declaration on Human Rights in Islam*, 5 August 1990; UN General Assembly, *Convention on the Elimination of All Forms of Discrimination Against Women*, 18 December 1979, United Nations, Treaty Series, vol. 1249, p. 13; UN General Assembly, *Convention on the Rights of Persons with Disabilities : resolution / adopted by the General Assembly*, 24 January 2007, A/RES/61/106; UN General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, p. 3; UN General Assembly, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3; UN General Assembly, Universal Declaration of Human Rights (adopted 1948 UNGA Res 217 A(III) (UDHR); WHO, The Right To Health, Joint Fact sheet, OHCHR, 323, August 2007

[1015] Greer, 'Universal Healthcare Coverage: A Political Struggle and Governance Challenge', (2015) 105 American Journal of Public Health S637; Goodman, et al. 'Opportunities and Challenges for Measuring Cost, Quality, and Clinical Effectiveness in Health Care' (2004) 61 *Medical Care Research Review* 124S-143; Kelley, et al. "Health care quality indicators project." *OECD Health Working Papers*, No. 23 (OECD Publishing 2006)

[1016] Allin et al, 'Measuring inequalities in access to Healthcare: A review of the indices' (European Commission 2007);; Kaplan, K De Camargo, 'A Call for Global Discussion on Universal Coverage' (2016)

The AAAQ allows all aspects affecting the Right to Health and universal healthcare to be assessed individually and to form an accurate idea of the degree to which these are enjoyed in a given country.[1017] According to the WHO, the main factors to consider when assessing healthcare provision are availability, accessibility, acceptability and quality.[1018] It appears that the AAAQ framework goes hand in hand with the requirements and obligations of healthcare provision in Sharia. If similarities are found, the modern day AAAQ test could be utilised to more readily examine and practically assess Sharia compliance of healthcare policies. Moreover, such research would allow for combining and unifying the findings of Sharia and non-Sharia literature discussing the right to health and universal healthcare.

Finally, future research may investigate the compliance of models of privatisation that focus on the second purpose of privatisation, which is improvement of efficiency. This thesis has purposefully focused on models of privatisation that cut costs in the context of healthcare, and therefore the state of Sharia compliance regarding the remaining privatisation models in the context of healthcare is unknown.

---

106 American Journal of Public Health 594; O'Connell et al, 'What does Universal Healthcare Coverage mean?' (2014) 383 Lancet 277; Yamey et al, 'What does UHC mean?' (2014) 383 Lancet 951

[1017] Aday, et al. 'Evaluating the Healthcare System: Effectiveness, efficiency, and equity' (Health Administration Press 2004); Allin et al, 'Measuring inequalities in access to Healthcare: A review of the indices' (European Commission 2007); Berwick, et al. "Connections between quality measurement and improvement." (2003) 41 *Medical care* 30; Brown, et al. "Improving the measurement of service quality." (1993) 69 *Journal of retailing* 127-139; Chew et al, 'A Nationwaide survey on the expectation of public healthcare providers' (2014) 4 BMJ; Eddy, et al. "Healthcare quality measurement." U.S. Patent No. 8,538,773. 17 Sep. 2013; EuroREACH, 'The Health Data Navigator: Your Toolkit for comparative performance analysis' (2013)

[1018] WHO, The Right To Health, Joint Fact sheet, OHCHR, 323, August 2007

Bibliography

'Boxed In: Women and Saudi Arabia's Male Guardianship System' (Human Rights Watch 2016)

'Foreign doctors Should Face Tougher exams', BBC, 18 April 2014

'Half of foreign Doctors Not Trained Enough', Sky News, 18 April 2014

'New strategy for health services in Saudi Arabia'. 39. Al-Egtisadia Daily, 9 September 2009 [in Arabic].

'*Looser Rein, Uncertain Gain: A Human Rights Assessment of King Abdullah's Reforms in Saudi Arabia*. (Human Rights Watch 2010)

'Operating Costs' *The Economist* (London 30 April 2016) 30

'Round up: Health sector policy, financing and privatisation' (2011) 19 *Reproductive Health Matters* 213

'Saudi Arabia: Huge Obstacles for First Woman Lawyer' (Human Rights Watch. 2011)

'Saudi Arabia: King's Reform Agenda Unfulfilled' (Human Rights Watch 2015)

'*Saudi Arabia: New Law to Criminalise Domestic Abuse: Absence of Enforcement Mechanism Will Inhibit Effectiveness*' (Human Rights Watch 2013)

'Saudi Arabia outlaws domestic violence: Landmark legislation is aimed at protecting women, children and domestic workers against domestic abuse, official says' *AlJazeera Newspaper* 30 august 2013

'Transforming Saudi Arabia: National Transofrmation Program 2020 Approve' Shearman and Sterling, 14 June 2016

'*World Report 2012: Saudi Arabia*.' (Human Rights Watch 2012)

Abadeer, *Norms and Gender Discrimination in the Arab World* (Palgrave MacMillan 2015)

Abbas, et al. ‘The key players’ perception on the role of Islamic microfinance in poverty alleviation’ (2015) 6 *Journal of Islamic Accounting and Business Research,* 244 -267.

Abbasi, et al., ‘Islamic Economics: Foundations and Practices’ (1989) 16 *International Journal of Social Economics* 5

Abdul Aziz, ‘Fulfillment of Maqasid al-Shari’ah via Takaful’ (2013) 1 *International Policy Review*

International Centre for Education in Islamic Finance (INCEIF)

Abdul Ghafour, P.K. (2005) "Saudi Arabia: Health Insurance Mandatory from Jan", Arab News, Oct 25.

Abdul Ghafour, P.K. (2007a) "New Medicine Firm to Sell 30 Percent in IPO", Arab News, 30, August.

Abdul Ghafour, ‘CCHI Set to Extend Health Insurance to Aged’ Arab News, 23 February 2007

Abdul Ghafour, "Government Hospitals to Become Corporations" Arab News, Monday, 19 February 2007c

Abdul Ghafour, P.K. (2007d) "Saudi Insurance Market to Reach S.R 30bn: Analysts", Arab News, Wednesday, 14, February

Abdelkader, *Social Justice in Islam* (IIIT 2000)

Abdul-Qadeer, A, ‘Health Workforce in S.A.’ at the Public Administration Institute Health Workforce in S.A. Conference, 6-8 November, 1988, Riyadh, S.A. [In Arabic].

AbdulHussain, ‘Ensoulment & The Prohibiton of Abortion in Islam’ (2005) 16 *Islam & Christian-Muslim Relations* 103

Abdullah, ‘Maqasid AlShariah, Maslahah and corporate social responsibility’ (2007) 24 *The American Journal of Islamic Social Sciences* 25

Abdullah, et al. "Risk in Funding Infrastructure Projects through Sukuk or Islamic Bonds."(2014) 3 *International Review of Management and Business Research* 915

Abdullah, 'Risk Management via Takaful from a Perspective of Maqasid of Shari'ah' (2012) 65 *Social and Behavioral Sciences* 535

Abdul Rahman, Takaful: Potential Demand and Growth, (2009) 22 *J.KAU: Islamic Economics* 55

AbdulRauf, *Defining Islamic Statehood: Measuring and Indexing Contemporary Muslim States,* (Springer 2015)

AbdulRazak, Economic and Religious Significance of the Islamic and Conventional Pawnbroking in Malaysia: Behavioral and Perception Analysis. (PhD, University of Durham 2011)

AbdulWajid, Utility in Classical Islamic Law: The concept of Maslahah in Usul Alfiqh (University Microfilms 1986)

AbdurRahman, *Non-Muslims under Shariah (Islamic law)*, (International Graphics 1979)

Abiiro, et al. "Universal health coverage from multiple perspectives: a synthesis of conceptual literature and global debates." (2015) 15 *BMC international health and human rights* 17

Aboudah, "Dealing with Economic Sustainability Challenges Evolving from Declining Oil Production in Saudi Arabia" (MS Thesis, MTU 2015).

Abou ElFadl, Reasoning with God: Reclaiming Sharia in the Modern Age. (Littlefield 2014)

Abou El Fadl, *The Search for Beauty in Islam: A Conference of the Books* (Rowan

and Littlefield 2006)

Abu Aisha, 'Women in Saudi Arabia: do they have the right to give their own consent for medical procedures?' (1985) 6 *Saudi medical journal* 74

Abu-Dayyeh 'Path to progress proceeds at snail's pace for Saudi Arabian women, The Guardian 4 September 2015

Abu-Hilal, et al. 'The Arab Culture and the Arab Self: Emphasis on Gender' in King, et al. *The Psychology of Asian Learners* (Springer 2016)

AbulFazl, *Sayings of the Prophet Muhammad* (Award Publishing House 1980)

Ackerman, et al., *Human Well-Being and Economic Goals* (Island Press 1997)

Adam, *Medicine in the Quran and Sunnah: An intellectual reappraisal of the legacy and future of Islamic medicine and its represent* (International Institute of Islamic Thought 2002)

Aday, et al., 'Equity of Access to Medical Care: A Conceptual and Empirical Overview' (1981) 19 *Medical Care* 4

Aday, et al., *Evaluating the healthcare system: effectiveness, efficiency, and equity*, (Health administration press 2004)

Adler, et al., 'Socioeconomic status and health: what we know and what we don't.' (1999) 896 *Annals of the New York academy of Sciences* 3

AfzalurRahman, *Economic Doctrines of Islam Vol III*, (Islamic Publications Ltd 1980)

Agerfalk, P.J. & Fitzgerald, B. (2008). Outsourcing to an unknown workforce: Exploring open sourcing as a global sourcing strategy. *MIS Quarterly, 32*(2), 385-409.

Aggarwal, et al. 'Islamic Banks and Investment Financing' (2000) 32 *Journal of Money, Credit and Banking* 93

Aghnides, *Mohammedan Theories of Finance* , (1916)

Agil, *Readings in the concept and methodology of Islamic Economics* (Pelanduk Publications 1989)

Ahmad, 'Eonomic Development in Islamic Perspective Revisited' (2000) 9 *Review of Islamic Economics* 83

Ahmad, 'Role of finance in achieving Maqasid al-Shariah' (2011) 19 *Islamic Economic Studies* 1

Ahmad, A*lKhaskhasah Mafaheem wa Tajarub*, [Privatization Concepts and Experiences] (Markaz AlMajed 1998) [In Arabic]

Ahmad, *Economic Development in an Islamic Framework* (The Islamic Foundation 1979)

Ahmad, 'Eonomic Development in Islamic Perspective Revisited' (2000) 9 *Review of Islamic Economics* 83

Ahmad, et al. "Dynamic relationships between oil revenue, government spending and economic growth in Oman." (2015) 3 International Journal of Business and Economic Development

Ahmad, *Islam, Poverty and Income Distribution: A Discussion of the Distinctive Islamic Approach to Eradication of Poverty and Achievement of an Equitable Distribution of Income and Wealth* (Islamic Foundation 1991)

Ahmad, 'Islamic Law, Adaptability and Financial Development' (2006) 13 *Islamic Economic Studies* 79

Ahmad, *Studies in Islamic Economics* (The Islamic Foundation 1980)

Ahmad, *Theoretical Foundations of Islamic Economics* (Islamic Development

Bank 2002)

Ahmed, 'Defining ethics in Islamic Finance: Looking beyond legality' (2012). A paper presented at the 8th International Conference on Islamic Economics and Finance, Qatar, 11th February.

Ahmed, 'Frontiers of Islamic Banking: A Synthesis of Social Role and Microfinance' (2004) 3 *European Journal of Management and Public Policy* 27

Ahmed, 'Maqasid al-Shari'ah and Islamic Financial products : a framework for assessment' (2011) 3International journal of Islamic Finance 149

Ahmed, A. 'Methodological Approach to Islamic economics: Its Philosophy,

Theoretical Construction and Applicability' in Ahmad, H., *Theoretical*

Foundations of Islamic Economics. (Islamic Research and Training Institute

2002)

Ahmed, et al., 'Law, state power, and taxation in Islamic history', (2009) 71

Jorunal of economic behaviour and organization 704

Ahmed, et al., Accessibility to Basic Healthcare Services and its implications on

MAqasid AlShariah: A study of Muslim Community in Uganda' (2015) 20 *IOSR-*

JHSS 66

Ahmed, H. Financing microenterprises: An analytical study of Islamic

microfinance institutions. (2002) 9 *Islamic Economic Studies* 27-64.

Ahmed, *Risk Management: An analysis of issues in Islamic Financial Industry* (Islamic Development Bank 2001)

Ahmed, H. Waqf-Based Microfinance: Realizing the Social Role of Islamic

Finance. Paper presented at the Integrating Awqaf in the Islamic Financial

Sector, Singapore. (2007).

Ahmed, *The concept of an Islamic state* (Frances Printer Publishers 1987)

Aidid, Economic Determinants of Family Takaful Consumption: Evidence from Malaysi*a* (2009) 5 *International Review of Business Research Papers* 193

Aidit, G. & Omar, S. *Readings in the Concept and Methodology of Islamic Economics*. (Pelanduk Publications 1989)

Ajeeban, 'Shura calls Justice to educate women about their rights and legal legitimacy. *AlJazirah Newspaper* 5 October 2016

Ajijola, *The Islamic Concept of Social Justice* (Islamic Publications Ltd 1977)

Akhmetova, 'The Arab Spring, Good Governance and Citizens' Rights' (2014) 5 *Islam and Civilisational Renewal* 334

Akhtar, 'Understanding Islamic Finance: Local Innovation and Global Integration' (2008) 6 *Asia Policy*

Akhter, 'Risk Management in Takaful' (2010) 1 *Enterprise Risk Management* 128

Akinci, 'Privatization in Healthcare: Theoretical Considerations and Real Outcomes' (2002) 3 *Journal of Economic Education Research* 62

Akinci, 'The Role of Privatisation in Healthcare Services' (2000) 3 *Academy for Economics and Economic Education* 14

Akoum, Ibrahim. "Privatization in Saudi Arabia: is slow beautiful?." *Thunderbird International Business Review* 51.5 (2009): 427-440

Aksan et al, 'The change in capacity and service delivery at public and private hospitals in Turkey: A closer look at regional differences' (2010) 10 *BMC Health Services Research* 300

Al Tamawi, *Umar Bin Al Khitab wa Usul Al Siyasah [Omar ibn al-Khattab and the origins of politics]* (AlIdarah AlHadithah 1969) [In Arabic]

Al Alhareth, et al. ‘Review of women and society in Saudi Arabia’ (2015) 3 *American Journal of Educational Research* 121

Al-Amri ‘A survey of the Islamic insurance literature – takaful’ . (2015) 6 *Insurance Markets and Companies*

AL-Amri, ‘The Saudi Policy System’ (1982) 15 *Journal of Economics and Administration* 8-82

Al-Atawneh, M. *Wahhabi Islam Facing the Challenges of Modernity: Dar al-Ifta in the Modern Saudi State* (Brill Publication 2010).

Al-Barrak, ‘Initial public offerings in Saudi Arabia: motivations, barriers and effects.’ (PhD Thesis, Newcastle University 2005)

Al-Darwish, et al. *Saudi Arabia: Tackling Emerging Economic Challenges to Sustain Growth*. (International Monetary Fund 2015)

Al Ghalib, ‘Justice will be done, NHRA tells Rania’ *Arab News* 14 April 2004

Al-Ghamdi, A., ‘Attitudes on the Impact of Foreign Labor Force in Saudi Arabia Society, (PhD Thesis Michigan State University 1985)

Al-Harbi, Y. et. al, ‘The Changing Face of Healthcare in Saudi Arabia’ (2008) 28 Annals of Saudi Medicine 243

Al-Kalai ‘Arabian medicine in the Middle Ages’ (1984) 77 *Journal of the Royal Society of Medicine* 60–65.

Al-Khaldi, et al. "Audit of Referral of Diabetic Patients to an Eye Clinic from a Primary Health Care Clinic." (2002) 23 *Saudi Medical Journal* 177–81.

Al-Khalili, *Pathfinders the Golden Age of Arabic Science* (Penguin Books 2010)

Al-Naimi, *Investing for the Future in Turbulent Times*, Chatham House. Speech held at the Middle East and North Africa Energy 2012 Conference.

Al-Omar, F. *Management of Zakah Through Semi-Government Institutions. Management of Zakah in Modern Muslim Society* (Islamic Development Bank 1985)

Al-Otaibi, Adel 'Assessment of the Health Insurance in the Kingdom of Saudi Arabia' (Master thesis, Maastricht University 2005)

Al-Rajhi Company for Cooperative Insurance. *Decision no. 3 on 26/07/2009, the Shariah Board*,

Al-Rasheed, *Contesting the Saudi State: Islamic Voices from a New Generation.* (Cambridge University Press 2007)

Al-Salloum, T., 'Policy choices in developing countries: the case of privatization in Saudi Arabia'. (PhD Thesis George Mason University 1999)

Al-Sarhan, M. and Presley, J. "Privatisation in Saudi Arabia: an attitudinal survey." (2001) 27 *Managerial Finance* 114-122

Al-Shaikh, Said, 'Saudi Health Care Sector: Need for More Investment' *Arab News* 7 August 2006

AL-Shalawi, A, 'Saudisation and Manpower Development in Saudi Arabia: A Case Study of the Saudi Arabian National Guard Hospitals' (PhD Thesis, University of Birmingham 1988)

AlSibai 'Women in the reign of King Abdullah bin Abdulaziz' *Okaz* 23 January 2015

Al-Sultan, Financial Characteristics of Interest-Free Banks and Conventional Banks. (PhD,The University of Wollongong, 1999)

Al-Suwailem, *Hedging in Islamic Finance* (Islamic Development Bank 2006)

Al-Yousif, Y. "Do Government Expenditures Inhibit or Promote Economic Growth: Some Empirical Evidence from Saudi Arabia." (2000) 48 *Indian economic journal* 92

AlAasmi, *Aletmam BeJam'e Ayat AlAhkam* [Legal Context of the Quran] (Sultan University 2009) [In Arabic]

AlAhmadi, 'So That You Don't Leave Hospital With a New Disease' AlRiyadh Newspaper 12 October 2015

AlAhmadi, et al., 'Quality of primary health care in Saudi Arabia: a comprehensive review' (2005) 17 *International Journal for Quality in Health Care* 331

Alaiban, "A survey assessing patient satisfaction at public and private healthcare facilities in Riyadh, Saudi Arabia" (2003) 23 *Annals of Saudi Medicine* 417-419

AlAlbani, *Alseerah AlNabawiyah* [The Life of The Prophet] (Damascus 2001) [In Arabic]

AlAli, *Dawlat AlRasul fi AlMadinah: Dirasah fi Takawwuniha wa Tanzimiha* [The Prophet's state in Medinah: A study of its establishment and organization] (Sharikat AlMatbu'at LilTawzi' wa AlNashr 2001)

AlalSheikh, *AlFatwa Bain Mutabqat AlShariah wa Musayarat AlHawa* [Fatwas between Shariah Compliance and Following Desire] (Jareer 2013) [In Arabic]

Alam C. Masudul, and Al-Sakran. "Culture, finance and markets in Saudi Arabia." (2001) 27 *Managerial Finance* 25-46

Alam C., Masudul, and Azizur Rahman. "Macroeconomic relations in the Islamic economic order." (1986) 13 *International Journal of Social Economics* 60-78

Alama,'A*lIjtihad AlFiqhi wa Atharah fi Ta'adud AlMadhahib AlFiqhia* [Ijtihad Jurisprudence and its Impact on the Multiplicity of Islamic Legal Schools)' (Jan 2006) 41 AlRabetah 475 [in Arabic]

AlAmoudi, et al. 'Renewable energy resource facilities in the Kingdom of Saudi Arabia: Prospects, social and political challenges' (2017) 12 *JES* 8

AlAmri, 'The Saudi Policy System' (1982) 15 JEA 8

Alankar, et al., 'Health system in India: opportunities and challenges for improvements' (2006) 20. *Journal of Health Organisation and Management* 560

AlAnsari, Bimaristans and Waqf in Islam (PhD Thesis UOS 2013)

AlAtawneh, Wahhabi Islam Facing the Challenges of Modernity: Dar alIfta in the Modern Saudi State (Brill 2010)

Alawi, H. and Mujahid, G., *Skilled Health Manpower Requirement for the Kingdom of Saudi Arabia* (King Saud University Press 1982)

Albani, *Alseerah AlNabawiyah* [The Life of The Prophet] (Damascus 2001) [In Arabic]

Albaz, *Patient satisfaction with primary health care services in Saudi Arabia: A case study of Alriyadh city* (Ph.D. thesis, Washington University 1992)

Albejaidi, F. "Healthcare system in Saudi Arabia: An analysis of structure, total quality management and future challenges." (2010) 2 *Journal of Alternative Perspectives in the Social Sciences* 794-818

AlBorie et al 'A 'DIRE' needs orientation to Saudi health services leadership'

(2013) 26 *Leadersh Health Serv*

Albreht, 'Privatization processes in health care in Europe: a move in the right direction, a "trendy" option, or a step back?' (2009) 19 *European Journal of Public Health* 448

AlDaghistani, 'Semiotics of Islamic Law, Maslahah, and Islamic Economic Thought' (2016) 29 *International Journal for the Semiotics of Law* 389

AlDakheel, 'Ra'I Fi AlRuy'ah 2030: Qira'ah Tahliliyah Naqdiyah' ['An opinion on the 2030 Vision: A Critical Analytical Reading'] (Riyadh 2016)

AlDoghaither, et al., 'Consumers' satisfaction with primary health services in the city of Jeddah, Saudi Arabia' (2000) 21 *Saudi medical journal* 447

AlDosari, *Human Rights in Islam* (PhD Thesis UCL 2010)

AlDossary, 'Health and Development in poor countries with particular reference to Saudi Arabia' (PhD Thesis, University of Aberdeen 1991)

AlDuri, *AlNuthum AlIslamiyah* [Islamic Systems] (Bait AlHikmah 1988) [In Arabic]

Alexander, J. & Lewis B. 'The financial characteristics of hospitals under for-profit and nonprofit contract management' (1984) 21 *Inquiry* 230-42

AlFadhil, 'AlTameen AlSihhi fi AlShariah wa AlNitham' [Healthcare Insurance in Shariah and Law] (Masters Thesis, Islamic University of Madinah 2012) [In Arabic]

AlFaqeeh, 'Acess and utilization of primary health care services in Riyadh

province, Kingdom of Saudi Arabia' (University of Bedfordshire PhD Thesis 2015)

AlFaris, et al., 'Patient's satisfaction with accessibility and services offered in Riyadh health centers' (1996) 17 *Saudi medical journal* 11

Alghamedi, 'Lack of Diversification is a Challenge Facing Saudi Arabia' (2014) 8 Journal of Global Business Issues 57

AlGhanim, 'Assessing knowledge of the patient bill of rights in central Saudi Arabia: a survey of primary health care providers and recipients' (2012) 32 *Ann Saudi Med* 151

AlGhanim, 'Factors Influencing the Utilisation of Public and Private Primary Health Care Services in Riyadh City' (2004) 19 *JKAU: Econ and Admin* 3

AlGhanoushi, *Huquq Ghayr AlMuslimin Fi AlMujtama AlIslami* [Rights of Non-Muslims in the Islamic Society] (International Institute of Islamic Thought 1993) [In Arabic]

Alghazal, 'Medical Ethics in Islamic History at a Glance' 3 (2004) *Journal of International Society for the History of Islamic Medicine* 12

AlHarthi, *Khaskhasat AlKhadamat* [Privatization of Services] (Arak Research 2012) [In Arabic]

Alhabdan, *Domestic Violence in Saudi Arabia* (JSD, Indiana University 2015)

AlHbabi, 'The Evaluation and Development of a Model for Primary Healthcare in the UAE' (PhD Thesis, University of Aberdeen 2003)

ALHibri, 'An Islamic perspective on Domestic Violence' (2003) 27 *Fordham International Law Journal* 195

AlHowaish, Economic Costs of Diabates in Saudi Arabia, (2013) 20 JFCM

Alhowaish, "Healthcare spending and economic growth in Saudi Arabia: A Granger causality approach." (2014) 5 International Journal of Scientific & Engineering Research 1471-1476.

AlHussain, 'AlNitham AlSihhi bilMamlakah: Mn ain yabda' Tahseen AlKhadamat wa AlAda?!' [Saudi Healthcare System: Where does improving the services and performance begin?!] *Risalat Maahad AlIdarah* (Riyadh, December 2004)

AlHussayen, *'AlQawanin AlWad'ia fi Mizan AlShariah AlIslamiah'* [Man-made laws and Islamic Laws] (AlNaeem 1988) [In Arabic]

Ali, Basis And Models of Takaful: The need for Ijtihad. (ICMIF Takaful 2006)

Ali, 'Fluency in the consulting room' (2003) 53 *The British Journal of General Practice* 514

Ali, *Health systems in western Saudi Arabia: Location analysis and spatial planning, monitoring and evaluation* (PhD thesis, The University of Wisconsin-Milwaukee 1984)

Ali, 'Principles and Practices of Insurance under The Islamic Framework' (1989) Insurance Journal 29

Ali, Abbas J. "Middle East competitiveness in the 21st century's global market." *The Academy of Management Executive* 13.1 (1999): 102-108.

Ali, *AlIslam wa alHadharah AlArabiyah* [Islam and the Arab Civilisation] (Lajnah 1968) [In Arabic]

Ali, *AlKhaskhasah* [Privatization] (AlAhram 1996) [In Arabic]

Ali, *AlTa'leem wa AlKhaskhasah* [Education and Privatization] (AlAhram 1996)

Ali, et al. "The Middle East and North Africa: Cursed by Natural Resources?." in *Economic Development in the Middle East and North Africa*. (Palgrave Macmillan 2016) 71-93.

Ali, et al., 'A study of patient satisfaction with primary health care services in Saudi Arabia' (1993) 18 *Journal of community health* 49

Ali, et al., 'The role of culture in the general practice consultation process' (2006) 11 *Ethnicity and Health* 389

Ali, *Human Rights in Islam* (Aziz Publishers 1980)

Ali, M. 'Health Systems in Western Saudi Arabia: Location Analysis and Spatial Planning, Monitoring and Evaluation' (PhD Thesis, University Microfilms International 1984)

Ali, *The Concepts of Islamic Ummah and Shariah* (Darul Ehsan Publications 1992)

AlJarAllah, 'The Impact of Health Insurance Programme on the Quality of the Private Hospital's Services in the Kingdom of Saudi Arabia' (PhD Thesis, University of Hull 2007)

AlJarAllah, et al. *Physician's duties towards patients. In ethics of the medical profession- Manual Guide for Medical Practitioners* (Saudi Council for Health Specialities 2003)

Aljuaid, Mohammed, et al. "Quality of care in university hospitals in Saudi Arabia: a systematic review." (2016) 6 *BMJ open* e008988

Al-Juhani, Abdulrahman Mohammed Bukhait. (1994) A study of patient satisfaction with medical care services in Yanbu Al-Sinaiya, Saudi Arabia, Ph.D. thesis, The University of Texas H.S.C. at Houston School of Public Health.

Alkabba, A. et al. "The major medical ethical challenges facing the public and healthcare providers in Saudi Arabia." (2012) 19 *Journal of Family and*

Community Medicine 1

AlKadi, S. "The Healthcare System in Saudi Arabia and its Challenges: The Case of Diabetes Care Pathway." (2016) 10 *Journal of Health Informatics in Developing Countries* 1

AlKalai, "Arabian Medicine in the Middle Ages"(1984) 77 *JRSM* 60

AlKatani, *Nitham AlHukumah AlNabawiyah: AlTarateeb AlIdariyah* [The Prophetic Government: Administrative Formalities] (Dar AlArqam 2008) [In Arabic]

AlKhabrani, 'MOH: Female patients are allowed to give consent without guardian signature' *Sabq* 16 January 2019

AlKhaldi, et al., 'Availability of resources of diabetic care in primary health care settings in Aseer region, Saudi Arabia' (2002) 23 *Saudi medical journal* 1509

AlKhaldi, et al., 'Health education resources availability for diabetes and hypertension at primary care settings, Aseer region, Saudi Arabia' (2005) 12 *Journal of family & community medicine* 75

AlKhalili, Pathfinders the Golden Age of Arabic Science (Penguin 2010)

AlKhamis A, A comparison of access to medical care for insured and uninsured expatriates in Saudi Arabia (Master Thesis, Univeristy of Liverpool 2013)

Alkhamis et al,. 'Financing healthcare in Gulf Cooperation Council countries: a focus on Saudi Arabia' (2014) 29 International Journal of Health Planning and Management e64

AlKhamis, 'Letter to the Editor' (2012) 18 EMHJ 1078

Alkhamis, A., and Miraj, S. "Association between demographic characteristics and health status of uninsured expatriate workers in Saudi Arabia." (2016) 9

BBRC 587

AlKhamis, Privatization of health services: a necessity or a luxury? AlEqtisadiah, 21 July 2015 [In Arabic]

AlKhateeb, et al. *Change from within: Diverse Perspectives on Domestic Violence in Muslim Communities* (Peaceful Minds Project 2007)

AlKhayat, 'Health as a Human Right in Islam' in *The Right Path to Health: Health Education through Religion* (WHO Regional Office, Cairo, 2004)

AlKhayat, *Health: An Islamic Perspective* (WHO 1997)

AlKhitamy et. al, 'Bioethics for Clinicians: Islamic Bioethics' (2001) 164 Canadian Medical Association Journal 60-63

Allan, et al., 'Exploring the influence of income and geography on access to services for older adults in British Columbia: A multivariate analysis using the Canadian Community Health Survey (Cycle 3.1)' (2011) 30 *Canadian Journal on Aging* 69

Allin et al, *Measuring inequalities in access to Healthcare: A review of the indices* (European Commission 2007)

AlLli, *AlHurriyyat AlAmmah Fil Nizam Al Siyasi Fil Islam [Public Rights in Islamic Political Regimes]*. (Dar AlFikir 1974) [In Arabic]

Allotey et al., 'Rethinking health-care systems: a focus on chronicity' (2011) 377 *Lancet* 450

Allotey, et al., 'Universal Coverage in an era of privatisation can we guarantee health for all?' (2012) 12 *BMC Public Health* s1

Alluhaidan, '*Ijtihad AlQadi fi AlSharia wa Tatbiqatiha fi AlMamlaka AlArabia*

AlSaudiah' [Ijtihad of Judges in Sharia and its applications in Saudi Arabia] (Master thesis, Naif Arab University 2004)[in Arabic]

AlMaamiry *Private Personal Ownership and its limitations in Islam* (Lancer Books 1987)

AlMaamiry, *Economics in Islam* (Lancer Books 1987)

AlMaghribi, *Kitab fi AlSiyasah [The Book of Politics]* (Al Ma'had AlFransi 1948) [In Arabic]

AlMagrabi, *Geographical aspects of health and use of primary health care services in Jeddah, Saudi Arabia.* (University of Strathclyde 2011)

Almalki et al. 'The healthcare system in Saudi Arabia: An overview' (2011) 7 *East Mediterr Health J* 784-793

Almasabi, M. "An overview of health system in Saudi Arabia." (2013) 7 *Res J Med Sci* 70-4

Almasabi, M. "Factors influence and impact of the implementation of quality of care in Saudi Arabia." (2013) 4 *Journal of Medicine and Medical Sciences* 92-95

Almashabi, et al., 'Saudi Arabia's Deputy Crown Prince Outlines Plans: Transcript.' *Bloomberg*, 4 April 2016

AlMatroudi, *The Hanbali Scool of Law and Ibn Taymiyyah* (Taylor and Francis 2006)

AlMaududi, *Hawl Tatbeeq AlShariah fi AlAssr AlHadher* [On the Application of Shariah in the Present Era] (AlRushd 2012) [In Arabic]

Almeida C, et al. 'Methodological concerns and recommendations on policy consequences of the World Health Report 2000' (2001) 357 *The Lancet* 1692

AlMishaal, 'Mulakhas an Tajrubat Tatbeeq AlTameen AlSihhi fi Dawlat Taiwan' [Summary of the Experience of Application of Healthcare Insurance in Taiwan] *Sehat AlSharqia* (Dammam, January 2008)

AlMishaal, 'Mumayizat Nitham AlTameen AlSihhi AlWatani NHI fi Dawlat Taiwan' [The Benefits of NHI in Taiwan] *Sehat AlSharqia* (Dammam, January 2008)

AlMoajel, et al., 'Patient Satisfaction with Primary Health Care in Jubail City, Saudi Arabia' (2014) 11 *World Journal of Medical Sciences* 255

AlMobarak, 'Beneficiaries' Satisfaction with the Cooperative Health Insurance System (CHIS) in the Kingdom of Saudi Arabia: A Case Study of Riyadh City' (PhD Thesis, University of Hull 2010)

Almobarak, Patients` Perception of Health Insurance in Saudi Arabia, (Saudi International Innovation Conference, University of Leeds 2008)

AlMobeeriek, 'Dentist-patient communication as perceived by patients in Riyadh, Saudi Arabia' (2012) 25 *International journal of occupational medicine and environmental health* 89

AlMubarak, 'Applications of Maqasid al-Shari'ah and Maslahah in Islamic Banking practices: an analysis' at the International Seminar on Islamic Finance in Kochi, India 4 - 6 October 2010

AlMukhtar, 'Empowering women: Kingdom leads the way' *Arab News* 16 May 2012

AlMukhtar, 'Women no longer need identifiers at Saudi Courts' *Arab News* 14 February 2014

AlMunajjed, *Women in Saudi Arabia Today* (st Martins Press 1997)

AlNahedh, 'Sociodemographic variables affecting the health seeking behaviour of mothers in a Saudi community' (2004) 11 *Journal of family & community*

medicine 3

Alnaif, M. S. 'Physicians perception of health insurance in Saudi Arabia'. (2006) 27 *Saudi Medical Journal* 693

AlNozah, et al. 'Coronary Artery Disease in Saudi Arabia' (2004) 24 *Saudi Med J* 1165

AlNuaim, 'Overweight & Obesity in Saudi Arabian Adult Population, Role of Sociodemographic Variables' (1997) 22 *Journal of Community Health* 211

AlOadah, 'Men are the protectors and maintainers of women' *IslamToday English* available at http://en.islamtoday.net/artshow- 264-3151.htm accessed 5 January 2019

AlObaidi, 'AlKhaskhasah bain AlEqtissad AlIslami wa AlEqtissad AlWad'i' [Privatisation between Islamic Economics and Positive Economics] (Dairat AlShu'oon AlIslamiyah 2011) [In Arabic]

AlObaidi, *AlMulkiyat AlThalath: Dirasah A'an AlMulkiyah AlA'amah wa AlMulkiyah AlKhasah wa Mulkiyat AlDawlah Fe AlNitham AlIqtisadi AlIslami* [The Three Ownerships: A study about Private public ownership, Private personal ownership, and Governmental public ownership in the Islamic Economical System] (Islamic Affairs 2009)

Alomair, Saleh (2001) "The role of Insurance Companies in the Health Insurance Sector and the Experience of NCCI", Riyadh.

Al-Omar, Badran A. (2002) Applications of Total Quality Management Principles in Riyadh City Hospitals from the Nursing practitioners point of views, Journal of Public Administration, 42(2):305-352, (Arabic reference).

AlOmar, et al. The changing face of healthcare in Saudi Arabia.(2008) 28 ASM

Alosaimi M, & Alsharif A, *The equity in access to health services in cooperative health insurance system, Jeddah, 2008-2009.* (Arab Board in Community

Medicine 2009)

AlOsimy, 'Evaluation of primary health care in Riyadh, Saudi Arabia' (1994) 1 *Journal of family & community medicine* 45

AlQahtani, et al. 'Sharia compliance status & investor demand for IPOs: Evidence from Saudi Arabia' (2017) 46 *Pacific-Basin Finance Journal* 258

AlQurashi et al. The prevalence of sickle cell disease in 40. Saudi children and adolescents: a community-based survey (2008) 29 SMJ

Alrabeah, Abdulrahman, et al. "TQM in the Saudi Health Care System: A National Cultural Perspective." Proceedings of the 26th International Business Research Conference, 7-8 April 2014, Imperial College London

AlRabeie, *AlKhaskhasah wa Atharha ala AlTanmiyah fe Alduwal AlNamiyah* [Privatization and its effect on development in developing countries] (Madbouli 2004) [In Arabic]

AlRaysuni, *Theory of the Higher Objectives and Intents of Islamic Law* (IIIT 2005)

AlRaziq, *AlIslam wa Usul AlHukm* [Islam and the Origins of Governance] (Dar AlJanub 1996)

AlRibdi, *The geography of health care in Saudi Arabia: provision and use of primary health facilities in Al-Qassim region.* (University of Southampton 1990)

AlRifaei, *Ala Men Tajib AlZakat?* [Who is Eligible for Zakat?] (Alalookah 2012) [In Arabic]

AlRumi, *Manhaj AlMadrassah AlAqliyah AlHadithah Fi AlTafseer* [Modern School of Interpretation] (AlRisalah 1983) [In Arabic]

AlSa'idi, *AlSiyasah fi Ahd AlNubuwwah [Politics in the era of the Prophet]* (Dar AlFikr AlArabi) [In Arabic]

Al-Sakkak, Maher, Al-Nowaiser, Noura, Al-Khashan, Hesham, Al-Abdrabulnabi, Ashraf and Jaber, Rana (2008) Patient satisfaction with primary health care services in Riyadh, Saudi Medical Journal, 29 (3): 432-436.

AlSaleh, 'Gender inequality in Saudi Arabia: Myth and Reality' (2012) 39 *International Proceedings of Economics Development & Research* 123

AlSaleh, 'Realist Evaluation of Public Partnerships in the Kuwaiti health care system' (PhD Thesis, University of Surrey 2012)

AlSaqa, *Tajrubat AlKhaskhasah Fe AlMamlakah AlMutahidah* [The Experience of Privatisation in the U.K] (AlMujalad Kuwait University 1997)

AlSayyari et al., End Stage Chronic Kidney Disease in Saudi Arabia: A rapidly changing scene, (2011) 32 SMJ 399

AlShabani, *AlKhaskhasah Mn AlManthoor AlIslami: Ba'i AlQit'a AlA'am LilAfrad* [Privatization from an Islamic Perspective: Selling the Public Sector to Individuals] (AlBayan 1995)

AlShahrani, et al. *Economic growth and government spending in Saudi Arabia: An empirical investigation*. (International Monetary Fund 2014)

Al-Shahrani, Nasser Mobammad (1999) Expectations and perceptions of patient satisfaction in a Saudi Arabian Hospital, Ph.D. dissertation, University of Wales.

AlShahrani, *The accessibility and utilization of primary health care services in Riyadh, Kingdom of Saudi Arabia.* (University of East Anglia 2004)

AlShaikh, 'Saudi Health Care Sector: Need for More Investment', *Arab News* (Riyadh 7 August 2006)

Al-Shamekh, *Determinants of patient general satisfaction with primary health care services in Riyadh, Saudi Arabia* (Ph.D. thesis, University of Pittsburgh 1992).

Alshammasi, *The Influence of Economic, Political and Socio-cultural Factors on the Development of Health Services in Saudi Arabia* (Ph.D. thesis, University of Hull 1986).

AlSharafi, et al. 'Techo-economic analysis and optimization of solar and wind energy systems for power generation and hydrogen production in Saudi Arabia' (2017) 69 *RSER* 33

AlSharqi et al, "Diagnosing" Saudi health reforms: is NHIS the right

"prescription"? (2013) 28 International Journal of Health Planning and

Management 308

AlShayaa, *Mukhtassar Seerat AlNabbi* [The Concise Life story of The Prophet]

(AlRayyan 2003) [In Arabic]

AlSheikhi, 'The Success of Health Insurance for Saudi Citizens: Hospital

Privatisation in Saudi Arabia' (2016) 8 *European Journal of Business*

Management 183

Al-Shekh, A.A.A. (2003) Perceptions of hospital experiences in Riyadh City, Saudi Arabia: a comparison of service quality in public and private hospitals, Ph.D. thesis, University Wales, Swansea.

AlShohaib, et al. *Health and Well-being in Islamic Societies: A Background,*

Research and Applications (Springer 2014)

AlSuhaim, Fatwa 195, (AlDawah wa AlErshad, Dawa and Guidance 2000)

AlSulaiman, 'Provide wives with 'family cards'!' *Saudi Gazette* 13 November

2015

AlSumairi, et al. 'A case study: The impact of low-cost carriers on inbound

tourism of Saudi Arabia' (2017) 62 *JATM* 129

AlSwailem, A. "Assessing health care delivery in Saudi Arabia", (1990) 10 *Annals of Saudi Medicine* 63-8.

AlTassan, 'The Emergence of Health Insurance in the Kingdom of Saudi Arabia'

(PhD Manchester Metropolitan University, 2003)

Alterman, J. and Hunter, S. *The Idea of Philanthropy in Muslim Context* (CSIS 2004)

AlTurki, Overview of chronic diseases in the Kingdom of 41. (2000) 21 SMJ

AlUlfi, 'AlTa'meen AlSihhi Dirasah Tatbeeqiyah' [Health Insurance: An Emprical Study] *AlHIkmah* (Riyadh 2006)

Alvarez L, Salmon W, Swartzman D. 'The Colombian health insurance system and its effect on access to health care' (2011) 41 *International Journal of Health Services* 355–370

Alwan A, Introduction: The Work of WHO in the Eastern Mediterranean Region: Annual Report of the Regional Director, 1 January – 31 December 2011

AlYaemni, et al. 'Gender Inequities in Health: An Exploratory Qualitative study of Saudi Women's Perceptions' (2013) 53 *Women & Health* 741

Alyagout, F, and Siti-Nabiha. "Public Sector Transformation: Privatization in Saudi Arabia." in *Public Sector Transformation Processes and Internet Public Procurement: Decision Support Systems: Decision Support Systems* (IGI Global 2012)

AlYousef, et al., 'Organization of the Saudi health system' (2002) 8 *East Mediterr Health J* 645

AlZahm, '*AlKhibrah wa Dawruha wa AlHukm fi AlShariah AlIslamiah wa AlNitham AlSaudi'* [The role of Experience, Islamic law and the Saudi regime)' (Master thesis, Islamic University of Madinah 2011) [in Arabic]

AlZeer The Registration of a Real Estate Mortgage (Masters thesis, IMSIU

1430H)

AlZuahaily, *Fiqh AlIslam wa Adallatuh [Islamic Jurisprudence and Justice]* (Darul Fikr 1989) [In Arabic]

Amirkhanyan, et al. 'Putting the Pieces Together: A Comprehensive Framework for Understanding the Decision to Contract Out and Contractor Performance' (2007) 30 *International Journal of Public Administration* 6

Amuna P, Zotor FB. Epidemiological and nutrition transition in developing countries: impact on human health and development. Proc Nutr Soc 2008;67(1):82–90

Andersen, et al., 'Access to Medical Care for Low-Income Persons: How do Communities Make a Difference?' (2002) 59 *Medical Care Research and Review* 384

Andersen, et al., 'Culturally competent healthcare systems: a systematic review' (2003) 24 *American journal of preventive medicine* 68

Andersen, et al., 'Exploring dimensions of access to medical care' (1983) 18 *Health services research* 49

Andersen, et al., *Equity in health services: Empirical analyses in social policy* (Ballinger Pub. 1975)

Andersen, et al., *Improving access to care in America. Changing the US health care system: key issues in health services policy and management* (Jossey-Bass 2007)

Anderson, et al 'Culturally competent healthcare systems' (2003) 24 *AJPM* 68

Anderson GF, Reinhardt UE, Hussey PS, Petrosyan V: It's the prices, stupid: why the United States is so different from other countries. Health Affairs (Millwood) 2003, 22: 89-105.

Angell, 'Privatizating health care is not the answer: lessons from the United States' (2008) 179 CMAJ 916

Anqari, et al., *Urban and Rural Profiles in Saudi Arabia* (Gebrüder Borntraeger 1989)

Ansari, Analysis of the impact of reforms on insurance industry of Saudi Arabia (2011) 1 *Interdisciplinary Journal of Research in Business* 28

Aoun,"Oil and Gas Resources of the Middle East and North Africa: a Curse or a Blessing?." in *The New Energy Crisis* (Palgrave Macmillan 2013) 133-160

Appleby, 'Migrants' healthcare: who pays?' (2013) *BMJ* 347

Arab Social Media Report, The Governance and Innovation Program at the Mohammed bin Rashid School of Government in Dubai 2014

Arah, et al. "A conceptual framework for the OECD health care quality indicators project." (2006) 18 *International Journal for Quality in Health Care* 5-13

Aramco Medical Department. Epidemiology Bulletin, Dhahran, Saudi Arabia. 1972 Oct;:1–2.

Arberry, A. *Muslim Saints and Mystics* (Routledge 1966)

Arcury, et al., 'The Effects of Geography and Spatial Behavior on Health Care Utilization among the Residents of a Rural Region' (2005) 40 *Health Services Research* 135

Ariff, *Economics and Ethics in Islam. Readings in the Concept and Methodology of Islamic Economics* (CERT Publication 2005)

Arishi, *A study of Patient Satisfaction with the Medical Care Services Provided by the Royal Commission's Hospitals in Al-Jubail Al-Sinaiayah, Saudi Arabia* (Ph.D. thesis, University of Wales 2000)

Armstrong, *Mohammed: A prophet from our time* (Harper One 2007)

Arora, et al., *Public Payment and Private Provision. The Changing Landscape of Health Care in the 2000s.* (Nuffield Trust 2013)

Arrowsmith J., Sisson, K. 'Decentralization in the public sector: the case of the UK National Health Service' (2002) 57 *Relations Industrielles* 2

Asad, *The Principles of State and Government in Islam,* (Berkeley 1961)

Ashraf M, *Al-Ghazali on Divine Predicates and their Properties: al-Iqtisad fil-I'tiqad*, (Lahore 1970)

Ashraf, A.,. & Hippler, W. 'Performance of microfinance institutions in Muslim countries' (2014) 30 *Humanomics* 162 – 182.

Askari, et al., *New Issues in Islamic Finance and Economics: Progress and Challenges* (John Wiley & Sons 2011)

Askari, H., & Iqbal, Z., *New Issues in Islamic Finance and Economics: Progress and Challenges* (John Wiley & Sons 2011)

Askari, H., et al. *Risk Sharing in Finance : The Islamic Finance Alternative* (John Wiley & Sons 2012)

Askari, *Saudi Arabia's Economy: Oil and the Search for Economic Development*, (Jai Press 1990).

Aslam, M.N. 'Role of Islamic microfinance in poverty alleviation in Pakistan: An empirical approach' (2014) 4 *International Journal of Academic Research in Accounting, Finance and Management Sciences* 143-152.

Asman, 'Abortion in Islamic Countries- Legal and religious Aspects' (2004) 23 *Med Law* 73-89

AsSayid, *Fiqh AsSunnah [Jurisprudence of Sunnah]* (Darul Kitab AlArabi 1985)

Attia, *Towards Realization of the Higher Intents of Islamic Law* (IIIT 2007)

Attieh, *Nahu Tafe'el Maqasid AlShariah* [Towards Activating The Role of Maqasid AlShariah] (Dar AlFikr 2001) [In Arabic]

Atzori, Daniel. "The Political Economy of Oil and the Crisis of the Arab State System." 61 (FEEM 2013)

Auda, *Maqasid Al-Shariah as Philosophy of Islamic Law: A Systems Approach* (The International Institute of Islamic Thought 2008)

Avery, 'Outsourcing Public Health Laboratory Services: A Blueprint for determining whether to provatise and how' (2002) 60 *Public Administration Review*

Ayo-Yusuf, et al., 'Health insurance, socio-economic position and racial disparities in preventive dental visits in South Africa' (2013) 10 *International journal of environmental research and public healthc* 178

Ayub, M. *Understanding Islamic Finance* (John Wiley & Sons 2007)

Azhar, *Economics of an Islamic economy,* (BRILL 2010)

Azmat, et. al, 'The Shariah Compliance Challenge in Islamic Bond Markets'

(2014) 28 *Pacific-Basin Finance Journal* 47-57

Azzam, H., *The Gulf Economies in Transition* (Macnillan Press 1988)

Bachman, D., "China and 'privatization," Paper presented at the Privatization Working Conference, Princeton University (Princeton, 1988)

Badar, 'Islamic Law (Sharia) and the Jurisdiction of the international criminal court' (2011) 24 *LJIL* 411

Badawi, *Gender Euity in Islam: Basic Principles* (American Trust Publications 1995)

Badawi, *Zakat And Social Justice* (Finance in Islam Publications 2005)

Baderin, *Islamic Legal Theory* (Routledge 2017)

Baer, 'The Waqf as a prop for the social system (16th-20th Centuries), (1997) 4 *Islamic Law and Society* 264

Baffes, et al. *The great plunge in oil prices: Causes, consequences, and policy responses* (World Bank Group 2015)

Bahammam, L. M. A. *Gendered discourses and discursive strategies employed in Twitter-hashtagged debates about Saudi-women's issues.* (PhD thesis, University of Reading 2018)

Baker E., Potter M., & Jones D., 'The public health infrastructure and our nation's health' (2005) 26 *Annu Rev Public Health* 303–318

Baker, A. 'Rich Nation, Poor People: Saudi Arabia by Lynsey Addario' *Time* 23 May 2013

Bakhashwain, *Acceptance and utilisation of primary health care in Jeddah City,*

Saudi Arabia. (PhD Thesis University of Hull 1995)

Bakhtiari, 'An empirical investigation of the effects of health and education on income distribution and poverty in Islamic Countries' (2010) 37 *International Journal of Social Economics* 293

Baltaji, *AlMulkiyah AlFardiyah fe AlNitham AlEqtissadi AlIslami,* [Private Ownership in The Islamic Economical System] (AlShabab 1988)

Bambra, et al. 'All things being equal: does it matter for equity how you organise and pay for health care? A review of the international evidence' (2014) 44 *Intl J Health Services* 457

Banafea, et al 'Assessment of economic diversification in Saudi Arabia through nine development plan' (2018) 42 *OPECER* 42

Banoob, "Global directions for reforming health systems and expanding insurance. What is suitable for the Arab Gulf countries?" (2001) 22 *Saudi Medical Journal* 743-748.

Banoob, Private and public financing-health care reform in eastern and central Europe. (1994) 15 *World Health Forum* 329-34

Banoob, S., "Private and public financing-health care reform in eastern and central Europe" (1994) 15 *World Health Forum* 329-34.

Barakah, D. & AlSaleh, S, 'The Cooperative Insurance in Saudi Arabia: a Nucleus to Health Reform Policy' (2011) 21 *IPEDR* 6

Barakah, D., & Alsaleh, S., *The Cooperative Insurance in Saudi Arabia: A Nucleus to health Reform Policy*. Paper presented at the 2011 International Conference on Information and Finance.

Barakat, *The Arab World: Society, Culture and State* (University of California Press 1993)

Barlow, et al, 'Europe sees mixed results from public-private partnerships for building and managing health care facilities and services' (2013) 32 *Health Affairs* 146

Barnet, *Does Human Rights need God?* (Wm B Eerdmans 2005)

Barr, N., *The Economics o f the Welfare State* (Weidenfeld and Nicolson. 1987)

Barron, Michael (2000) "Insurance plan is symptom of Saudi economic ills", Journal of Commerce, Feb 7:6.

Bartley, 'Health costs of social injustice: there is such a thing as society' (1994) 309 *BMJ* 1177

Bashatah, Fawziyah. *Saudi Women Between the Theological and the Social* (Madarek 2011) [in Arabic]

Basri, 'Economic Facilities for Non-Muslims in a Muslim country in the light of the Quran and Sunnah' (2011) 1 *Journal of Humanity and Islam* 28

Basu S. et al, 'Comparative Performance of Private and Public Healthcare Systems in Low and Middle Income Countries: A Systematic Review' (2012) 9 PLoS Med

BBC 'Saudi Arabia's King appoint Women to Shura Council' 11 January 2013

BBC "Which is the world's biggest employer?" 20 March 2012

BBC "Which is the world's biggest employer?" 20 March 2012

BBC News, Call for Dentists, 3 June 2007, Retrieved 15 April 2014

BBC, "Health Tourists could get refund", 7 December 2007, retrieved 11 February 2014

BBC, Huge contrasts in Devolved NHS, 28th of August 2008.

Bearman, et al., *The Law Applied: Contextualizing the Islamic Sharia* (I.B Tauris 2008)

Bearmen, Peters, Vogel, *The Islamic School of Law: Evolution, Devolution and Progress* (HUP 2005)

Beauchamp D. 'Public health, pri- vatization, and market populism: a time for reflection' (1997) 5 *Qual Manage Health Care* 73–79

Béchamps M, Bialek R, Chaulk C. *Privatization and public health: a report of initiatives and early lessons learned.* (Public Health Foundation 1999)

Beck, T., et al. 'Finance, Inequality and the Poor' (2007) 12 *Journal of Economic Growth* 27-49

Beer, 'Privatisation in health system in developing countries: whats in a name?' (2011) 19 *Reproductive Health Matters* 4

Behdad, "Property Rights in Contemporary Islamic Economic Thought: A Critical Perspective" (1989) 2 *Review of Social Economy* 185

Behdad, *Property Rights and Islamic Economic Approaches* in Jomo, *Islamic Economic Alternative. Critical Perspectives and New Directions* (Macmillan 1992)

Bekhouche, et al. *The Global Gender Gap Report 2013* (World Economic Forum 2013)

Belli, 'Incentives and the reform of healthcare systems' (PhD Thesis, London School of Economics and Political Science)

Belli, P., Shahriari, H., 'Out-of-pocket Payments in the Health Sector: evidence from Georgia' (2004) 70 *Health Policy* 109-123

Benchea, "Rebuilding the Arab Economies: New Regional and Global Strategies"

(2015) 7 *European Journal of Interdisciplinary Studies* 29

Benchea, L, and Rodica M. 'The Arab World at a crossroad: Facing the Economic and Social Challenges" the 7th international scientific conference Lithuania (Technika 2012)

Bennett, *Decentralization, local governments, and markets: towards a post-welfare agenda*. (Clarendon Press 1990)

Bennett, S., Creese, A., and Monasch, R, *Health insurance schemes for people outside formal sector employment* (The WHO 1998)

Benson, 'The impact of privatization on access in Tanzania'(2001) 52 *Social Science & Medicine* 1903

Berer, 'Privatisation in health system in developing countries: what's in a name?' (2011) 19 *Reproductive Health Matters* 4

Berer, 'who has responsibility for health in a privatised health system?' (2010) 18 *Reproductive Health Matters* 4

Berg , et al. 'Divestiture in developing countries' (The World Bank 1987) World Bank Discussion Papers No 11

Bergman, S. 'Swedish models of health care reform: a review and assessment' (1998) 13 *International Journal of Health Planning and Management* 91–106.

Bergstrom, Health for all by the year 2000?, (1996) *BMJ* 313

Bersamin, et al., 'Does distance matter? Access to family planning clinics and adolescent sexual behaviors' (2011) 15 *Maternal and child health journal* 652

Berwick, et al. "Connections between quality measurement and improvement." (2003) 41 *Medical care* 30

Beveridge, Social Insurance and Allied Services, HM stationary Office, November 1942.

Bhala, *Understanding Islamic Law* (LexisNexis 2011)

Bhalla, *The institution of property: Legally, Historically and Philosophically Regarded* (Eastern Book co. 1984)

Bianchi, "Capitalism and Islam." *The Oxford Encyclopedia of the Modern Islamic World*

Bielefeldt, '"Western" versus "Islamic" Human Rights Conceptions?: A Critique of Cultural Essentialism in the Discussion on Human Rights' (2002) 28 *Political Theory* 90

Bienen, et al. 'Economic stabilisation, conditionality and political stability' (1985) 39 *International Organisation* 729

Bienen, et al. 'The political economy of privatisation in developing countries' (1989) 17 *World Development* 617

Billah, *Principles and Practices of Takaful and Insurance Compared* (GECD Printing 2001)

Birdsall, et al., 'Winners and losers: Assessing the distributional impact of privatisation' (2003) 31 *World Development* 1617

Birdsall, N. and Hecht, R., 'Swimming against the tide: Strategies for Improving Equity in Health' *HRO Working Papers,* the World Bank (1995).

Biu, et al. ‘The relevance of Islamic Legal Maxims in determining some contemporary legal issues’ (2016) 24 IIUMLJU 415

Biygautane, "Infrastructure Public–Private Partnerships in Kuwait, Saudi Arabia, and Qatar Meanings, Rationales, Projects, and the Path Forward." (2016) 22 *Public Works Management & Policy* 85

Biygautane, M. Hodge, G. and Gerber, P. "The Prospect of Infrastructure Public-Private Partnerships in Kuwait, Saudi Arabia, and Qatar: Transforming Challenges into Opportunities." (2016) *Thunderbird International Business Review*

Bjorvatn, ‘Islamic Economics and Economic Development’ (1998) 25 *Forum for Development studies* 229

Black, and Hosen, *Modern Perspective on Islamic Law* (Edward Elgar 2013)

Black, D., *Inequalities in Health,* (HMSO 1980)

Black, *The History of Islamic Political Thought: From the Prophet to the Present* (EPU 2011)

Blair, ‘Saudi Arabian domestic violence campaign shows woman in niqab with black eye’ *The Telegraph* 29 April 2013

Blas, J., Smith, G. In U-Turn, Saudis Choose Higher Prices Over Free Oil Markets. – *Bloomberg*, 29 September 2016

Blazquez, et al ‘Oil subsidies and renewable energy in Saudi Arabia: a general equilibrium approach’ (2017) 38 *Energy* 29

Blendon R, Donelan K, Jorell J, Pellise L, Lombardia EC. Spain's citizens assess their health care system. Health Affairs 1991; 10:216–28.

Blumenthal D, Hsiao W. Privatization and its discontents – the evolving Chinese health care system. New England Journal of Medicine, 2005, 353(11):1165–1170.

Bookman, *Medical tourism in developing countries* (Springer 2007)

Borland, 'The truth about health tourism that costs us millions: NHS is chasing £65million from foreign patients… with one alone owing £467,000' *Daily Mail*. 2015.

Bos, *Privatization: a theoretical treatment* (Oxford University Press 1991)

Bossert T., *Decentralization of Health Systems: Chile, Colombia and Bolivia: Latin American and Caribbean Regional Health Sector Reform Initiative,* Report 29. (2000)

Bossert, T. Analysing the decentralization of health systems in developing countries: decision space, innovation and performance. (1998) 47 *Social Science and Medicine* 1513–27.

Bossert, T., *Lessons from the Chilean Model of Decentralization: Devolution of Primary Care to Municipal Authorities.* (LAC Health and Nutrition Sustainability 1993)

Bouachrine, *Women and Islam: Myths, Apologies and the Limits of Feminist Critique* (Lexington Books 2014)

Boucek, C. *Saudi Fatwa Restrictions and the State-Clerical Relationship* (Carnegie Endowment for International Peace 27 October 2010)

Bovbjerg, R. & Pauly, M. 'Privatization and bidding in the health-care sector' (1987) 6 *Journal of Policy Analysis and Management* 648-666.

Bowering, *Islamic Political Thought: An Introduction* (PUP 2015)

Boycko et al.,'A theory of privatisation' (1996) 106 *The Economic Journal* 309

Boycko, et al. Voucher Privatisation (1994) 35 *Journal of financial Economics* 249-266

Brandt, R. *A Theory of the Good and the Right* (Oxford University Press 1979)

Brannen J. Mixing methods: the entry of qualitative and quantitative approaches into the research process. International Journal of Social Research Methodology 2005;8(3):173–84.

Bremmer, I. "The Saudi Paradox." (2004) 21 *World Policy Journal* 23-30

Brewer, et al., 'Travel time and distance to health care only partially account for the ethnic inequalities in cervical cancer stage at diagnosis and mortality in New Zealand' (2012) 36 *Australian and New Zealand Journal of Public Health* 335

Brigit. "The right to health." (2001) *Economic, social and cultural rights* 169-190

Britz, et al 'Charging migrants for health care could compromise public health and increase costs for the NHS' (2016) 38 *Journal of Public Health* 384

Brown, 'Political Islam and Human Rights' (2008) 113 *Humanism Ireland*

Brown, et al. "Improving the measurement of service quality." (1993) 69 *Journal of retailing* 127-139

Brown, Rita Mae (1983), Sudden Death, Bantam Books, New York p. 68.

Bryant, John, *Health and The Developing World* (Cornhill University Press 1969)

Bsoul, 'An Arab Muslim Scientific Heritage: Islamic Medicine' (2016) 21 *IOSR Journal of Humanities and Socil Sciences* 29

Buchanan, 'Privatistaion and just healthcare' (1995) 9 *Bioethics* 220

Bulman, 'Doctors fight against becoming "border guards" for Home Office immigration enforcement'. *The Independent* 25 August 2017

Bulmus, *Plague, Quarantines and Geopolitics in the Ottoman Empire* (Edinburgh University Press 2012)

Burgess J, Wilson P. 'Variation in inefficiency among US hospitals' (1998) 36 *Information Systems and Operational Research* 84–102.

Burki,"Economic management within an Islamic context." in *Islamic Reassertion in Pakistan: The Application of Islamic Laws in a Modern State* (Syracuse University Press 1986): 49-58

Burns, Karima. "The Yoga of Islamic Prayer." (2012).

Busse R, Nimptsch U, Mansky T. 'Measuring, Monitoring, and Managing Quality in Germany's Hospitals' (2009) 28 *Health affairs* 294–304

Butler, S. *Privatizing Federal Spending: A Strategy to Eliminate the Deficit* (Universe Books 1985).

Butler, T 'The Times: Are they a-Changin'? Saudi Law finally addresses Domestic Violence with its regulation on protection from abuse' (2015) 100 *Iowa Law Review* 1233

Buttigieg, et al, International Best Practices in Healthcare Management, vol 17 Emerald Publishing, Bingley 2015

Callen, et al. *Economic diversification in the GCC: Past, present, and future*. (International Monetary Fund 2014)

Camacho,"Islamic financing for large infrastructure projects." (2005) 1 *Journal of Property Investment and Finance* 283-284

Campbell, *Arabian Medicine and its influence on the Middle Ages* (Routledge 2013) pp. 2–20

Carr-Hill, R., Hardman, G., Martin, S., Peacock, S., Sheldon, T. and Smith, P., *A Formulae for Distributing NHS Revenue Based on Small Area Use of Hospital Beds.* (Centre for Health Economics, Occasional Papers. 1994)

Carson, et al. *Handbook of Religion and Health* (Oxford University Press 2012)

Casla, et al 'Disclosure of patients' data to the UK home office must stop' (2017) 358 *BMJ*

Chaider S. Bamualim, Cheyne Scoot, et al, *Islamic Philanthropy and Social Development in Contemporary Indonesia* (CSRC-Ford Foundation 2006)

Chalkley, et al., 'Contracts for the National Health Service' (1996) 106 *EJ* 1691

Champion, D. The Kingdom of Saudi Arabia: elements of instability within stability. (1999) 3 *Middle East Review of International Affairs* 49 – 73.

Chang, et al., 'Health care regulation and the operating efficiency of hospitals: Evidence from Taiwan' (2004) 23 *Journal of Accounting and Public Policy* 483

Chapra, *Corporate Governance in Islamic Financial Institutions* (Islamic Development Bank 2002)

Chapra, *Islam and the Economic Challenge* (International Institute of Islamic Thought 1992)

Chapra, *Regulation and Supervision of Islamic Banks*, (Islamic Development Bank 2000)

Chapra, *The Economic Problem: Can Islam Play an Effective Role in Solving it Efficiently as well as Equitably?* IRTI Working Paper Series (2011) 1432

Chapra, *The Islamic Vision of Development in the Light of the Maqasid Al-Shari`ah* (Islamic Development Bank 2008)

Chapra, *The Islamic welfare state and its role in the economy*. (The Islamic Foundation 1979)

Chapra, U. (1992). *Islam and economic challange*, Leicester: Islamic Foundation.

Chapra, 'Why has Islam prohibited interest: Rationale behinds the prohibition of interest' 2000) 9 *Review of Islamic Economics* 5

Chaudhary, *Human Rights in Islam* (Kluwer Law International 1994)

Cheng, et al. 'Hospital competition and patient-perceived quality of care: Evidence from a single-payer system in Taiwan' (2010) 1 *Health Policy* 65

Cherif, et al.'Soaring of the gulf falcons: Diversification in the GCC oil exporters in seven propositions' No. 14-177. (International Monetary Fund 2014)

Cheung, et al. 'Health Finance' (2002) 35 *The Chinese Economy* 34

Chew et al, 'A Nationwide survey on the expectation of public healthcare providers' (2014) 4 *BMJ*

Chittick, *The Vision of Islam* (AUC Press 2006)

Chossudovsky, M, 'Under Development and the Political Economy of Malnutrition and In Health' (1983) 13 *International Journal of Health Services* 3

Choudhury, et al. "Oil and non-oil sectors in the Saudi Arabian economy." (2000) 24 *OPEC Energy Review* 235-250.

Christianson, J. 'Competitive bidding: The challenge for health care managers' (1985) 10 *Health Care Management Review* 39-53.

Churchill, C. 'What is insurance for the poor' in Churchill, C. *Protecting the Poor: A Microinsurance Compendium* (ILO 2006) 12-24.

Civaner, 'Transforming our health by privatistaion' (2011) 342 *BMJ* 723

Cuddy, et al. 'Men as Cultural Ideals: How Culture shapes Gender Stereotypes' (2010) *Harvard Business School Working Paper* 10-097

Clark, 'Health and poverty in rural Scotland' (1997) 55 *Health bulletin* 299

Clarke et al. *Healthcare Systems: Germany* (Civitas 2013)

Clukey R., (2007), Islamic Medical Ethics, Concordia College

Colliers International, 'Kingdom Of Saudi Arabia Healthcare Overview' (2012) Q1

Collins, 'Strategic planning for state enterprises in Africa:public versus private options' (1989) 9 *Public Administration and Development 65-82*

Collins, C. and Green, A. (1994) Decentralization and primary health care: some negative implications in developing countries. *International Journal of Health Services*, 24: 459–75.

Cologni, A, and Manera, M. "Exogenous oil shocks, fiscal policies and sector reallocations in oil producing countries." (2013) 35 *Energy economics* 42-57.

Cologni, A, and Manera, M. "Oil Revenues, Ethnic Fragmentation and Political Transition of Authoritarian Regimes." (2012) 24 *FEEM*

Comber, et al., 'A spatial analysis of variations in health access: linking geography, socio-economic status and access perceptions' (2011)10 *Int J Health Geogr* 44

Commision on Social Determinants of Health Report, 2008, WHO

Commonwealth Fund (2006) Framework for a high performance health system for the United States. New York: The Commonwealth Fund.

Connell, 'A new inequiality? Privatization, urban bias, migration and medical tourism' (2011) 52 *Asia Pacific Viewpoint* 260

Connell,"Contemporary medical tourism: Conceptualisation, culture and commodification." (2013) 34 *Tourism Management* 1-13

Cooper, et al., 'Overcoming barriers to health service access: influencing the demand side' (2004) 19 *Health policy and planning* 69

Cooper, M. and Culyer A., *Health Economics* (Penguin 1973)

Cooperative Health Insurance System Booklet (CHISB) (1999) Riyadh, Saudi Arabia: The Council of Cooperative Health Insurance.

Cooperative Health Insurance Magazine, Gray Business Communications,

Coronavirus: Two Deaths and One New Case of CoronaVirus in Riyadh. Alriyadh Newspaper, 10 October 2015 [In Arabic]

Coulson, *A History of Islamic Law* (Universal Law Publishing Company 1997)

Coulson, *The State and the Individual in Islamic Law*, (CUP 1957)

Country cooperation strategy for WHO and Saudi Arabia 2006–32. 2011. Cairo, World Health Organization Regional Office for the Eastern Mediterranean, 2007

Coutts, et al., 'Understanding privatisation's impacts on health: lessons from the soviet experience' (2008) 62 *Journal of Epidemiology and Community Health* 664

Cowan, L. G., "A global overview of privatization." in Hanke, S., *Privatization and Developmemt* (Institute for Contemporary Studies, 1987)

Cowie and Salvatore, The Long Exception: Rethinking the place of the New Deal in American History, (2008) 74 *International Labor and Working-Class History* 3-32

Crane, 'Human Rights in Traditionalist Islam: Legal, Political, Economic, and Spiritual Perspectives' (2007) 25 *The American Journal of Islamic Social Sciences* 82

Crone, *God's Rule: Government and Islam,* (CUP 2005)

Cullis, J. and West, P., *The Economics of Health: An Introduction.* (Martirn Robertson & Co. 1979)

Culyer,A.,Wagstaff,A 'Equity and Inequality in health and healthcare' (1993) 11 *JournalofHealthEconomics* 207-210.

Cunningham, et al., 'The prospective effect of access to medical care on health-related quality-of-life outcomes in patients with symptomatic HIV disease' (1998) 36 *Medical care* 295

Dacey, et al., *Islam & human rights, Defending Universality at the United Nations* (Center for Inquiry Interntional 2008)

Daily Telegraph, Biggest Revolution in the NHS for 6o years, 9 July 2010, Retrieved 10 March 2014.

Daleure, "Economic Vision of the UAE." in *Emiratization in the UAE Labor Market*. (Springer 2017). 27-37

Dandan, et al. "Oil Price, Revenues and Expenditures in Saudi Arabia" (2015) 6 *Research Journal of Finance and Accounting* 201

Daniels, N., Kennedy, B. & Kawachi, I., 1999. 'Why justice is good for our health: the social determinants of health inequalities' (1999) 4 *Daedalus* 215-251.

Dar, H., and Presley, J. "The Gulf Co-operation Council: A Slow Path to Integration?." (2001) 24 *The World Economy* 1161-1178.

Daraghi, 'The implementation of the Sharia Law in Medical Practice: A Balance between Medical Ethics and Patients Rights' (2011) 4 *J Med Ethics Hist Med* 7

Das, *Research in Strategic Alliances* (Information Age Publishing 2013)

Datar, et al. "Health infrastructure & immunization coverage in rural India." (2007) 125 *Indian Journal of Medical Research* 31.

David, et al. *Six Countries, Six Reform Models: The Healthcare Reform Experience Of Israel, The Netherlands, New Zealand, Singapore, Switzerland And Taiwan - Healthcare Reforms "Under The Radar Screen"* (World Scientific 2009)

Davis et al., Fiscal and Macroeconomic Impact of Privatisation, (IMF 2000)

Dayan et al. *How good is the NHS?* (Nuffield Trust 2018)

De Costa, et al. "'Where is the public health sector?': Public and private sector healthcare provision in Madhya Pradesh, India." (2007) 84 *Health Policy* 269-

276

De Santis, Roberto A. "Crude oil price fluctuations and Saudi Arabia's behaviour." (2003) 25 *Energy economics*155-173

Debs, 'The law of property in Egypt: Islamic and Civil Code' (PhD Thesis Princeton University 1963)

Deihim, et al. 'Women's Rights in the Persian Gulf: Some Relations' (2015) 4 *International Journal of Advanced Research in Management and Social Sciences* 119

Delling, *Islam and Human Rights*. (GUP 2004)

Department of Health, '2012 Review of overseas visitors charging policy Summary Report' April 2012

Department of Health 'Guidance on overseas visitors hospital charging regulations'(2012) last updated 25 May 2018

Department of Health *Visitor and Migrant Cost Recovery – Extending Charging: Impact Assessment*, (2015)

Dethier, *Governance, decentralization and reform in China, India and Russia* (Kluwer Academic Publishers 2000)

Deuraseh, 'Health and Medicine In the Islamic Tradition Based on The Book of Medicine (Kitab AlTibb) of Sahih Bukhari' (2006) 5 *JISHIM* 2

Dewey, 'Saudi Arabia launches powerful ad campaign against domestic violence' *The Washington Post* 1 May 2013

Dibooğlu, et al. "Oil prices, terms of trade shocks, and macroeconomic fluctuations in Saudi Arabia." (2004) 22 *Contemporary Economic Policy* 50-62

Dixon-Warren, 'Privatisation of health care', (2009) 180 CMAJ 429

Donahue, J. *The Privatization Decision: Public Ends, Private Means* (Basic Books 1989)

Drache, et al. *Health Reform: Public success, Private failure* (Routledge 2005)

Drakeford, et al. *Privatisation and Social Policy* (Longman 2000)

Dreger, et al. "The impact of oil revenues on the Iranian economy and the Gulf states." (2016) 40 *OPEC Energy Review* 36-49.

Drury 'Education: The Key to Women's Empowerment in Saudi Arabia?' *Middle East Institute* 30 July 2015

Duderija, Maqasid AlSharia and Contemporary Reformist Muslim Thought (Springer 2014)

Dusuki, et al., 'The framework of maqasid al-shariah (Objective of the shariah) and its implications for Islamic finance' (2011) ISRA Research paper (No.2/2011)

Dusuki, et al. 'Maqasid AlShariah, Maslahah and Corporate Social Responsibility' (2007) 24 *The American Journal of Islamic Social Science* 25

Dworkin, R. 'What is Equality? Part 1: Equality of Welfare' (1981) 10 *Philosophy & Public Affairs* 185- 246.

Dworkin, R. 'What is Equality? Part 2: Equality of Resources' (1981) 10 Philosophy & Public Affairs 283-345.

Dyer, Government responds to Stafford inquiry with new "whistleblower in chief" to rate hospitals, BMJ 2013;346:f2030

Dyer, NHS must adopt a culture of “zero tolerance” for patient harm, Francis report says, BMJ 2013:346:f847

Eddy, et al. "Healthcare quality measurement." U.S. Patent No. 8,538,773. 17 Sep. 2013.

Edriss, et al. ‘ Islamic Medicine in the Middle Ages’ (2017) *AJMS* 18

Eich, et al. *Muslim Medical Ethics: From Theory to Practice* (University of South Carolina Press 2008)

Eich, et al. *Muslim Medical Ethics: From Theory to Practice* (University of South Carolina Press 2008)

Eissa, *AlKhaskhasah wa ElEqtisad AlMutanawa’a* [Privatisation and a Diversified Economy] (AlMuntalaq 1996) [In Arabic]

El Bcheraoui, Charbel, et al. "Access and barriers to healthcare in the Kingdom of Saudi Arabia, 2013: findings from a national multistage survey." (2015) 5 *BMJ open* e007801

El Hag, S, and El Shazly, M.. "Oil dependency, export diversification and economic growth in the Arab Gulf States." (2012) 29 *European Journal of Social Sciences* 397-404.

El-Gamal, M., *A basic guide to contemporary Islamic banking and finance* (Rice University 2000)

El-Gamal, M., *Islamic Finance: Law, Economics, and Practice* (Cambridge University Press 2006).

Elahi, Y., and Aziz, M. "Islamic options (al-Khiyarat); Challenges and opportunities." *International Conference on Information and Finance, IPEDR*. Vol.

21. 2011.

Elbanna, A. 'Islamic Religion as a Basis for a Health Education Programme.' (PhD Thesis, Indiana University 1979)

Elder JW. Comparative cross-national methodology. Annual Review of Sociology 1976;2:209–30.

Elgood, *A Medical History of Persian and the Eastern Caliphate: From the Earliest Times until the Year A.D. 1932,* (CUP 2010)

ElKadi, 'Health and Healing in the Quran', (1985) 2 *American Journal of Islamic Social sciences* 291

ElKaleh, 'The Ethics of Islamic Leadership' (2013) 2 *Administrative Culture* 188

Ellerman, 'Lessons from Eastern Europe's voucher privatisation' (2001) 44 *Challenge* 14

Ellis, R. and McGuire, T. 'Optimal payment systems for health services' (1990) 9 *Journal o f Health Economics* 375-396.

Ellis, R., MeGuire, T., 'Supply-side and demand-side cost sharing in health care' (1993) 7 *Journal of Economic Perspectives* 135-151.

Elola J, Daponte A, Navarro V. Health indicators and the organization of health care systems in Western Europe. American Journal of Public Health 1995;85:1397–401.

Emami, K, and Adibpour M. "Oil income shocks and economic growth in Iran." (2012) 29 *Economic Modelling* 1774-1779.

Emon, 'Huquq Allah and Huquq AlIbad: A Legal Heuristic for a Natural rights regime' (2006) 13 *Islamic Law and Society* 325

Emon, et al *Islamic Law and International Human Rights Law* (OUP 2012)

Engineer, *The Rights of Women in Islam* (Sterling Publishers 2004)

Engineer, 'Rights of Women in Muslim societies' (2011) 7 *Socio-Legal Review* 44

English, 'Using public-private partnerships to deliver social infrastructure: the Australian experience' in *The Challenge of public-private partnerships: learning from international experience* (Elgar 2005) 290

Enthoven, *Reflections of the management of the NHS.* London: (Nuffield & Provincial Hospitals Trust 1985)

Eren, et al. 'Impacts of privatisation of management of health organisations on public health: turkish Health sector evaluation' (2013) *Social and Behavioural Sciences* 726

Ernst, *Following Muhammad: Rethinking Islam in the Contemporary World* (University of North Carolina Press 2004)

Esposito, *What Everyone Needs to Know about Islam* (OUP 2002)

Estes, Y. *Misquoting Muhammad.* (Islam News Room 2011)

European Centre for Disease Prevention and Control (2015), 'Assessing the burden of key infectious diseases affecting migrant populations in the EU/EEA'

European Observatory on Health Systems . Health Care Systems in Transition: Spain. (WHO 2000)

EuroREACH, 'The Health Data Navigator: Your Toolkit for comparative performance analysis' (2013)

Evans, 'Politics, Coercion and Power: An analysis of economic failure in healthcare systems' (PhD Thesis, Brunel University 2006)

Ewers, "The Arab Gulf States after Oil: Deploying Windfalls for Sustainable Development." (2014) 17 *The Arab World Geographer* 186-207

Ewers, M., and Malecki, E. "Megaproject: A 4-decade perspective of the Gulf development model." (2011) *Engineering Earth*. Springer Netherlands 533-550

Fadel, 'Analogical Reasoning in Islamic Jurisprudence: A Study of the Juridical Principle of Qiyas' (2001) 15 *Journal of Law and Religion* 359-362

Fadel, 'The True, the Good, and the Reasonable: The Theological and Ethical Roots of Public Reason in Islamic Law' (2008) 21 *Canadian Journal of Law and Jurisprudence*

Falkenberg, 'How privatisation and corporatization affect healthcare employee's work climate, work attitudes and ill-health' (Thesis, Stockholm University 2010)

Farhad, *Islam and the everyday World: Public Policy Dilemmas,* (Routledge 2006)

Fariborz, et al. *Privatization for Development: Strategies and Techniques* (International Law institute 1987)

Farid A and Hussein S. *The Decline of Arab Oil Revenues* (Croom Helm and Arab Research Centre 1986)

Farmer, et al., 'Rural/urban differences in accounts of patients' initial decisions to consult primary care' (2006) 12 *Health Place* 210

Farooq, 'An Analytical Study of the Potential of Takaful Companies.' (2010) *EJEFAS*

Farsi M. Changes in hospital quality after conversion in ownership status. (2004) 4 *International Journal of Health Care Finance and Economics* 211–230

Fasano, et al. 'GCC countries: from oil dependence to diversification' (International Monetary Fund 2003)

Fasano, Ugo. "Diversification in oil-dependent economies: The experience of the GCC countries." *UNFCCC Workshop. Tehran, October*. 2003.

Fattouh, et al. "The dynamics of the revenue maximization–market share trade-off: Saudi Arabia's oil policy in the 2014–15 price fall." (2016) 32 Oxford Review of Economic Policy 223-240.

Fatwa 26608 dated 2 September 2015

Fauzia, A. *Faith and State; A History of Islamic Philanthropy in Indonesia* (Brill 2013)

Fee E, Brown T. 'The unfulfilled promise of public health: deja vu all over again' (2002) 21 *Health Aff.* 31–43

Feikin, et al., 'The impact of distance of residence from a peripheral health facility on pediatric health utilisation in rural western Kenya' (2009) 14 *Tropical Medicine & International Health* 54

Feldstein, P. *Health Care Economics* (John Wiley & Sons 1979)

Feldstein, P. *Health policy issues: An economic perspective on health reform*. (Health Administration Press 1994)

Ferguson, Empire, Basic Books 2004 page 307

Ferngren, *Medicine and Religion: A Historical Introduction* (JHU Press 2014)

Fesler, J. 'Centralization and decentralization' in Sills, D. *International encyclopedia of the social sciences*, vol. 2 (The Macmillan Company and The Free Press 1968)

Field, et al., 'Socio-economic and locational determinants of accessibility and utilization of primary health-care' (2001) 9 *Health & social care in the community* 294

Field, M. *Success and Crisis in National Health Systems* (Routledge 1989)

Fielding, et al. 'Can managed competition solve the problems of market failure?' (1993) *Health Affairs* 216

Fields, G, *Poverty, Inequality, and Development* (CUP 1980)

Filiz, Şahin. "Etiqette Of Life In Islam." Necmettin Erbakan Üniversitesi İlahiyat Fakültesi Dergisi 7.7 (1997).

Fisher, O. and Taylor, D. Prospects for Evolution of Takaful in the 21st century, (*Proceedings of the Fifth Harvard University Forum on Islamic Finance* 2000) 237

Fisherman et al, 'Islamic Sunni Mainstream Opinions on Compensation to Unrelated Live Organ Donors' (2011) 2 *Rambam Maimonides Medical Journal* 1-7

Fishman PA, Hornbrook MC, Meenan RT, Goodman MJ: Opportunities and Challenges for Measuring Cost, Quality, and Clinical Effectiveness in Health Care. Medical Care Research Review 2004, 61: 124S-143.

Fishman, (2011), Islamic Sunni Mainstream Opinions on Compensation to Unrelated Live Organ Donors, Rambam Maimonides Medical Journal, 2(2): e0046

Folland, S. & Stano, M. *The economics of health and health care* (Prentice-Hall 2001)

Footman, et al., 'Quality check: does it matter for quality how you organise and pay for health care? A review of the international evidence' (2014) 44 *Intl J Health Services* 479

Forde, K. & Malley A 'Privatisation in health care: Theoretical considerations, current trends and future options' (1992) 15 *Australian Health Review* 269-77.

Francis R. Robert Francis inquiry report into Mid-Staffordshire NHS Foundation Trust.

Frenk, J. (2010) The World Health Report 2000: expanding the horizon of health system performance, Health Policy and Planning, 25: 343–5.

Freudenberg, 'Time for a national agenda to improve the health of urban populations' (2000) 90 *American Journal of Public Health* 837

Fryklund, 'Privatisation: American Style' (1994) 19 *Business Forum* 495

Gallagher EB, Modernization and Health Reform in Saudi Arabia, Chapter 4 in Twaddle AC, Health Care Reform Around the World. Londonn, auburn House, 2002: 181-197

Garba, 'Managing urban growth and development in the Riyadh metropolitan area, Saudi Arabia' (2004) 28 *Habitat International* 593

Gardiner, et al., *Market development approaches in Pakistan: a case study* in Gardiner, et al. *Market Development Approaches Scoping Report* (HLSP Institute 2006)

Gardner, et al. 'Privatization in health care: Shifting the risk' (1988) 45 *Medical Care Review* 215-253

Gause, 'Saudi Arabia over a barrel' (2000) 1 Foreign Affairs 80

Gazi, et al. 'The effect of social franchising on access to and quality of health services in low- and middle-income countries' (2009) 21 *Cochrane Database of Systematic Reviews*

General Presidency of Scholalry Research and Ifta, The Takaful Islamic Insurance Company, Decision No. 51 dated 25 March 1977

Gentleman, 'Grenfell Tower survivors "too scared to seek help" because of immigration status'. *The Guardian*, 22 June 2017

Gentleman, 'Pregnant women without legal status "too afraid to seek NHS care"'. *The Guardian*, 20 March 2017

Gerber, *State, Society, and Law in Islam* (SUNY Press 1994)

Gershberg, A. 'Decentralization, recentralization and performance accountability: building an operationally useful framework for analysis' (1998) 16 *Development Policy Review* 405

Gertler, P. and Hammer, J. 'Strategies for Pricing Publicly Provided Health Services' in Schieber *Innovations in Health Care Financing* (World Bank Disc 1997) 365.

Gertler, P. and Van der Gaag, J. *The willingness to pay for medical care: Evidence from two developing countries* (John Hopkins Univ. Press 1990)

Gertler, P., and Molyneaux, J. *Pricing public health services: Lessons from a social*

experiment in Indonesia: (RAND 1990)

Gesler, M., *Health Care in Developing Countries* (Association of American Geographers 1984)

Geyman, 'The corporate transformation of Medicine and its impact on costs and access to care' (2003) 16 *J Am Board Fam Med* 443

Geyman, *Health care in America: can our ailing system be healed?* (Butterworth-Heinemann 2002)

Ghannouchi, 'The State and Religion in the Fundamentals of Islam and Contemporary Interpretation' (2013) 6 Contemporary Arab Affairs 164

Ghassemzadeh, 'Privatization of health Organisations in Iran: How to avoid too much of a good thing?" (2010) 1 Intl J Occup Environ Med 60

Ghazali, Development and Islamic Perspective. Malaysia: (Pelanduk 1990)

Gilson, 'Trust and the development of healthcare as a social institution' (2003) 56 Social Science and Medicine 1453

Ginzberg, 'Privatization of health care: A US perspective' (1988) 530 *Annals of the New York Academy of Sciences* 111

Glazer, J., McGuire, T., 'Payer Competition and Cost Shifting in Health Care' (1994) 5 *Journal of Economics and Management Strategy* 71-92

Glennerster, *Understanding the finance of welfare* (Policy Press 2009)

Gocer, et al. "The Effects of Falling Crude Oil Prices On Macroeconomic Performance and Political Stabilities in the First Seven Net Oil Exporters' Countries." (2017) 11 *CEA Journal of Economics*

Goddard, et al., 'Equity of access to health care services: Theory and evidence from the UK' (2001) 53 *Social Science & Medicine* 1149

Goldmann, F. (1946) Foreign programs of medical care and their lessons, New England Journal of Medicine, 234: 155–60.

Gollust, et al., 'Privatisation of public services: Organizational reform efforts in public education and public health' (2006) 96 *Public Health* 1733

Gonzalez-Block M, Leyva R, Zapata O, Loewe R, & Alagon J, 'Health Services Decentralization in Mexico: Formulation, Implementation & Results of Policy' (1989) 17 Health Policy and Planning; 14-31

Goodman, et al. 'Opportunities and Challenges for Measuring Cost, Quality, and Clinical Effectiveness in Health Care' (2004) 61 *Medical Care Research Review* 124S-143.

Goodman, et al. *The economics of health and health care* (Prentice-Hall, 2001)

Gorini, 'Bimaristans and Mental Health in Two Different Areas of the Medieval Islamic World'(2008) 7 *JISJIM* 16

Gostin L, Boufford J, Martinez R. The future of the public's health: vision, values, and strategies. (2004) 23 *Health Aff.* 96–107.

Govindan, et al. 'Nationalism and privatization in state-owned oil multilatinas' (2017) 9 *International Journal of Business and emerging Markets*

Grais, "Corporate Governance and Shari'ah Compliance in Institutions Offering Islamic Financial Services", World Bank Policy Research Working Paper 4054, November 2006

Greer, 'Universal Healthcare Coverage: A Political Struggle and Governance Challenge', (2015) 105 American Journal of Public Health S637

Greer, et al., 'When does marketization lead to privatisation? Profit-making in English health services after the 2012 health and social care act' (2015) 124 *Social science and medicine* 215

Greer, et al., *Marketization, Inequality, and Institutional Change*. (University of Greenwich 2013)

Grimsey, D. & Lewis, M. 'Public Private Partnerships and Public Procurement' (2007) 14 *Agenda: A Journal of Policy Analysis and Reform* 171-188.

Grimsey, D., & Lewis, M. 'Public private partnerships and public' (2007) 18 *Economics*, 29-46.

Gross, 'Urban health disorders, spatial analysis, and the economics of health facility location' (1972) 2 *International Journal of Health Services* 63

Gruen, et al., 'Outreach and improved access to specialist services for indigenous people in remote Australia: the requirements for sustainability' (2002) 56 *Journal of epidemiology and community health* 517

Grzybowski, et al., 'Distance matters: a population based study examining access to maternity services for rural women' (2011) 11 *BMC health services research* 147

Guagliardo, et al., 'Physician accessibility: an urban case study of pediatric providers' (2004) 10 *Health & Place* 273

Guasch, et al, 'Renegotiation of concession contracts in Latin America: evidence from the water and transport sectors' (2008) 26 *Intl J Indust Org* 421

Gudorf,"Water privatization in Christianity and Islam." (2010) *Journal of the Society of Christian Ethics* 19-38.

Gulaid, *Ownership in Islam* (Islamic Development Institute 1991)

Gummi, "The Islamic Welfare State: The Basic Imperatives Toward a Better Society." (SSRN 2013)

Gupta, S. Verhoeven, M., Tiongson, E., 2001, *Public Spending on Health Care and the Poor,* IMF Working Paper /01/127

Gürer, et al. "The economic cost of low domestic product prices in OPEC Member Countries." (2000) 24 Opec Review 143-183

Gwatkin, D. 'Poverty and Inequalities in Health with Developing Countries' in Leon, D. and Walt,G. *Poverty, inequality, and health* (Oxford University Press 2000)

Gwatkin, D.,'Health inequalities and the health of the poor: what do we know? what can we do?' (2000) 78 *Bulletin of the World Health Organization* 3-18.

Hadley, 'Sicker and poorer--the consequences of being uninsured: a review of the research on the relationship between health insurance, medical care use, health, work, and income' (2003) 60 *Med Care Res Rev* 3S

Haider, *Islamic Concept of Human Rights* (The Book House 1978)

Hajlzadeh, et al. 'Equity of health care financing in Iran: The effect of extending health insurance to the uninsured' (2010) 38 Oxford Development Studies 461

Hakeem, *Policing Islamic Communities* (springer 2012)

Hall, et al., 'Expanding the Definition of Access: It Isn't Just About Health Insurance' (2008) 19 *Journal of Health Care for the Poor and Underserved* 625

Hallaq, *A History of Islamic Legal Theories: An Introduction to Sunni Usul Al-fiqh* (CUP 1997)

Hallaq, *Shariah: Theory, practice, transformations.* (CUP 2009)

Hallaq, *The Impossible State: Islam, Politics, and Modernity's Moral Predicament* (Columbia University Press 2012)

Hallaq, *The Origins and Evolution of Islamic Law* (CUP 2005)

Halling, et al.,'Distance to hospital and socioeconomic status influence secondary health care use' (2013) 31 *Scandinavian journal of primary health care* 83

Halverson P, Kaluzny A, Mays G, & Richards T. 'Privatizing health services: alternative models and emerging issues for public health and quality management' (1997) 5 *Qual Manage Health Care* 1–18.

Halverson P, Mays G, Kaluzny A, & Richards T. 'Not-so-strange bedfellows: models of interaction between managed care plans and public health agencies' (1997) 75 *Milbank Q.* 113–138.

Halverson P. 'Embracing the strength of the public health system: Why strong government public health agencies are vitally necessary but insufficient' (2002) 8 *J Public Health Manage Pract* 98–100.

Ham, C. (2009) Health policy in Britain, 6th edn. Chippenham: Palgrave Macmillan.

Ham, C. *Health policy in Britain* (Palgrave Macmillan 2009)

Hamarneh *Health Sciences in Early Islam* (Zahra 1984)

Hamarneh, S. *A pharmaceutical view of Abulcasis al-Zahrawi in Moorish Spain, with special reference to the "Adhean",* (Brill 1963)

Hamdan, The reasons for Terminating a Mortgage (MPhil thesis, IMSIU 1435H)

Hamid S, Roberts, J. & Mosley, P. 'Can micro health insurance reduce poverty? Evidence from Bangladesh' (2011) 78 *The Journal of Risk and Insurance* 57-82.

Hamid, 'An Islamic Alternative? Equality, Redistributive Justice, and the Welfare State in the Caliphate of Umar' (2003) 13 *Renaissance Islamic Journal* 8

Hamidullah, *The Prophet's establishing a state and his succession,* (National Hijra Council 1988)

Hammad, 'Saudi women in the Civil Status and Passports' *AlMadinah News* 6 August 2013

Hammad, 'Women and the lack of Civil status. How long?' *AlMadinah News* 1 April 2014

Hanieh, A. *Capitalism and class in the Gulf Arab states*. (Springer 2016)

Hanke, *Privatization and Development* (Institute for Contemporary Studies 1987)

Hansen, et al., 'Socio-economic inequalities in health care utilisation in Norway: a population based cross-sectional survey' (2012) 12 *BMC health services research* 336

Hantrais L. International comparative research: theory, methods and practice. Basingstoke: Palgrave Macmillan; 2009.

Harastani, H. and Turkey, M., *Some Riyadh Hospital Out-patients Waiting Time*, (Public Administration Institute 1985) [In Arabic]

Hardie, *Social Justice in Islam*, (Islamic Publications International 2000)

Hargaves, et al., 'The Contribution of Insurance Coverage and Community Resources to Reducing Racial/Ethnic Disparities in Access to Care' (2003) 38 *Health Services Research* 809

Hargreaves, et al ' Extending migrant charging into emergency services' (2016) 352 *BMJ*

Harik, I, Sullivan, D. and Patton, M. *Privatization and liberalization in the Middle East* (Indiana University Press 1992)

Harker, NHS Funding and Expenditure, SN/SG/724, House of Commons Library

Harrington, et al., 'Access granted! barriers endure: determinants of difficulties accessing specialist care when required in Ontario, Canada' (2013) 13 *BMC health services research* 146

Hart, The inverse care law (1971) 1 *Lancet* 405

Hartley, 'Rural Health Disparities, Population Health, and Rural Culture' (2004) 94 *American Journal of Public Health* 1675

Hartley, et al., 'Urban and rural differences in health insurance and access to care' (1994) 10 *J Rural Health* 98

Hasan, 'Islamization of knowledge in economics; issues and agenda' (1998) 6 Journal of Economics & Management 1

Hasan, *The Principles of Islamic Jurisprudence: The Command of the Shariah and Juridical Norm* (Adam 2005)

Hasan, *The third wave of Zakah optimizing Islamic philanthropy for social justice* (IISS 2016)

Hashim I. 'Reconciling Islam and feminism' (1999) 7 *Gender and development*, 7–14.

Haskel J, Szymanski S.. 'Privatization, Liberalization, Wages and Employment: Theory and Evidence for the UK' (1993) 60 *Economics* 161–182.

Hasnain et al, 'Patient-centered care for Muslim women: provider and patient perspectives' (2011) 20 Journal of Women's Health 73

Hassan, Javid "Insurance Sector in Good Health" *Arab News* 6 December 2006

Hassan, Riaz. "*On Being Religious: Patterns of Religious Commitment in Muslim Societies"*. (2007) 97 *The Muslim World* 437-478

Hassan, Z. 'Treatment of Consumption in Islamic Economics: An Appraisal' (2005) 18 *Islamic Economics* 29-46.

Hassan, 'Women in Islam: Qur'anic ideals versus Muslim realities' (1995) 2 *Planned parenthood challenges* 5

Hassanien, Renal Care in Saudi Arabia: A Review of the Quality of Healthcare Management, (PhD Thesis Imperical College London 2013)

Hatim, *AlKhibrah AlDuwaliyah Fe AlKhaskhasah* [Global Experience in Privatization] (Cairo 1994) [in Arabic]

Haykal, *Al-Faruq Umar [The Farouk Omar]* (Maktabah AlNidah AlMisriyah 1969) [In Arabic]

Health and Social Care Act 2012

Health statistical year book. Riyadh, Saudi Arabia, Ministry of Health, 2009

Hehmeyer,,Alia Khan,. "Islam's forgotten contributions to medical science", (2007) 176 *Canadian Medical Association Journal* 1467

Heise, et al. *Violence against women: The Hidden Health Burden,* World Bank Discussion Papers No. WDP 255

Hellander, et al. *Bleeding the patient: the consequences of corporate health care*. (Common Courage Press 2001)

Heller, 'The Budgetary Impact of Privatisation: Examples from New Zealand and prospects for Ireland' in McDowell et al., *Privatisation: Issues of Principle and Implementation in Ireland* (Gill and Mcmillan 1989)

Hemming, et al. *Privatisation and Public Enterprises* (International Monetary Fund 1988)

Henderson, 'The plastic surgery postcode lottery in England' (2009) 7 *IJS* 550

Henry A. Azar, *The Sage of Seville: Ibn Zuhr, his time, and his medical legacy* (AUCP 2008)

Herr A. 'Cost and technical efficiency of German hospitals: does ownership matter?' (2008) 17 *Health Economics* 1057-1071

Hertog, S. "The private sector and reform in the Gulf Cooperation Council." (LSE 2013).

Hertog, S. *Princes, brokers, and bureaucrats: oil and the state in Saudi Arabia*

(Cornell University Press, 2011)

Hewitt, et al., *Defining "rural" Areas: Impact on Health Care Policy and Research* (Health Program Office of Technology Assessment 1989)

Hiam et al. 'Creating a hostile environment for migrants: the british government's use of health service data to restrict immigration is a very bad idea' (2018) 13 *Health Economics, Policy and Law* 107

Hiam, 'Grenfell survivors shouldn't be afraid to go to hospital' (2017) 358 *BMJ*

Hiam, et al 'Making a fair contribution: is charging migrants for healthcare in line with NHS principles?' (2016) 109 *Journal of Royal Society of Medicine* 226

Hippler, et al., Performance of microfinance institutions in Muslim countries, (2014) 30 *Humanomics*

Hitti, P, *Islam: a Way of Life.* (University of Minnesota Press 1970)

Hodge, et al. 'The Evolution of Administrative Systems in Kuwait, Saudi Arabia, and Qatar: The challenge of implementing market based reforms' (2016) Digest of Middle East Studies

Hoffman, et al., 'Health insurance and access to health care in the United States' (2008) 1136 *Ann N Y Acad Sciv*149

Homaidahi, K "Health Insurance as part of health economics" (2002) 478 *Riyadh Commerce* 48-52

Home Office, 'Controlling Immigration — Regulating migrant access to health services in the UK Results of the public consultation' 22 October 2013

Home Office, Department of Health, NHS Digital 'Memorandum of understanding between Health and Social Care Information Centre and the Home Office and the Department of Health', (2017)

Hong, et al., 'Too Costly To Be Ill: Healthcare Access and Health-Seeking Behaviours among Rural-to-Urban Migrants in China' (2006) 8 *World Health Popul* 22

Horden, "The Earliest Hospitals in Byzantium, Western Europe, and Islam". (2005) 35 *Journal of Interdisciplinary History* 361–389.

Hoteit, 'Saudi Cleric sacked over co-ed university spat' AlArabiya News 4 October 2009

House of Commons. Health services: private sector: written question—21844. 2014.

House of Commons. NHS: private sector health. 2011

Howard, 'Muslim Legal Approaches to Modern Problems.' (2001) 8 *Islam 21*, 2–3.

Howe A. 'RCGP response to government consultation on 'Controlling Immigration – Regulating Migrant Access to Health Services in the UK' 28 August 2013.

Hunter, 'The Slow, lingering death of the english NHS' (2016) 5 Int J Health Policy Manag 55

Hunter, 'Change of government: one more big bang health care reform in England's National Health Service' (2011) 41 International Journal of Health Services 159

Hursh, J. 'The Role of Culture in the Creation of Islamic Law' (2009) 84 *Indian Law Journal* 1401

Hussain, *Islam: Its Law and Society* (Federation Press 2004)

Hussain, *Privatisation and its social affects on people of the Gulf* (Ghabbash 1996)

Hyman, *Public finance: A contemporary application of theory to policy* (The Dryden Press 1993)

Ibn Ashur Islamic Maqasid AlSharia (AlSalam 2005)

Ibn Qayyim, *AlTuruq AlHukmiyyah fi AlSiyasah AlShar'iyyah [The Legal Methods in Islamic Administration]* (Darul Kutub Alllmiyyah 1956) [In Arabic]

Ibn Rajab, *The Heirs of the Prophets* (Starlatch Press 2001)

Ibn Taymiyyah, *AlSiyasah AlShar'iyyah fi Islah AlRa'i wa AlRa'iyyah [Shariah Politics in improving the ruler and the ruled]* (Dar AlKutub AlArabiyyah 1961) [In Arabic]

Ibrahim, 'Issues in Islamic banking and finance: Islamic banks, Shariah compliant investment and sukuk' (2015) 34 Pacific-Basin Finance Journal 185-191

Ibrahim, N. & Abdalla, M 'A critical examination of Qur'an 4:34 and its relevance to intimate partner violence in Muslim families'. . (2010) 5 *Journal of Muslim Mental Health* 327-349.

Iglehart, J. 'Cutting the costs of health care for the poor in California: A two-year follow-up' (1984) 311 *New England Journal of Medicine* 745.

Imam, 'Islamic health care services in the contemporary world' (1995) 39 *Islamic Quarterly* 234

Imran, et al. 'Civilian Status: Saudi Identity cards become mandatory' *Middle East News* 26 March 2013

Implementing Regulations of the Cooperative Health Insurance Law in the Kingdom of Saudi Arabia (Amended) Cooperative Council for Health Insurance, Session 73 Ministerial Decision DH/1/30/6131 (2009)

INCEIF, *Takaful Realities and Challenges* (Pearson 2012)

Institute of Medicine. *The Future of Public Health.* (National Academy Press 1988)

Institute of Medicine. *The Future of the Public's Health in the 21st Century* (National Academies Press; 2003)

International Monetary Fund (IMF).(2004). Health and Development.

Ipsos MORI. Public Perceptions of the NHS and Social Care Survey: Spring 2013 and Winter 2013 Waves

Iqbal, *An Introduction to Islamic Finance: Theory and Practice* (Wiley Press 2007)

Iqbal, *Challenges facing Islamic Banking* (Islamic Development Bank 1998)

Iqtisad Al-islamy (Islamic Economics), *Risk Management in Islam Takaful* (Islamic Relief Worldwide 2003)

Islamic Fiqh Academy, Resolution 9(2) held in Jeddah, Saudi Arabia 22-28 December 1985

Ismail, "What Derives Public Health Expenditures in Saudi Arabia? Macro-Econometric Analysis." (2016) 6 International Journal of Science and Research

623

Ismail, et al., *Essential Guide to Takaful (Islamic Insurance)* (CERT Publications 2008)

Ismail, M.A., Nik Ab Malik, N.M.A. & Mohd Shafiai, M.H. (2015). Empowering the peripheral ummah through waqf. *Journal of Muamalat and Islamic Finance Research, 12*(1), *32-43.*

Jack, W., , Public spending on health care: how are the different criteria related? A second opinion, (2000) *Health Policy.*

Jack, W., *The evolution of health insurance institutions: theory and four examples from Latin America,* (World Bank Group 2000)

Jackson, *Islamic Law and The State* (BRILL 1996)

Jacobs, et al., 'Addressing access barriers to health services: an analytical framework for selecting appropriate interventions in low-income Asian countries' (2012) 27 *Health Policy and Planning* 288

Jadwa, The Saudi economy in 2016 available on www.jadwa.com

Jaffer. *Islamic Insurance: Trends, Opportunities and the Future of Takaful* (Euro money Institutional Investment Plc. 2007)

Jaffer, 'Takaful industry: global challenges and opportunities' (2005) *Islamic Finance Review* 45

James, et al., 'To retain or remove user fees?: reflections on the current debate in low- and middle-income countries' (2006) 5 *Appl Health Econ Health Policy* 137

Jan, 'A Critique of Islamic Finance in Conceptualising a Development Model of

Islam: An attempt in Islamic Moral Economy' (PhD Thesis, Durham University 2013)

Jan, Shafiullah. *A Critique of Islamic Finance in Conceptualising a Development Model of Islam: An Attempt in Islamic Moral Economy*. (LLM Thesis Durham University, 2013)

Janin, *Islamic Law: The Sharia from Muhammad's Time to the Present* (McFarland 2007)

Janin, et al. *Cultures of the World: Saudi Arabia* (Marshall Cavendish Corporation 2003)

Jannadi, B., et al. "Current structure and future challenges for the healthcare system in Saudi Arabia." (2008) 3 *Asia Pacific Journal of Health Management* 43.

Janoska, 'Privatisation of public health services at european health markets from a law and economic perspective' (2011) 3 German Journal for Young Researchers 13

Janssen, R. & Van der Made, J. 'Privatisation in health care: Concepts, motives and policies' (1990) 14 Health Policy 191-202.

Jefferies, M. & McGeorge, W. 'Using public-private partnerships (PPPs) to procure social infrastructure in Australia' (2009) 16 *Engineering, Construction and Architectural Management* 415-437.

Jegasothy, 'Population and rural-urban environmental interactions in developing countries' (1999) 26 *International Journal of Social Economics* 1027

Jereshah, *Usul AlShariah AlIslamiyah Madhmunha wa Khasa'isuha* [Origins of Islamic Law, Content and Characteristics] (Wahbah 1979) [in Arabic]

Jian, et al., 'China's rural-urban care gap shrank for chronic disease patients, but inequities persist' (2010) 29 *Health Aff (Millwood)* 2189

Jindal, S. 'Privatization of Healthcare: New Ethical Dilemmas' (1998) 6 Indian Journal of Medical Ethics 85

Joha et al., 'Public-private partnerships, outsourcing or shared service centres?: Motives and intents for selecting sourcing configurations' (2010) 4 *Transforming Government: People, Process and Policy* 232

Johansen, *Contingency in a Sacred Law: Legal and Ethical Norms in the Muslim Fiqh* (BRILL 1999)

Johns, L., Anderson, M. & Derzon, R. 'Selective contracting in California: Experience in the second year' (1985) 22 Inquiry 335-47.

Johnson, O et al, *Information please almanac : atlas and yearbook 1992* (Houghton Mifflin 1992)

Jone, C., Levis. A, 'Challange to Saudi Arabian Hospitals?' (1984) 5 Saudi Medical Journal 1

Jones, et al, Share issue privatizations as financial means to political ends, (1999) 53 *Journal of Financial Economics* 217– 253.

Jones, et al. *Public Enterprise in Less-Developed Countries* (Cambridge University Press 1982)

Kahf, M. *Shari'ah and Historical Aspects of Zakah and Awqaf* (Islamic Development Bank 2004)

Kahf, M. *Waqf and its socio-political aspects*. (IDB 2000)

Kahn, et al., *Privatisation and the welfare state* (Princeton University Press 2014)

Kamali, '*Siyāsah shar'īyah* or the Policies of Islamic Government' (1989) 6 *The American Journal of Islamic Social Sciences* 60

Kamali, 'The limits of power in an Islamic state', (1989) 28 *Islamic Studies Quarterly* 104

Kamali, *A Textbook of Hadith Studies: Authenticity, Compilation, Classification and Criticism of Hadith* (Islamic Foundation 2005)

Kamali, *Citizenship and Accountability of Government: An Islamic Perspective* (IAIS & Ilmiah Publishers 2013)

Kamali, *Equity and Fairness in Islam* (Islamic Texts Society 2005)

Kamali, *Freedom Equality and justice in Islam*. (The Islamic foundation 1999)

Kamali, *Fundamental Rights of the Individual: An Analysis of Haqq in Islamic Law*, (International Institute of Islamic thought 1993)

Kamali, M. *Freedom, Equality, and Justice in Islam* (Islamic Texts Society 2002)

Kamali, *Maqasid AlShariah Made Simple* (International Institute of Islamic Thought 2008)

Kamali, *Maqasid AlShariah, Ijtihad and Civilization Renewal* (International Institute of Islamic Thought 2012)

Kamali, *Principles of Islamic Jurisprudence* (The Islamic Texts Society 2002)

Kamali, *Right to Education, Work and Welfare in Islam* (Islamic Texts Society

2010)

Kamali, *Shariah Law: An Introduction* (OneWorld 2008)

Kamel, S. "The Privatisation in Saudi Arabia." *The Economic World* (1995): 22-26.

Kamil, *Privatisation and Singularity in the Market* (TA 1997) [In Arabic]

Kaminski, *The Contemporary Islamic Governed State: A Reconceptualisation* (Springer 2017)

Kaminski, *The importance of Economic Justice in a Contemporary Islamic Governed State* (Springer 2017)

Kamrava,"Structural Impedimentsto Economic Globalizationin the Middle East." (2004) 11 Middle East Policy 96-112.

Kane, et al. 'Assessing the impact of privatisation public hospitals in three American states: implications for universal health coverage' (2013) 16 Value in Health S24

Kaplan, G. & De Camargo, K. 'A Call for Global Discussion on Universal Coverage' (2016) 106 *American Journal of Public Health* 594

Karcic, 'Applying the Shariah in Modern Societies: Main Developments and Issues.' (2001) 40 *Islamic Studies* 207

Kareemi, Islamic Law and the State, (University of Toronto LLM 2011)

Karim, N., Tarazi, M. & Reille, X. *Islamic microfinance: An emerging market niche*. (CGAP 2008).

Karlaftis, 'Privatisation, regulation and competition: A thirty-year retrospective

on transit efficiency' (2008) *ITF Round Tables* 67-108

Kattan, et al. 'Factors of Successful Women Leadership in Saudi Arabia' (2016) 12 *Asian Social Science* 94

Kauser, et al. 'The Arab Women: Participation, Barriers, and Future Prospects' (2011) 12 *Journal of International Business and Economy* 35

Kawachi I, Kennedy B., 'Income inequality and health: Pathways and mechanisms' (1999) 34 *Health Services Research* 215-227.

Kaya, et al. "Inclusive Economic Institutions in the Gulf Cooperation Council States: Current Status and Theoretical Implications." (2016) 12 *Review of Middle East Economics and Finance* 139-173

Keane C, Marx J, Ricci E. Local health departments' mission to the uninsured.(2003) 24 *J Public Health Policy* 30–149.

Keane C, Marx J, Ricci E. Perceived outcomes of public health privatization: a national survey of local health department directors. (2001) 79 *Milbank Q* 115–137.

Keane C, Marx J, Ricci E. Privatization and the scope of public health: a national survey of local health department directors. (2001) 91 *Am J Public Health* 611–617.

Keane C, Marx J, Ricci E. Public health privatization: proponents, re- sisters, and decision-makers. (2002) 23 *J Public Health Policy* 133–152.

Keane C, Marx J, Ricci E. Services privatized in local health departments: a national survey of practices and perspectives. (2002) 92 *Am J Public Health* 1250–1254.

Keane C, Marx J, Ricci E. The perceived impact of privatization on local health departments. (2002) 92 *Am J Public Health* 1178–1180.

Keane C. The effects of managerial beliefs on service: Privatization and discontinuation in local health departments. (2005) 30 *Health Care Manage Rev* 52–61.

Keane, et al. Local health departments' mission to the uninsured. (2003) 24 *J Public Health Policy* 130–149

Keane, et al. Managerial and professional beliefs influencing public health privatization: results of a national survey of local health department directors (2003) 44 *J Health Soc Behav* 97–110.

Keane, et al. Privatization and the scope of public health: a national survey of local health department directors. (2001) 91 *Am J Public Health* 611–617.

Keane, et al. Public health privatization: proponents, resisters, and decision-makers.(2002) 23 *J Public Health Policy* 133–152.

Keane, et al. Services privatized in local health departments: a national survey of practices and perspectives. (2002) 92 *Am J Public Health* 1250–1254

Keane, et al. The perceived impact of privatization on local health departments. (2002) 92 *Am J Public Health* 1178–1180.

Keane, et al. The privatization of environmental health services: A national survey of practices and perspectives in local health departments (2002) 117 *Public Health Rep* 62–117

Keane, The effects of managerial beliefs on service: Privatization and discontinuation in local health departments (2005) 30 *Health Care Manage Rev* 52–61

Kechichian, *Legal and Political Reforms in Saudi Arabia* (Routledge 2013)

Kechichian, 'The role of the Ulama in the politics of an Islamic state: The case of Saudi Arabia' (1986) 18 *International Journal of Middle East Studies* 53

Kelley, et al. "Health care quality indicators project." *OECD Health Working Papers*, No. 23 (OECD Publishing 2006)

Kelly, S et al. *Women's Rights in the Middle East and North Africa: Progress Amid Resistance* (Rowman & Littlefield 2010)

Kelly, S. et al. *Women's Rights in the Middle East and North Africa: Gulf Edition* (Freedom House 2009)

Kemp, *Privatisation: The Provision of Public services by the Private Sector* (McFarland & Co 2007)

Kessner, D.M., Kalk, C.E. and Singer, J. 'Assessing health quality – the case for tracers' (1973) 288 New England Journal of Medicine 189–94.

Kettell, B. *Islamic Finance in a Nutshell*. (John Wiley & Sons 2011)

Kettle *Sharing Power: Public Governance and Private Markets.* (The Brookings Institution 1993)

Keyman, "Modernity, secularism and Islam: The case of Turkey." (2007) 24 *Theory, culture & society* 215-234

Khadduri, M. *Islamic Jurisprudence.* (Johns Hopkins Pr 1961)

Khaliq A., 'The Saudi Healthcare System: A View from the Minaret' (2012) 13 *World Health & Population* 52-64.

Khaliq, Ahmad, and Hassanudin Mohd Thas Thaker. "Revisiting of an Islamic Options Permisibility from Shariah Perspectives." (2015) 1 *Global Review of*

Islamic Economics and Business 175-184

Khallaf, *AlSiyasah al Shar'iyyah fi AlShu'un AlDusturiyyah wa al Kharijiyyah wa AlMaliyyah [Shariah Politics in Constitutional, External and Financial Matters]* (Dar al Qalam, 1988) [In Arabic]

Khammash, Hussam (2003) Medical Insurance in Saudi Arabia, U.S. & Foreign Commercial Service & U.S. Department of State.

Khan, et al. 'Impact of Green roof and orientation on the energy performance of buildings: A case study from Saudi Arabia' (2017) 9 *Sustainability* 640

Khan, "Islamic economics: the state of the art." (1999) 16 *American Journal of Islamic Social Sciences* 89

Khan, S 'Saudi Arabian women take to Twitter to campaign against male guardianship' *The Independent* 2 September 2016

Khan, et al. *The Influence of Faith on Islamic Micro-finance Programmes.* (Islamic Relief Worldwide 2010)

Khan, et al. 'Transition towards sustainable energy production- A review of the progress for solar energy in Saudi Arabia' (2017) 36 *EEE* 3

Khan, et al.,. 'A case study on public-private partnership working for rural women's reproductive health in Pakistan' Paper presented at: Public-private sector partnerships working for reproductive health: strategies for meeting the Millennium Development Goals. Society for International Development, Colombo, 2006.

Khan, *Foundations of Islamic Law* (Pentagon Press 2007)

Khan, What Is Wrong with Islamic Economics?, 2013

Khan,"Protecting the poor in the era of utility privatization." (2003) 7 *Energy for sustainable Development* 49-56.

Khanam, *Life and Teachings of the Prophet Muhammad* (Goodword Book Ltd. 2003)

Kharofa, *The Legal Methods in Islamic Administration* (International Law Book Services, 2000)

Khodaparast, et al. 'Inequity in Health care financing in Iran: Progressive or Regressive Mechanism' (2016) 48 Eurasian J Med 112

Kholwadia, et al, 'Wilayah (authority and governance) and its implications for Islamic bioethics: A Sunni perspective' (2013) 34 Theor Med Bioeth 95

Khoon, 'Reinventing the Welfarist state? The malaysian health system in transition' (2010) 40 Journal of Contemporary Asia 444

Khorasi, A. *An Analysis of Islamic Finance Framework, Authority in Islam and a Need for Paradigm Shift in Islamic Finance*. (LLM Thesis The British University in Dubai 2014)

Khorshid, *Islamic Insurance: A Modern Approach to Islamic Banking* (Routledge, 2004)

Khouja *Reform of Financing healthcare services in the GCC: Focus on establishing health insurance system in KSA,* (Master Thesis, University if Pittsburgh 2013)

Kikeri, S and Aishetu F. *Privatization: trends and recent developments* (Word Bank Publications 2005).

Kirby, et al., 'Neighborhood socioeconomic disadvantage and access to health care' (2005) 46 *Journal of Health and Social Behavior* 15

Klein R. Learning from others: shall the last be the first? Journal of Health Politics, Policy and Law 1997;22(5):1267–78.

Klein, K. *Fundraising for Social Change* (Jossey-Bass. 2007)

Koivusalo, M. Decentralization and equity of healthcare provision in Finland. (1999) 318 *British Medical Journal* 1198–200.

Konopantelis, et al., 'Patient experience of access to primary care: identification of predictors in a national patient survey' (2010) 11 *BMC family practice* 61

Kraemer, *Humanism in the Renaissance of Islam*: *The Cultural Revival During the Buyid Age* (Brill,1993)

Kralewski, J.E., B. Dowd, L. Pitt, & E.L. Biggs Effects of contract management on hospital performance. (1984). 19 Health Services Research, 479-98.

Kremic, et al. 'Outsourcing decision support: a survey of benefits, risks, and decision factors' (2006) 11 *Supply Chain Management: An International Journal* 6

Kreuter, et al., 'The role of culture in health communication' (2004) 25 *Annu. Rev. Public Health* 439

Kroessin, 'Concepts of Development in "Islam": A Review of Contemporary Literature and Practice' (2008) University of Birmingham Religions and Development Working Paper 20

Kroessin, Mohammad R. *Concepts of development in Islam: a review of contemporary literature and practice.* (RAD 2008).

Kumari, 'Migration and access to maternal healthcare: determinants of adequate antenatal care and institutional delivery among socio-economically disadvantaged migrants in Delhi, India' (2013) 18 *Tropical Medicine & International Health* 1202

Kuran, 'The Economic System in Contemporary Islamic Thought: Interpretation and Assessment', (1986) 18 International Journal of Middle East Studies 135

Kuran, T. "The Economic System in Contemporary Islamic Thought", in Jomo, K. *Islamic Economic Alternative. Critical Perspectives and New Directions* (Macmillan 1992)

Kuran, Timur (2011). The Long Divergence: How Islamic Law Held Back the Middle East, Princeton University Press

Laffont J, Tirole J. 'Privatization and incentives' in Laffont J, & Tirole J. *A theory of incentives in procurement and regulation* (MIT Press 1993)

Lahn, et al., *Burning Oil to Keep Cool. The Hidden Energy Crisis in Saudi Arabia.* (Chatham House 2011)

Lake J, Peterson E. An alternative structure for improving the public's health. (2002) 8 *J Public Health Manage Pract* 75–82.

Laldin 'The Foundations of Islamic Finance and The Maqasid al-Shari'ah Requirements' (2013) 2 *Journal of Islamic Finance*

Lalonde M: A New Perspective on the Health of Canadians. Ottawa: Office of the Canadian Minister of National Health and Welfare; 1974.

Laluddin, The concept of Maslahah with special reference to Imam AlGhazali (IIUM 1998)

Laluddin, et al, 'The Relationship between Islamic Human Rights and the Maqasidic Approach' (2012) 7 *The Social Sciences* 111

Lamarche, et al., 'The experience of primary health care users: a rural-urban paradox' (2010) 15 *Canadian Journal Of Rural Medicine* 61

Lambton, *State and Government In Medieval Islam* (OUP 1981)

Lambton, *State and Government in Medieval Islam: An Introduction to the study of Islamic Political Theory* (Psych Press 1981)

Lamiraud, K., F. Boysen, and X. Scheil-Adlung (2005). "The impact of social health protection on access to health care, health expenditure and impoverishment: a case study of South Africa", Extension of Social Security (ESS) Paper Series 23,ILO,Geneva

Lange, *On the economic theory of Socialism* (McGraw-Hill 1964)

Lapidus, *A History of Islamic Societies* (Cambridge University Press 2014)

Larkin, *Social Aspects of Health, Illness and Healthcare*, (McGraw- Hill Education 2011)

Lautier, 'International trade of health services: global trends and local impact' (2014) 118 Health Policy 105

League of Arab States, *Arab Charter on Human Rights*, 15 September 1994,

Leatherman, S., Dunford, C., Metcalfe, M., Reinsch, M., Gash, M. & Bobbi Gray. (2011). Integrating microfinance and health: Benefits, challenges and reflections for moving forward. 2011 Global Microcredit Summit Commissioned Workshop Paper,Valladolid, Spain, 14-17 November.

Leeuwen, *Waqfs and Urban structures: The Case of Ottoman Damascus* (BRILL 1999)

Levey, 'Medical Ethics of Medieval Islam with Special reference to AlRuhawi's Practical Ethics of the Physician' (1967) 57 *Transactions of the American Philiosophical Society* 3

Lewis, et al, 'Are public-private partnerships a healthy option?' (2014) 113 *Social Science & Medicine* 110

Lewis, M., Eskeland, G., Traa-Valarezo, X., *Challenging El Salvador's Rural Health Strategy* (World Bank 1999)

Lewis, Pellat, and Schacht, *The Encyclopaedia of Islam* (Brill 1991)

Lindsay, *Daily Life in the Medieval Islamic World* (Greenwood Publishing Group 2005)

Litaker, et al., 'Context and healthcare access: looking beyond the individual' (2005) 43 *Medical care* 531

Lizzie, 'DEAL: first IPO on Saudi's parallel market' (2017) *International Financial Law Review*

Lloyd, A.A. Government health care spending and the poor: evidence from Nigeria. (2009) 36 *International Journal of Social Economics*. 220-236.

Loeb, "The current state of performance measurement in health care." (2004) 16 *International journal for quality in health care* i5-i9

Loevinsohn, *Checklist for contracting of health services* (World Bank 2000)

Londono, B., Jaramillo, I., Uribe, J., *Decentralization and Reforms in Health Services, The Colombian Case.* (The World Bank 1999)

Longeran, "Islam's Financial Trap." (1996) 159 *Project and Trade Finance* 26-28

Lopez S, Rhodes L, Herzenberg S. *The Quiet Dismantling of Public Health* (Keystone Research Center 1999)

Lucas, et al, *Privatisation in Latin America:The Rapid rise, recent fall, and continuing puzzle of a contentious economic policy*, (Center for Global Development 2004)

Lutfi, et al, 'Sadaqah-based crowdfunding model for healthcare' (National University of Malaysia 2016)

Lyon, et al 'Surviving Out of Hospital Cardiac Arrest at Home: a Postcode Lottery?' (2004) 21 *EMJ* 619-624.

Ma, C., McGuire, T., , Optimal Health Insurance and Provider Payment, (1997) *American Economic Review* Sept 685-700.

Maarse 'The Privatization of Health Care in Europe: An Eight-Country Analysis'(2006) 5 *Journal of Health Politics, Policy and Law* 981

Maceira, D. *Income Distribution and the Public-Private Mix in Health Care Provision: the Latin American Case* (Inter American Development Bank 1998)

MacFarquhar, 'New Translation Prompts Debate on Islamic Verse' *The New York Times* 25 March 2007

Mackey, R. "Saudi Video Blogger Reportedly Detained for Showing Poverty in Riyadh' *The New York Times* (New York 19 October 2011)

Madkour, *Madkhal Alfiqh Alislami* [Islamic Jurisprudence] (Dar Alqawmiyah 1384H)[in Arabic]

Madkur, *Ma'alim AlDawal AlIslamiyyah [Features of Islamic Countries]* (Makataba AlFalah 1983) [In Arabic]

Mahal, A., Yazbeck, A., Peters, D., *The Poor and Health Service Use in India* (The World Bank, 2001)

Maharaj, et al., 'Healthcare for the poor and dispossessed: from Alma- Ata to the Millennium Development Goals' (2011) 60 *West Indian Med J* 493

Mahler, Half dan, The Meaning of "Health for all by the Year 2000". (1981) 2 World Health Forum 5-22.

Mahmood, *AlMarj'i fi AlHadharah AlArabiyah AlIslamiyah* [The Reference of The Arab Islamic Civilisation] (AlSalasil 1984) [In Arabic]

Mahmood, *Human Rights in Islam*, (Genuine Publications Ltd. 1993)

Mahmoud, I. 'The Development of the National Health System in Saudi Arabia with Emphasis on the Armed Forces Hospital' (M.A. Sangamon State University 1985)

Mainous, et al., 'A comparison of health status between rural and urban adults' (1995) 20 *Journal of Community Health* 423

Maisel, S. Tribes and the Saudi Legal-System, Middle East Institute, 2009

Majeed, 'How Islam Changed Medicine' (2005) 331 BMJ 1486

Majumdar, et al., 'Effects of cultural sensitivity training on health care provider attitudes and patient outcomes' (2004) 36 *Journal of Nursing Scholarship* 161

Makhdoomy, et al., 'Satisfaction with health care among primary health care

centers attendees' in Al-Khobar, Saudi Arabia' (1997) 18 *Saudi medical journal* 227

Malik. et al. *The political economy of Saudi Arabia (*Routledge 2007)

Manga, P. Privatization of health care services in Canada: Reform or regress? (1987) 10 Journal of Consumer Policy 1-24.

Manga, Privatization of health care services in Canada: Reform or regress? (1987) 10 *Journal of Consumer Policy* 1-24.

Mann 'Saudi Arabia's Economic Needs and the Price of Oil' (2010) 14 Middle East Review of International Affairs 72

Mannan *Islamic Economic Theory and Practice* (Ashraf 1987)

Mannan, *Social Justice Under Islam.* (Reference Press 2005)

Mansori, S., Kim, C.S. & Safari, M. A Shariah perspective review on Islamic microfinance. (2015) 11 *Asian Social Science* 273-280.

Mansour, A et al. "A Study of Health Centers in Saudi Arabia" (1996) 33 *International Journal of Nursing Studies* 309-315

Mansour, A.et al "A Study of Satisfaction among Primary Health Care Patients in Saudi Arabia." (1993) 18 Journal of Community Health 163–73

Marmor T, Freeman R, Okma K. Comparative perspectives and policy learning in the world of health care. Journal of Comparative Policy Analysis 2005;7(4):331–48.

Marshall, *The Cambridge Illustrated History of the British Empire* (CUP 1996) page 238-240

Marshall, *Social policy in the twentieth century.* (Hutchinson University 1965)

Martin, Bronwen, Mark P. Mattson, and Stuart Maudsley. "Caloric restriction and intermittent fasting: two potential diets for successful brain aging." Ageing research reviews 5.3 (2006): 332-353.

Martin, Richard C., "Riba". Encyclopedia of Islam and the Muslim World. Macmillan Reference USA. 2004

Martinez, et al. 'Evaluating the impact of immigration policies on health status among undocumented immigrants: a systematic review'(2015) 17 *Journal of Immigrant and Minority Health* 947

Maudoodi, *Human Rights in Islam* (Islamic Foundation 1976)

Maudoodi, S. *Introduction to the Study of the Qur'an.* (Flag Printing Distributed 1989)

Maudoodi, *The Islamic Law and Constitution* (Islamic Publications Ltd 1955)

Max M, *Science and Medicine: The Legacy of* Islam (Oxford University Press 1968)

May, et al 'Postcode lotteries in public health – the NHS health check programme in north west london' (2011) 11 *BMC Public Health* 738

Mayer, A (2002) Islam, Human Rights, and Gender: Traditions and Politics. The Washington Post reported on June 17.

Mayer, *Islam and Human Rights: Tradition and Politics* (Hachette 2012)

Mayer, *Islam and Human Rights: Tradition and Politics* (Westview Press 1991)

Mays et al., Assessing quality in cross-country comparisons of health systems and policies: Towards a set of generic quality criteria, (2013) 112 Health Policy 156– 162

Maysami, 'An analysis of Islamic Takaful Insurance: A Cooperative Insurance Mechanism' (1999) 18 Journal of Insurance Regulation 109

Mehdi, et al. 'Medical care in Islamic tradition during the middle ages (historicl review)' (2013) 10 *LSJ*

Mernissi, *The Forgotten Queens of Islam,* Translated by Lakeland (University of Minnesota Press 1997)

Mernissi *Women and Islam. A historical and theological enquiry*. (Blackwell Publishers, 1991)

Mills, 'Reforms to Women's Education Make Slow Progress in Saudi Arabia', *The Chronicle of Higher Education* 3 August 2009

Mitchell, J. E. (2009). Job Satisfaction and Burnout Among Foreign-trained Nurses in Saudi Arabia: A Mixed- method Study. Ann Arbor, MI: ProQuest.

McAuliffe, J. *Encyclopaedia of the Quran* (Vol. 4). (Brill 2004)

McGlynn,"Six challenges in measuring the quality of health care." (1997) 16 *Health Affairs* 7-21

McGuire, A; Henderson, J. & Mooney, G. *The Economics of Health Care*. (Routledge 1988)

McGuire, P. Conroy, J. & Thapa, G. *Getting the framework right: Policy and regulation for micro-finance in Asia* (The Foundation for Development Cooperation 1998)

McIntyre, D., Gilson, L, 'Putting equity in health back onto the social policy agenda: experience from South Africa' (2002) 54 *Social Science and Medicine*

1637-1656

McKee, ‘Grenfell Tower fire: why we cannot ignore the political determinants of health’(2017) 357 *BMJ*

McKee, M. (2010) The World Health Report 2000: 10 years on, Health Policy and Planning, 25(5): 346–8.

McKinsey Global Institute, *Saudi Arabia Beyond Oil. The Investment and Productivity Transformation*. (2015)

McLaughlin, C. ‘Privatization and health care’ in Halverson, & McLaughlin, *Managed Care & Public Health* (Aspen Publishers 1998)

McLaughlin, et al. *Managed Care & Public Health* (Aspen Publishers, 1998)

McManus et al. ‘PLAB and UK graduates’ performance on MRCP(UK) and MRCGP examinations: data linkage study’ (2014) Brit.Med.J. 348

Medical error: The Case of the Infectious Blood Transfusion, AlHayat Newspaper 23 May 2015 [In Arabic]

Megginson, et al. From state to Market: A survey of empirical studies on privatization, (2001) 39 *Journal of Economic Literature* 321-389

Melchert, *Ahmad Ibn Hanbal* (Oneworld Publications 2006)

Memish ZA, El Bcheraoui C, Tuffaha M, Robinson M, Daoud F, Jaber S, et al. Obesity and Associated Factors — Kingdom of Saudi Arabia, 2013. Prev Chronic Dis 2014;11:140236.

Messick, "Property and the Private in a Sharia System." (2003) *Social research* 711

Meyer, et al., 'Inequities in access to healthcare: analysis of national survey data across six Asia-Pacific countries' (2013) 13 *BMC health services research* 238

Milaat, "Public health in the saudi health system: A search for new guardian." (2014) 2 Saudi Journal of Medicine and Medical Sciences 77.

Miles, *The Hippocratic Oath and the Ethics of Medicine* (Oxford University Press 2005)

Miller, et al. 'Accounting, "economic citizenship" and the spatial reordering of manufacture.' (1994) 19 *Accounting, Organizations and Society* 15– 43.

Miller, 'Jundi-Shapur, bimaristans, and the rise of academic medical centres' (2006).99 *Journal of the Royal Society of Medicine* 615–617

Miller, et al., 'The association between geographic proximity to a dialysis facility and use of dialysis catheters' (2014) 15 *BMC nephrology* 40

Millman, *Access to health care in America*, (National Academies Press 1993)

Mills A, Brugha R, Hanson K and McPake B. 'What can be done about the private health sector in low- income countries?' (2002) 80 *Bulletin o f the World Health Organization* 325-330.

Mills, 'To contract or not to contract? Issues for low and middle-income countries' (1998) 13 *Health Policy and Planning* 32

Mills, A., Bennett, S. and McPake, B. *Private Health Providers in Developing Countries: Serving the Public Interest?* (Zed Books 1997)

Mills, ADecentralization and accountability in the health sector from an inter-national perspective: what are the choices? (1994) 14 *Public Administration*

and Development 281–92.

Mobaraki, et al. 'Gender inequity in Saudi Arabia and its role in public health' (2010) 16 *Estern Mediterranean Health Journal* 113

Moberly, Examination bar for overseas doctors must rise, (2014) BMJ 348

MOH penalizes a private hospital that fails to admit suspected coronavirus case, Alriyadh Newspaper, 11 September 2015 [In Arabic]

MOH: 47 Thousand Abortions in Saudi Arabia Last Year, Asharq al-Awsat, 28th March 2007 [In Arabic]

MOH: No Hospitals are Closed due to Coronavirus, Alriyadh newspaper, 10 March 2015, [In Arabic]

Mohammed *AlNitham AlSihhi bain AlTeb AlIslami wa Alteb AlTabi'i* [The Healthcare System between Islamic Medicine and Natural Medicine] (Dar AlHadi 2002) [In Arabic]

Mohammed, 'The Islamic Law Maxims' (2005) 44 *JSTOR* 191

Mohan, J. 'Rolling back the state?: Privatization of health services under the Thatcher governments' in Scarpaci, *Health Services Privatization in Industrial Societies* (Rutgers University Press 1989)

Moisseron, et al. *Are moral Islamic Economics an Answer to the Global Financial Crisis?*. Working papers 2014-152, Department of Research, Ipag Business School, 2014.

Mokdad et. al, Cost of Diabetes in the Kingdom of Saudi Arabia (2014) 6 JDM

Mokhtar, M., Sulaiman, R. & Ismail, A. 'Towards developing a sustainable microtakaful program in Malaysia'. *2nd ISRA Colloquium 2012*, 1-30.

Mokhtar, S. 'Microfinance Performance in Malaysia.' (Lincoln University 2011)

Monigsbaun, F., *Who Shall Live, Who Shall Die? Oregon's Health Financing Proposal.* (King's Fund College 1992)

Mooney, 'The Health of Nations: Toward a New Political Economy' (Zed Books 2012)

Mooney, *Economics, Medicine and Health Care.* (Wheatsheaf 1986)

Mooney, Gavin. The health of nations: Towards a new political economy. London: 2012, Zed Books.

Morakabati, Yeganeh, John Beavis, and John Fletcher. "Planning for a Qatar without oil: Tourism and economic diversification, a battle of perceptions." (2014) 11 *Tourism Planning & Development* 415-434

Morduch, J. The Microfinance Promise. (1999) *Journal of Economic Literature* 1569-1614.

Morsid, N. & Abdullah, R. The effectiveness of Islamic microfinance in Brunei Darussalam: A case study. (2014) 11 *Journal of Muamalat and Islamic Finance Research* 33-58.

Mottahedeh, *Lessons in Islamic Jurisprudence* (Oneworld 2014)

Motzki, *The Origins of Islamic Jurisprudence Meccan Fiqh before the classical schools* (BRILL 2002)

Mouline, *The Clerics of Islam: Religiois Authority and Political Power in Saudi Arabia* (Yale University Press 2014)

Mountin, J.W. and Perrott, G.S. (1947) Health insurance programs and plans of western Europe: summary of observations, Public Health Reports, 62(11): 369–99.

Mufti, *AlNitham AlSihhi AlSaudi Qadaya wa Ara'a* [The Saudi Healthcare System Issues and Opinions] (Quwa Alamn 2002) [in Arabic]

Mufti, M. H. *Healthcare development strategies in the Kingdom of Saudi Arabia*: Springer 2000).

Mufti, M. H. 'A need for managed care in Saudi Arabia' (2000) 21 *Saudi Medical Journal* 321-323

Mughal, et al., 'Urban growth management-the Saudi experience' (2004) 28 *Habitat International* 609

Mulla, et al. 'Privatization of general hospitals and its applications in Saudi Arabia' (King Fahad National Library 2001)

Müller et al, *Understanding the German Health care system,* (Mannheim Institute of Public Health 2013)

Mumisa, *Islamic Law: Theory and Interpretation* (Amana Publications 2002)

Murray, 'Privatisation' (1997) 86 *An Irish Quarterly Review* 51-61

Murray, C., Gakidou, E., and Frenk, J., Health inequalities and social group differences. (1999) 77 *Bulletin o f the World Health Organization* 537-44.

Murshed, et al. "Price level and inflation in the GCC countries." (2015) 39 *International Review of Economics & Finance* 239-252

Murtuza, *Insurance in Islam, Some Aspects of Islamic Insurance* (Islamic Economics Research and Bureau 1991)

Musgrove, P., *Public and Private Roles in Health: Theory and Financing Patterns*

(World Bank 1996)

Mushi, M. & Alsheikhi, H. 'The Success of Health Insurance for Saudi Citizens: Hospital Privatisation in Saudi Arabia' (2016) 8 European Journal of Business and Management 183

Muslehuddin, *Islam and Its Poliltical System* (Islamic Trust, 1988)

Mustafa, 'Islam and the four principles of medical ethics' (2014) 40 *Journal of Medical Ethics* 479-483

Nadim, 'The effect of medical insurance on medical services: positive or Negative?' in *Cooperative Health Insurance*, No. 3 (2008)

Nagamia, 'Islamic Medicine History and Current Practice' (2003) 2 *Journal of the International Society for the History of Islamic Medicine* 19

Nagamia, 'Medicine in Islam' (2008) *Encyclopaedia of the History of Science, Technology, and Medicine in Non-Western Cultures* 1541

Naghavi et al, *The utilization of healthcare services in Islamic Republic of Iran*, (Ministry of Health 2002)

Nahshal*, "My husband knows what is best for me...": An exploration of educated Saudi women's views towards domestic violence* (PhD Keele University 2018)

Naqvi, *Ethics and Economics : an Islamic Synthesis* (Islamic Foundation1981)

Naqvi, *Islam, Economics, and Society.* (Kegan Paul International 1994)

Naqvi, *Perspectives on Morality and Human Well-Being: A Contribution to Islamic Economics* (IF 2003)

Nasr, *Islamic Science: An Illustrated Study* (World of Islam Festival Publishing Company 1976)

Nasr, *Science and Civilization in Islam* (Harvard University Press 1987)

Nasr, *The Heart of Islam : Enduring Values for Humanity* (Harper 2002)

National Audit Office 'Recovering the cost of NHS treatment for overseas visitors'(2016)

National Health Services Act 2006

National Health Service (NHS) 'The National Health Service (charges to overseas visitors) (amendment) regulations 2017', 19 July 2017

Navarro V. Assessment of the World Health Report 2000. Lancet. 2000;356:1598–1601

Naylor C, Gregory S. Briefing: Independent sector treatment centres. King's Fund 2009

Nazir, et al. *Women's Rights in the Middle East and North Africa: Citizenship & Justice* (Rowman & Littlefield Publishers 2005)

NCRP. "Understanding Social Justice Philanthropy". (2003).

Nelson, 'Saudi Arabian Hashtag Calls for an end to Male Guardianship' *The Huffington Post* 2 September 2016

Nereim, "Saudi 2015 budget deficit is $98 billion as revenue drops." *Bloomberg Business* (2015)

Neudeck, W., Podczeck, K, Adverse selection and Regulation in Health Insurance Markets, (1996) 15 *Journal of Health Economics* 387-407.

Neuhauser, D. Assessing health quality: the case for tracers, (2004) 9 Journal of Health Services Research and Policy 246–7.

Newhouse, J. *Free for all? Lessons from the Rand health insurance experiment* (Harvard University Press 1993)

Newhouse, J., Do unprofitable patients face access problems? (1989) 11 *Health Care Financing Review* 33-42

Newhouse, J. *Handbook of Health Economics* (Elsevier Science 2000)

Nicholas, et al 'Variations in the organization and delivery of the 'NHS health check' in primary care' (2013) 35 *JPH* 85

Nicola R, Berkowitz B, Lafronza V. A turning point for public health. (2002) 8 *J Public Health Manage Pract* iv–vii.

Nienhaus *Takaful Islamic Insurance: Concepts and Regulatory Issues* (John Wiley & Sons 2009)

Nienhaus, *Zakat, taxes, and public finance in Islam*. in Behdad, et al., *Islam and the Everyday World: Public Policy Dilemmas* (Routledge 2006)

Noether, M., , Competition Among Hospitals, (1988) 7 *Journal o f Health Economics* 259-284.

Noland, et al. "Arab economies at a tipping point." (2008) 15 Middle East Policy 60

Nolte, et al, 'Assessing quality in cross-country comparisons of health systems and policies: Towards a set of generic quality criteria' (2013) 112 *Health Policy* 156-162.

Nolte, et. al 'Population health' in P.C. Smith et al. *Performance measurement for health system improvement: experiences, challenges and prospects*. (Cambridge University Press 2009)

Noor Ashikin Mohd Rom, Zuriah Abdul Rahman & Nurbani Md. Hassan. Financial protection for low income and poor. At 3rd International Conference on Business and Economic Research (ICBER 2012) Proceeding, 1409-1434.

Nowsheravi, 'Muslim Hospitals in the Medieval Period' (1983) 22 *Islamic Studies* 51

Nusair,"The effects of oil price shocks on the economies of the Gulf Co-operation Council countries: Nonlinear analysis." (2016) 91 *Energy Policy* 256-267

Nyazee, *Islamic Law Of Business Organization Corporations* (Islamic Research Institute Press 1998)

Nyazee, *Outlines of Islamic Jurisprudence*, (Federal Law House 2005)

Nyazee, *Shar'iah Bill of Rights for the New Millenium* (Advanced Legal Studies Institute 2001)

Nyazee, *Theories Of Islamic Law: The methodology of Ijtihad* (Islamic Research Institute Press 1994)

O'Connell et al, 'What does Universal Healthcare Coverage mean?' (2014) 383 Lancet 277

Obaidullah, M. *Introduction to Islamic Micro-Finance* (IBF Net Limited 2008)

Obaidullah, M. *Islam, Poverty and Micro Finance "Best Practices"* (Institute of Microfinance and Development 2008)

Obaidullah, 'Islamic Risk Management: Towards greater ethics and efficiency' (2002) 3 *International Journal of Islamic Financial Services*

O'Dowd, 'NHS regulator plans to make it easier for doctors to raise concerns and break "mafia" code of silence' (2013) 347 *BMJ* f6428

OECD Health Care Quality Framework, OECD Health Working Paper No. 23,

March 2006

OECD Health Statistics 2014, How does Spain compare? (OECD 2014)

OECD, *OECD Economic Surveys: Luxembourg 2008* (OECD Publishing, 2008)

Oh, *The Rights of God: Islam, Human Rights, and Comparative Ethics*

(Georgetown University Press 2007)

Olsen, E and Rogers, D., , The welfare economics of equal access, (1991) 45

Journal of Public Economics 91- 106

Omar, M. 'Reasoning in Islamic Law: Part Three' (1998) 41 *Arab Law Quarterly*

Orazaki, 'The Rights of Women in Islam: The question of public and private spheres for women's rights and empower in Muslim countries' (2014) 2 *Journal of Human Rights in the Commonwealth* 42

Organisation for Economic Cooperation and Development, *Towards High-Performing Health Systems* (OECD 2004)

Organization of the Islamic Conference (OIC), *Cairo Declaration on Human Rights in Islam*, 5 August 1990,

Osborne, D. & Gaebler, T. *Reinventing Government*, (Addison-Wesley 1992)

Otaghsara, 'The Relative Efficiency of Public and Non-public Health Centres in Iran' (PhD Thesis, University of Keele 2006)

Ott, et al. 'Preventing ethical dilemmas: understanding Islamic health care practices' (2003) 9 *Pediatric Nursing* 227

Otto, *Sharia Incorporated: A Comparative Overview of the Legal Systems of Twelve Muslim Countries in Past and Present* (AUP 2010)

Ozcan, Yusef Z. "Is Islam an obstacle to development? Evidence to the contrary and some methodological considerations." (1995) 2 *Intellectual Discourse* 1-22.

Padela, 'Islamic bioethics: between sacred law, lived experiences, and state authority' (2013) 34 Theor Med Bioeth 65

Padela, 'Social Responsibility and the State's Duty to provide Healthcare: An Islamic Ethico-Legal Perspective' (2016) *Developing World Bioeth*

Pakeeza, 'Role of Islamic Legal Maxims in Ijtihad' (2014) 5 *PI* 39

Palmer, 'The use of private-sector contracts for primary health care: theory, evidence and lessons for low-income and middle-income countries' (2000) 78 *Bulletin WHO* 821

Panzer, et al. "Increasing demands for quality measurement." (2013) 310 *Jama* 1971-1980.

Papanicolas et al, *Health System Performance Comparison* (McGraw-Hill Education 2013)

Parry, E. H. O., The Influence of Culture, (1984) 5 World Health Forum, 49-52.

Parry, *Privatization* (Kingsley 1990)

Parvez, *Building a New Society : An Islamic Approach to Social Change* (Revival 2000)

Parvin, 'On the Synergism of Gender and Class Exploitation: Theory and Practice under Islamic Rule' (1993) 51 *Review of Social Economy* 201

Patient Rights, National Guard Health Affairs 3 September 2014

Patient's Bill of Rights and Responsibilities, Ministry of Health 28 December 2011

Payton R. & Moody, M. *Understanding Philanthropy; Its Meaning and Mission* (Indiana University Press 2008)

Peedell, 'NHS Reforms: Further Privatisation is inevitable' (2011) 342 *BMJ* 1112

Penchansky, et al. 'The Concept of Access: Definition and Relationship to Consumer Satisfaction' (1981) 19 *Medical Care* 127

Penchansky, *The concept of access: a definition*, (National Health Planning Information Center 1977)

Perotti. Et al. "Machiavellian Privatization." (2002) 92 *American Economic Review* 240-258.

Pestieau, P. Assessing the performance of the public sector. (2009) 80 *Annals of Public and Cooperative Economics* 133–161.

Phillips, et al., 'Health in rural America: remembering the importance of place' (2004) 94 *Am J Public Health* 1661

Picone G, Chou S, Sloan F. Are for-profit hospital conversions harmful to patients and to Medicare? (2002) 33 *RAND Journal of Economics* 507–523.

Pierce, 'Distance and access to health care for rural women with heart failure' (2012) 7 *Online Journal of Rural Nursing and Health Care* 27

Pierru, et al. "The impact of oil price volatility on welfare in the Kingdom of Saudi Arabia: implications for public investment decision-making." (2014) 35

The Energy Journal

Pill, 'Law as Faith, Faith as Law: The Legalization of Theology in Islam and Judaism in the Thought of Al-Ghazali and Maimonides' (2014) 6 *Berkeley J. Middle E. & Islamic Law*. 1

Pitelis, *The Political Economy of Privatization* (Routledge 1993)

Podgorsak, 'Privatization is not an answer to healthcare access problems, increased public funding is' (2009) 16 *Current Oncology* 2

Pollock, *NHS Plc: The Privatisation of Our Health Care* (Verso 2005)

Pomeranz, 'Privatization and the Ethics of Islam' (1997) 14 American Journal of Islamic Social Sciences 264

Pope, et al. "Qualitative methods in research on healthcare quality." (2002) 11 *Quality and Safety in Health Care* 148-152

Pormann, *Islamic medical and scientific tradition: Critical concepts in Islamic studies* (Routledge 2011)

Pormann, *Medieval Islamic Medicine* (Edinburgh University Press 2007)

Pormann, P., & Savage-Smith, E. *Medieval Islamic Medicine*, (Edinburgh University Press 2007)

Pratt, et al., 'Rural-Urban Differences in Health Services Utilization in the US-Mexico Border Region' (2013) 29 *The Journal of Rural Health* 215

Presley, et al. *A guide to the Saudi Arabian economy* (Springer 2017)

Price, 'The consequences of health service privatisation for equality and equity in health care in South Africa' (1988) 27 Soc Sci Med 703

Price, et al. 'Rewriting the regulations: how the World Trade Organisation could

accelerate privatisation in health care systems' (2000) 356 The Lancet 1995

Pritchett, L , Summers, L.,. Wealthier is healthier. (1996) 31 *Journal o f Human Resources* 841-868.

Profanter, 'Achievements and Challenges in the Educational Realm in Saudi Arabia' (2014) 1 *European Scientific Journal* 207

Pryor, F. "The Islamic Economic System", (1985) 9 Journal of Comparative Economics 197-223

Qadhi, A. *An Introduction to the Sciences of the Quran*. (Al-Hidaayah Pub 1999)

Qadri, *Justice in Historical Islam* (Ashraf 1974)

Qasmi, *Islamic Government,* (Gyan 2008)

Qutb, *Social Justice in Islam* (Islamic Book Services 1999)

Rabi, *The Political Theory of Ibn Khaldun* (Brill 1967)

Ragab, 'Islam and Development' (2002) 8 *World Development* 513

Ragab, *The Medieval Islamic Hospital: Medicine, Religion and Charity* (Cambridge University Press 2015)

Rahman A.R.A. 'Islamic microfinance: An ethical alternative to poverty alleviation' (2010) 26 *Humanomics*, 284-295.

Rahman, 'The Development of the Health Sciences and Related Institutions during the First Six Centuries of Islam' (2000) 44 Islamic Quarterly 601

Rahman, 'The Quran And Fundamental Human Rights' (1978) 1 *Hamdard Islamicus* 71

Rahman, *Health and Medicine in the Islamic Tradition* (ABC International Group 1998)

Rahmani, 'Siasah Shariah: A Mean to Ensure Justice in the Society' (2011) 26 *AlAdwa* 9

Ram, P. "Management of Healthcare in the Gulf Cooperation Council (GCC) countries with special reference to Saudi Arabia." (2014) 4 *International Journal of Academic Research in Business and Social Sciences* 24.

Ram, P. "New Strategic Initiatives-A Case Study of the Saudi Health Ministry" (2014) 3 *International Journal of Academic Research in Economics and Management Sciences* 236.

Ramadan, *Ijtihad and Maslaha: Foundations of Governance* (Lexington 2006)

Ramadan, *In the footsteps of the prophet: lessons from the life of Mohammed* (OUP 2009)

Ramadan, *Understanding Islamic Law: From Classical to Contemporary* (AlTamira Press 2006)

Ramady, 'The Saudi Arabian economy: Policies, achievements, and challenges' (Springer 2010)

Ramady *Saudi Aramco 2030: Post IPO challenges* (Springer 2017)

Ramamurti, 'A multilevel model of privatisation in emerging economies' (2000) 25 *Academy of Management Review,* 525-550.

Ramanadham, *Public Enterprises and the Developing World* (Croom Helm 1984)

Raphaeli, N. "Demands for reforms in Saudi Arabia." (2005) 41 *Middle Eastern Studies* 517-532

Rasool, *State responsibility and privatization* (AlAmwal 1998) [In Arabic]

Rassool, 'The crescent and Islam: healing, nursing and the spiritual dimension. Some considerations towards an understanding of the Islamic perspectives on caring' (2000) 32 *Journal of advanced nursing* 1476

Ravindran, 'Privatisation in reproductive health services in Pakistan: three case studies' (2010) 18 *Reproductive Health Matters* 13

Reed, Saudi Vision 2030: Winners and Losers (Canergie 2016);

Rehman et al, 'How islamic are Islamic countries?' (2010) 10 Global Economy Journal 2

Reider et al, 'Urf: Islamic Biomedical Ethics in Rural Mali' (Springer 2008)

Reilly, et al. "The value-based Islamic economic system and other optimal economic systems: A critical comparative analysis." (1990) 17 *International Journal of Social Economics* 21-35

Reinhart, 'Islamic Law as Islamic Ethics' (1983) 11 *Journal of Religious Ethics* 186

Rejda, *Principles of Risk Management and Insurance* (Dorling Kindersley 2006)

Riaz, et al. 'Diversity of Interpretations Regarding Qawwam in Islamic Thought with Special Reference to Surah An-Nisa' (2013) 7 *Pakistan Journal of Islamic Research* 1

Rippin, *Textual Sources for the Study of Islam* (University of Chicago Press 1986)

Rizvi, "Pragmatic Pathways–Change is in the air "Preparing Youth for a new alternative economy in the GCC Region"." (2104) 9 *Middle East Journal of Business* 9-16

Rizvi, *The Ideal Islamic Government: As expounded by the Leader of the Faithful Ali Ibn Abi Talib,* (BMMT 1990)

Roald, *Women in Islam: The Western Experience* (Routledge 2001)

Roberts, et al, *Getting health reform right: A guide to improving performance and equity* (Oxford University Press 2008)

Rodini, 'Medical care in Islamic Tradition During the Middle ages' (2012) 3 *WMC*

Rodinson, *Islam and Capitalism* (Pantheon Books 1973)

Roemer, J. *Theories of Distributive Justice* (Harvard University Press 1996)

Roerich, et al, 'Delivering European healthcare infrastructure through public-private partnerships: the theory and practice of contracting and bundling' in *Research in Strategic Alliances* (Information Age Publishing 2013)

Rogers, 'The Islamic Ethics of Abortion in The Traditional Islamic Sources' (1999) 89 The Muslim World 122-129

Rogers, et al., 'Improving access needs a whole systems approach. And will be important in averting crises in the millennium winter' (1999) 319. *Bmj* 866

Rohrer J. Performance contracting for public health: the potential and the implications. (2004) 10 *J Public Health Manage Pract* 23–25.

Rondinelli, *Decentralization in developing countries*, Staff Working Paper 581 (World Bank 1983)

Rosko M. 'Cost efficiency of US hospitals: a stochastic frontier approach' (2001) 10 *Health Economics* 539–551

Ross, *The oil curse: How petroleum wealth shapes the development of nations* (Princeton University Press 2012)

Rowland, D. & Hanson, K. 'Medicaid: Moving to managed care' (1996) 15 *Health Affairs* 150-152

Royal Decree 33322, 7 March 2017

Rudnyckyj,*Spiritual economies: Islam, globalization, and the afterlife of development*. (Cornell University Press 2010)

Rules of Implementation of Cooperative Health Insurance System & Cooperative Health Policy, Ministry of Health Resolution 460/23/DH (2002)

Rulindo, R. & Pramanik, A. 'Finding a way to enhance impact of Islamic microfinance: The role of spiritual and religious enhancement programmes' (2013) 3 *Developing Country Studies* 41-52

Rundall, et al., 'The private management of public hospitals' (1984) 19 *Health Services Research* 519

Russell *Medicare's New Hospital Payment System: Is It Working?* (The Brookings Institution 1989)

Rutherford, *Egypt after Mubarak: Liberalism, Islam, and Democracy in the Arab World* (PUP 2013)

Saal, *International Handbook on Privatisation*, (Elgar 2003)

Saati, 'Privatisation of public hospitals: future vision and proposed framework'. *AlEqtisadiyah* (Riyadh 2 December 2003) [in Arabic]

Saba, *AlKhaskhasah wa Qita'a A'am Hazeel wa Gha'ib* [Privatization and a Weak and Absent Public Sector] (AlMawqif 1994) [In Arabic]

Sabri, *Privatisation: Transfering Public Ownership in Light of Islamic Shariah* (Awanj 2000) [In Arabic]

Sachedina, '"No Harm, No Harassment" Major Principles of Healthcare Ethics in Islam' in Guinn, D. *Handbook of Bioethics and Religion* (OUP 2006)

Sachedina, 'In Search of Principles of Healthcare Ethics in Islam' in *Islamic Biomedical Ethics Principles and Applications* (OUP 2009)

Sadeq, *Economic Development in Islam* (Pelanduk 1990)

Saeed, 'Rethinking citizenship rights of non-Muslims in an Islamic state' (1999) 10 *Islam and Christian-Muslim Relations* 307

Saeed, Islamic Banking and Interest: A study of prohibition of riba and its contemporary interpretation, (Brill 1999)

Saeed, *Islamic Thought: An Introduction* (Routeldge 2006)

Saeed, 'Satisfaction and correlates of patients‟ satisfaction with physicians‟ services in primary health care centers' (2001) 22 *Saudi Medical Journal* 262-267.

Safi, 'Toward an Islamic Tradition of Human Rights' (2001) 18 *American Journal of Islamic Social Sciences* 16

Safi, O. "The Challenges For Saudi Arabia Health Care System." (2016) 6 *Indian Journal of Applied Research*

Saha, et al., 'Patient centeredness, cultural competence and healthcare quality' (2008) 100 *Journal of the National Medical Association* 1275

Said-Foqahaa, et al. 'Arab women: Duality of deprivation in decision-making under patriarchal authority' (2011) 9 *Hawa: Journal of Women of the Middle East and the Islamic World* 234

Sajjad, et al. ' an assessment of the healthcare services in the Kingdom of Saudi Arabia: An analysis of the old, current and future systems' (2018) *International Journal of Healthcare Management*

Sajoo, *A Companion to Muslim Ethics* (Tauris 2012)

Saleh, *AlZakat LelTanmiyah AlEqtisadiyah wa AlIjtima'iyah* [The role of Zakat in Financial and Social Development] (AlBayan 2011) [In Arabic]

Salhab, 'Qira'ah Naqdiyah Limashroi AlKhaskhasah' [A Critical Study of the Privatisation Project] (AlMawqif, 1999) [in Arabic]

Salinas, et al., 'The rural–urban divide: Health services utilization among older Mexicans in Mexico' (2010) 26 *The Journal of Rural Health* 333

Saltman, R. B., & Figueras, J. (1998). Analyzing the evidence on European health care reforms. *Health Affairs, 17*(2), 85-108.

Saltman, R. B., Figueras, J., & Saltman, R. B. (1997). *European health care reform: analysis of current strategies*: World Health Organization, Regional Office for Europe.

Saltman, 'Melting public-private boundaries in European health system' (2003) 13 *Eur J Public Health* 24-29

Saltman, et al., 'Conceptualizing decentralization in European health systems: a functional perspective' (2006) 1 *Health Economics, Policy and Law* 127

Saltman, et al., *Decentralisation in health care* (OUP 2007)

Samargandi, *Essays on financial development and economic growth*. (PhD Thesis, Brunel University 2015)

Samier, *Fairness, Equity and Social Cooperation: A Moderate Islamic Social Justice Leadership Model* (Palgrave Macmillan 2016)

Sappington D, Stiglitz J. 'Privatization, information and incentives' (1987) 6 *Journal of Policy Analysis and Management* 567–582

Sattam, *Sharia and the Concept of Benefit: The Use and Function of Maslaha in Islamic Jurisprudence* (I.B Tauris 2015)

Saudi Gazette, Full text of Saudi Arabia's Vision 2030, April 2016

Saunders, *A History of Medieval Islam* (Routeledge 1978)

Scarpaci, *Health Services Privatization in Industrial Societies* (Rutgers University Press 1989)

Scarpaci, *Introduction: The theory and practice of health services privatization*. in

Schachet, *An Introduction to Islamic Law* (Universal Law Publishing Company 1997)

Schacht, *An Introduction to Islamic Law* (Clarendon Press 1983)

Schacht, J. Bosworth, C. and Arnold, T. *The Legacy Of Islam*. (Clarendon Press 1974)

Schacht, *The Encyclopaedia of Islam* (Brill 1991)

Schacht et al, The Origins of Muhammadan Jurisprudence (OUP 1950)

Scheil-Adlung, X. et al. *What is the Impact of Social Health Protection on access to Health Care, Health Expenditure and Impoverishment? A comparative Analysis of*

Three African Countries (ILO 2006)

Scheppers, et al., 'Potential barriers to the use of health services among ethnic minorities: a review' (2006) 23 *Family practice* 325

Schlesinger, M. Marmor, T. & Smithey, R. 'Nonprofit and for-profit medical care: Shifting roles and implications for health policy' (1987) 12 Journal of Health Politics, Policy & Law 427-457

Schmidt, 'The costs and benefits of privatization: an incomplete contracts approach' (1996) 12 *Journal of Law, Economics, and Organization* 1

Schnore, 'The Socio-Economic Status of Cities and Suburbs' (1963) 28 *American Sociological Review* 76

Schreyögg J, Stargardt T, Tiemann O. 'Costs and Quality of Hospitals in Different Health Care Systems: a Multilevel Approach with Propensity Score Matching' (2010) 20 *Health Economics* 85–100

Schreyogg, et al.,'Changes in hospital efficiency after privatisation' (2012) 10 *Health care Management Science*

Schweitzer, 'Providing public healthcare to irregular migrants. The everyday politics and local negotiation of formal entitlements and effective access in London and Barcelona' (2016) Grup de Recerca Interdisciplinari en Immigració - Universitat Pompeu Fabra. Barcelona (GRITIM-UPF Working Paper Series, 29)

Schweitzer, 'Integration against the state. Irregular migrants' agency between deportation and regularisation in the United Kingdom' (2017) 16 *Politics*

Schweitzer, et al. 'From Social Workers to Immigration Officers? Public Welfare Institutions as a Tool for Migration Control' (2018)

Segrado, C. *Islamic microfinance and socially responsible investments. Case study*. (Meda Project Microfinance, University of Torino 2005)

Sekhri, 'Private health insurance: implications for developing countries' (2005) 83 *Bulletin of the World Health Organization* 127-134.

Seren, et al, 'Nurses' perception about health sector privatisation in Turkey' (2013) 60 International Nursing Review 320

Shafiullah, *A critique of Islamic finance in conceptualising a development model of islam: an attemot in Islamic moral economy* (PhD Thesis Durham University 2013)

Shahab Al Din, *AlAhkam fi AlFatwa* [Rulings in *Fatwas*] (Cairo 1983) [in Arabic]

Shahmanesh, 'Neoliberal globalisation and health: a modern tragedy' (2007) 35 Critique 315

Shamrani, 'After 29 years and opposing 9 amendments to the Civil Status System, Shura discusses the wife's right to issuamce of 'family card'' *Okaz* 7 september 2015

Shamsi, *Human Rights and Islam*, (Reference Press 2003)

Shamsul Alam, M. & Siddiqui, K. "The Development of the Health Sciences and Related Institutions during the First Six Centuries of Islam" (2007) 3 *Journal of Center for Development and Research* 51-63.

Shanks, N. & Al-Kalai, D. "Arabian Medicine of the Middle Ages" (1984) 77 *Journal of the Royal Society of Medicine* 60-65.

Shapps, 'All your eggs in one basket. A comprehensive study into the continuing

postcode lottery in IVF provision through the NHS' 6th August 2009

Shayerah, I. "Islamic finance: Overview and policy concerns." *Congressional Research Service, Report for Congress, www. crs. gov*. (2010)

Shen Y. 'Changes in hospital performance after ownership conversions' (2003) 40 *Inquiry* 217– 34

Shen, et al., 'Equity in use of maternal health services in Western Rural China: a survey from Shaanxi province' (2014) 14 *BMC health services research* 155

Shen, Y. Eggleston, K. & Lau, J. 'Hospital ownership and financial performance: what explains the different findings in the empirical literature?' (2007) 44 *Inquiry* 41–68.

Sheshinski, et al., 'Privatization and its benefits: theory and evidence' (2003) 49 *Economic Studies* 429

Shleifer, State versus Private Ownership, (1998) 12 *Journal of Economic Perspectives* 133-150

Shomali, 'Islamic Bioethics: A General Scheme' (2008) 1 Journal of Medical Ethics & History of Medicine 1

Sibley, et al., 'An evaluation of access to health care services along the rural-urban continuum in Canada' (2011) 11 *BMC Health Serv Res* 20

Sidahmen, 'Thousands of Saudis sign petition to end male guardianship of women' *The Guardian* 26 September 2016

Siddiqi, *Islam's Approach to right of property,* (Islamic Publications Ltd 1978)

Siddiqi, M. *Insurance in an Islamic Economy* (The Islamic Foundation 1985)

Siddiqi, Paradise of Wisdom by alTabari, Berlin 1928

Siddiqi, *Some Aspects of the Islamic Economy,* (Islamic Publications Ltd 1978)

Siddiqui, "Ethics in Islam: key concepts and contemporary challenges." (1997) 26 *Journal of Moral Education* 423-431

Siegman, 'The State and Individual in Sunni Islam.' (1964) *The Muslim World* 54

Simoens, S. and Scott, A. 'Voluntary or compulsory health care reform? The case of primary care organizations in Scotland' (2005) 72 *Health Policy* 351–8

Simonsen, *Redefining rights: Islamic perspectives and the Cairo Declaration* in Hastrup *Legal cultures and human rights: the challenge of diversity* (Kluwer Law International 2001)

Singer, A. *Charity in Islamic societies* (Cambridge University Press 2008)

Sirry, *AlEqtisad AlIslami Mabadei wa Khasais wa Ahdaf* [Islamic Finance Principles, Characteristics, and Objectives] (Markaz AlIskandariya LilKetab 1988) [In Arabic]

Slack K., Savedoff, W., *Public purchaser-private provider contracting for health services: examples from Latin America and the Caribbean.* SDS Technical Paper (Inter-American Development Bank 2000)

Smith E, Brugha R and Zwi A. *Working with private sector providers for better health care, an introductory guide* (London School of Hygiene and Tropical Medicine 2001)

Smith, *Decentralization: the territorial dimension of the state* (Allen & Unwin 1985)

Smith, et al. ‘Political and economic aspects of the transition to universal health coverage’ (2012) 380 *Lancet* 924–32.

Smith, et al., ‘Ethnic inequalities in health: a review of UK epidemiological evidence’ (2000) 10 *Critical Public Health* 375

Smith, *Measuring up. Improving health system performance in OECD countries* (Organisation for Economic Cooperation and Development 2002)

Smith, S. & Lipsky, M. ‘Privatization in health and human services: A critique’ (1992) 17 Journal of Health Politics, Policy & Law 233-53.

Smock, D. *Applying Islamic Principles in the Twenty-first Century* (Institute of Peace 2005)

Sobel, *The Pursuit of Wealth*, (McGraw Hill 1999)

Soldatos, "A Critical Overview of Islamic Economics from a Welfare-State Perspective." (MPRA Paper, University of Munich 2016).

Sons, ‘Saudi Arabia: oil as a burden in the struggle for energy diversification’ in Thielges, et al., *Sustainable energy in the G20: prospects for a global energy transition* (IASS 2016)

Sons, S. ‘In Dire Need for a New Social Contract: Saudi Arabia’s Socioeconomic and Political Challenges in Times of Changing Energy Dynamics’ in Jalilvand, et al., *The Political and Economic Challenges of Energy in the MENA* (Routledge 2017)

Souaiaia, *Islamic Law and Government*. (Writers Club Press 2002)

Starr, “The meaning of privatization,” (1988) 6 *Yale Law and Policy Reviews*

1101-1136

Starr, P., "The limits of privatization," in *Prospects for Privatization* (The Academy of Political Science 1987) 124-137

Starr, *The Social transformation of American Medicine,* (Basic 1982)

Steele, et al 'The Immigration Bill: extending charging regimes and scapegoating the vulnerable will pose risks to public health'(2014) 107 *Journal of Royal Society of Medicine* 132

Stiglitz, J. 'Monopoly, Non-linear Pricing and Imperfect Information: The Insurance Market' (1977) 4 *Review of Economic Studies* 407-428.

Straub et al. Renegotiation of concession contracts in Latin America : Evidence from the water and transport sectors, World Bank Policy Research Working Paper No. 3011 (2002)

Streeten, P. *First Things First: Meeting Basic Human Needs in the Developing Countries* (The World Bank 1981)

Sullivan, K. 'In Saudi Arabia, unemployment and booming population drive growing poverty' *The Washington Post* (3 December 2012)

Sullivan, K. 'Saudi Arabia's riches conceal a growing problem of poverty' *The Guardian* (London, 1 January 2013)

Syahida, 'Risk Management via Takaful from a perspective of Maqasid Alshariah' (2012) 65 *Social and Behavioral Sciences* 535

Syed, et al., 'Traveling towards disease: transportation barriers to health care

access' (2013) 38 *Journal of community health* 976

Szczepura, 'Access to health care for ethnic minority populations' (2005) 81 *Postgraduate Medical Journal* 141

Tabari, *Tarikh AlUmam wal Mulook [The History of Nations and Kings]* (Matba'ah AlIstiqamah 1993)

Taher, Moral & Ethical Issues in Liver & Kidney Transplantation, (2005) 16 *Saudi Journal of Kidney Diseases & Transplantation* 375

Tahir, 'A true vision of human rights in Islam' (2013) 40 *AlAdwa* 7

Taj, *AlSiyasah AlShar'iyyah wa AlFiqh AlIslami [Shariah Politics and Islamic Jurisprudence]* (Beirut: Dar al Fikr, 1976) [In Arabic]

Taleqani, *Islam and Ownership* (Lexington 1983)

Tanahashi, 'Health service coverage and its evaluation' (1978) 56 *Bulletin of the World Health Organization* 295

Taylor, 'Contracting for Health Services' in *Private Participation in Health Handbook* (World Bank 2000)

Teckle, et al., 'Is the health of people living in rural areas different from those in cities? Evidence from routine data linked with the Scottish Health Survey' (2012) 12 *BMC Health Serv Res* 43

Terzi, et al 'Privatisation of health care facilities in Istanbul' (2011) 19 European Planning Studies 1117

The Basic Law of Governance, Royal Decree No.A/90, 31st January 1992

The Cooperative Health Insurance Act, Royal Decree M/10 August (1999)

The Cooperative Health Insurance Act, Royal Decree M/10 August (1999)

The Fifth Annual Report on Privatization (Reason Foundation 1991).

The first International Conference on Islamic Economics held in Makkah, Saudi Arabia February 21-26, 1976

The General Presidency of Scholalry research and Ifta, The Obligations of the Ruler (1994) Fatwa 38 page 222

The Law of Protection from Abuse, Royal Decree M/52 20th September 2013

The Saudi Arabian Monetary Agency Charter, Royal Decree No. 23, 15 December 1957

The Saudi Banking Control Law, Royal Decree No. M/5, 11 June 1966

The Saudi Commission for Health Specialities Law, Royal Decree No. M/2, 5th August 1992

The Saudi Health Law, Royal Decree No. M/11, 4th June 2002

The Saudi Health Profession Practice Law, Royal Decree No. M/59, 6th December 2005

Thesis, Manchester Metropolitan University 2003)

Tiemann O. & Schreyögg, J. 'Effects of ownership on hospital efficiency in Germany' (2009) 2 *Business Research* 115

Tiffin, Annual Review of Competence Progression (ARCP) performance of doctors who passed Professional and Linguistic Assessments Board (PLAB) tests compared with UK medical graduates: national data linkage study, BMJ 2014; 348

Todd, 'Health inequalities in urban areas: a guide to the literature' (1996) 8

Environment and Urbanization 141

Travis, et al., 'Overcoming health-systems constraints to achieve the Millennium Development Goals' (2004) 364 *The Lancet* 900

Tripp, *Islam and the Moral economy: The Challenge of Capitalism* (Cambridge University Press 2006)

Turam, "The politics of engagement between Islam and the secular state: ambivalences of 'civil society'" (2004) 55 *The British journal of sociology* 259-281

Turner, *Science in Medieval Islam: an Illustrated Introduction* (University of Texas Press 1997)

Ulrichsen, K. *The Politics of Economic Reform in Arab Gulf States* (The Baker Institute 2016)

Umeh, J. 'Healthcare financing in the Kingdom of Saudi Arabia: a review of the options' (1995) 31 World Hospitals and Health Services 3

UN Economic and Social Council, Committee on Economic, Social, and Cultural Rights, General Comment No. 14 E/C. 12/2000/4

UN General Assembly Universal Declaration of Human Rights (adopted 1948 UNGA Res 217 A(III) (UDHR)

UN General Assembly, *Convention on the Elimination of All Forms of Discrimination Against Women*, 18 December 1979, United Nations, Treaty Series, vol. 1249, p. 13

UN General Assembly, *Convention on the Rights of Persons with Disabilities : resolution / adopted by the General Assembly*, 24 January 2007, A/RES/61/106,

UN General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, p. 3,

UN General Assembly, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3

Usmani, *An introduction to Islamic finance* (Kluwer Law International 2002)

Usmani, M. *The Meanings of the Noble Quran* (Maktaba Ma'ariful Qur'an 2006)

Van der Gaag, J. *Private and public initiatives: working togetherfor health and education. Directions in development Series.* (The World Bank 1995)

Van Eijk, 'Sharia and National Law in Saudi Arabia' in Otto, *Sharia Incorporated: A Comparative Overview of the Legal Systems of Twelve Muslim Countries in Past and Present* (AUP 2010)

Vargas, et al., 'Barriers of access to care in a managed competition model: lessons from Colombia' (2010) 10 *BMC Health Serv Res* 297

Vernon, R. *The Promise of Privatization: A Challenge for American Foreign Policy* (Council on Foreign Relations 1988)

Vickers, et al., 'Economic perspectives on privatization' (1991) 5 *The Journal of Economic Perspectives* 111

Vickers, et al., *Privatization: an Economic Analysis* (MIT Press 1988)

Victora et al, 'Making Health Systems more equitable' (2004) 364 *Lancet* 1273–80

Vikor, *Between God and the Sultan: A History of Islamic Law* (Oxford University Press 2005)

Villalonga B. 'Privatization and efficiency: differentiating ownership effects from political, organizational, and dynamic effects' (2000) 42 *Journal of Economic Behavior and Organization* 43–74

Vlahov, et al., 'Urbanization, urbanicity, and health' (2002) 79 *J Urban Health* S1

Vogel, *Islamic Law and the Legal System of Saudi Arabia* (BRILL 2000)

Vogel, *The Islamic School of Law: Evolution, Devolution and Progress* (HUP 2005)

Wagstaff, A et al.. 'Equity in Health Care Financing: Redistributive Effects and Horizontal Inequality' Equity Project Working Paper # 8 (Erasmus University 1997)

Wagstraff, A.,Van Doorslaer J. 'Equity in Health Finance and Delivery' in Newhouse, J. *Handbook of Health Economics* (Elsevier Science 2000)

Walker, L. "The Right to Health and Access to Health Care in Saudi Arabia with a Particular Focus on the Women and Migrants" in Toebes, et al. *The Right to Health: a multi-country study of law, policy and practice* (Asser Press 2014) 165-192

Walker, *The Right to Health in Saudi Arabia. 'Right to health in the Middle East' project* (University of Aberdeen 2009)

Wallet, et al, 'Health care financing in Iran: Is privatisation a good solution?' (2012) 41 Iranian J Publ Health 14

Wamala, et al. 'Gender inequity and public health. Getting down to real issues' (2002) 12 *European journal of public health* 163–5.

Waren, ' Privatization of health care' (2009) 180 CMAJ 429

Wasem, J. 'A study on decentralizing from acute care to home care settings in Germany'(1997) 41 *Health Policy* s109-29

Waterbury, et al., 'The political economy of privatisation in developing countries' (1989) 17 *World Development* 617

Waterbury, J., "The political context of public sector reform and privatization in Egypt, India; Mexico and Turkev." Paper presented at the Privatization Working Conference: (Princeton University 1988)

Waterhouse, *Privatization: the facts* (Price Waterhouse 1990)

Waters, H. 'Measuring Equity in Access to Health Care' (2000) 51 *Social Science and Medicine* 599-612

Watt, *Muhammad at Mecca* (Clarendon Press 1953).

Watt, *Muhammad at Medina* (OUP 1956)

Weber, M. (1947) *The theory of social and economic organization*. New York, Oxford University Press.

Weil, 'What can the canadians and americans learn from each other's health care systems?'(2016) 31 Int J Health Plann Mgmt 349

Welch, et al. *Economics: Theory and Practice* (The Dryden Press 1992)

White, 'Madina Charter and Pluralism' (2010) 76 *The Fountain*

Whitehead, M. *The Health Divide: Inequalities in Health in the 1980's in U.K.* (The Health Education Authority 1987)

WHO 'A WHO Framework for Health System Performance Assessment' (1999)

WHO 'A WHO Framework for Health System Performance Assessment' (1999)

WHO, ‘Constitution of the World Health Organization’, The International Health conference, New York 22 July 1948

WHO ‘Health Systems Financing: The Path to Universal Health Coverage’ (2010)

WHO ‘Privatization in Health’ 1995

WHO ‘The Right to Health’ Factsheet August 2007

WHO ‘The World Health Report 2003: Shaping the Future’ (2003)

WHO ‘Universal Healthcare Coverage (UHC)’ Factsheet updated December 2016

WHO (Task Force on Health Economics) ‘Privatisation in Health’ (1995) WHO/TFHE/TBN/95.1

WHO [World Health Organization]. The world health report 2000: health systems; improving performance. (World Health Organization 2000)

WHO [World Health Organization]. The world health report 2010: health systems financing: the path to universal coverage, Berlin: World Health Organization; 2010.

WHO Factsheet 323, 2007

WHO, ‘Islamic Code of Medical and Health Ethics’ (2005) EM/RC52/7

WHO, ‘Islamic Code of Medical and Health Ethics’ (2005) EM/RC52/7

WHO, (1981), The World's Main Health Problems. WHF, 2 (2): PP.264-280.

WHO, (1982), A Management Approach to Health Systems Development, WHF, 3 (1): PP.64-67.

WHO, Everybody’s business. Strengthening health systems to improve health outcomes: WHO’s framework for action, 2007

WHO. (2013). Research for universal health coverage

WHO. (2013). Saudi Arabia, Country Cooperation Startegy at a glance. 09/2013

Wilson, "Islamic project finance and private funding schemes." (1998) 5 *IIUM Journal of economics and management* 41-60

Wilson, R. "The political economy of Saudi Arabia." (2008) 44 *Journal of Middle Eastern Studies* 637-639.

Wolinsky, et al., 'The use of health services by older adults' (1991) 46 *Journal of Gerontology* S345

Wolman, H. 'Decentralization: what it is and why we should care' in Bennett, R. *Decentralization, local governments, and markets: towards a post-welfare agenda* (Clarendon Press 1990)

World Bank (PPPIRC), 'Privatisation' (2016)

Wynne, 'Hazards in corporatization of healthcare' (2004) 80 *New Doctor* 2

Yabroff, et al., 'Access to preventive health care for cancer survivors' (2013) 45 *American journal of preventive medicine* 304

Yadav, P. & Mittal, P. 'Healthcare System: The Public vs Private Debate' (2016) 5 International Journal of Scientific Research 505

Yamey et al, 'What does UHC mean?' (2014) 383 Lancet 951

Yang, et al, 'On the development of public-private partnerships in transitional economies: an explanatory framework' (2013) 73 *Public Adm Rev* 301

Yarrow, 'Privatization in Theory and Practice' (1986) 2 *Economic Policy* 324

Yasin, et al. 'Universal Coverage in an era of privatisation: can we guarantee health for all?' (2012) 12 BMC Public Health

Yazid, et al., 'The practices of Islamic Finance in upholding the Islamic values and the Maqasid AlShariah' (2015) 4 *IRMBRJ* 286

Ybarra, 'Zakat in Muslim society: an analysis of Islamic economic policy' (1996) 35 *Social Science Information* 643

Yergin, et al, *The Commanding Heights: The Battle for the World Economy* (Free Press 1998)

Yescombe, *Public-private partnerships: principles of policy and finance*. (Butterworts-Heinemann 2007)

Yildirim, 'Peace and Conflict Resolution in the Medina Charter' (2006) 18 *Peace Review* 109

Yotopoulus, 'The (rip) tide of privatization: Lessons from Chile' (1989) 17 *World Development* 5

Young et al, *Guidance for Good Governance: Explorations in Qur'anic, Scientific and Cross-cultural Approaches* (IIUM Press 2008)

Young et al., 'The policitcal economy of privatization' in Kahn, et al., *Privatisation and the welfare state* (Princeton University Press 2014)

Young, 'Privatizing health care' (1990) 5 *International Journal of Health Planning and Management* 237-270

Younis, "Privatization: a review of policy and implementation in selected Arab countries." (1996) 9 International Journal of Public Sector Management 18-25.

Yusuf, *Economic Justice in Islam* (Lahore 1977)

Yusuf, N. "Private and public healthcare in Saudi Arabia: future challenges." (2014).2 *International Journal of Business and Economic Development*

Yusuf, 'Prospects of Takaful's (Islamic Insurance) Contribution to the Nigerian Economy' (2012) 1 Journal of finance and Investment Analysis 217

Zafar, et al., 'Disparities in access to surgical care within a lower income country: an alarming inequity' (2013) 37 *World journal of surgery* 1470

Zahner S. 'Local public health system partnerships' (2005) 120 *Public Health Rep* 76–83.

Zain, M. Kassim, N. and Kadash, N. "Isnt it now a crucial time for Saudi Arabian firms to be more innovative and competitive?' (2017) 21 *International Journal of Innovation Management* 1750021

Zain Al-Abedin, Suhaila. 2009. "Wife's Obedience to Her Husband: A Corrective Examination" [in Arabic]. Paper presented at the 4th Annual Arabic Meeting: Women Through a New Lens, Al-Manama, Bahrain

Zaman, H. 'Microcredit programmes: Who participates and what does it matter?' in Wood, G. and Sharif, I. *Who Needs Credit? Poverty and Finance in Bangladesh* (Dhaka University Press 1997)

Zaman, M. *The Ulama in contemporary Islam; Custodians of Change* (OUP 2004)

Zangeneh, et al., ' The value-based Islamic economic system and other optimal economic systems: a critical comparative analysis' (1990) 17 *International Journal of Social Economics* 21

Zarqa, 'An Approach to Human Welfare' in Ghazali, et al., *Readings in the Concept and Methodology of Islamic economics.* (Pelanduk Publications 1989)

Zayd, AlGhazali on Divine Predicates and their Properties (Ashraf 1970)

Zein, et al, 'Qur'anic Guidance on Good Governance' in Young et al, *Guidance for Good Governance: Explorations in Qur'anic, Scientific and Cross-cultural*

Approaches (IIUM Press 2008)

Zhang, et al., 'Persistent problems of access to appropriate, affordable TB services in rural China: experiences of different socio-economic groups' (2007) 7 *BMC Public Health* 19

Ziauddin, *Influence of Islam on Western Civilisation.* (National Book foundation 1978)

Ziauddin, *Islam poverty and Income Distribution*. (The Islamic foundation 1991)

Zigante, 'Consumer choice, competition and privatisation in European health and long term care systems: Subjective well being effects and equity implications' (PhD Thesis, The London School of Economics and Political Science 2013)

Zikria, 'Adab Altabib [Doctor Ethics]' (1981) 13 *Journal of IMA* 79-80

Zoepf, 'Sisters in Law: Saudi Women are beginning to know their rights' *The New Yorker* 11 January 2016

Zubaida, *Law and Power in the Islamic World* (I.B Tauris 2005)

Zurayk, et al. 'Women's health problems in the Arab World: a historic policy perspective' (1997) 58 *International Journal of Gynecology and Obstetrics* 13

Zweifel, 'Does privatization contribute to the performance of a health care system?' (2014) 34 Economic Affairs 171