

Factors Influencing Patients' Choice of Public or Private Hospitals in Jeddah, Saudi Arabia: A Cross-Sectional Study

Mona Tarek Skaik^{1*}, Mohammed Khaled Al-Hanawi²

¹Department of Health Services and Hospitals Administration, Faculty of Economics and Administration, King Abdulaziz University, Jeddah, Saudi Arabia

²Professor of Health Economics and Financing at King Abdulaziz University, Saudi Arabia

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*Corresponding author: Mona Tarek Skaik

Department of Health Services and Hospitals Administration, Faculty of Economics and Administration, King Abdulaziz University, Jeddah, Saudi Arabia

Abstract

Background: Saudi Arabia's health sector is undergoing substantial reform under Vision 2030, including expansion of insurance-based financing and private-sector participation. Evidence on the factors that shape patients' choice between public and private hospitals in Jeddah remains limited. **Objective:** To identify demographic, socioeconomic, service, efficiency, and treatment-cost factors associated with patients' choice of public versus private hospitals in Jeddah. **Methods:** A quantitative cross-sectional study was conducted among adults aged 18 years or older who had used a public or private hospital in Jeddah within the preceding 12 months. Data were collected using a structured online questionnaire adapted from a prior Saudi study. Of 429 respondents, 400 complete responses were analyzed. The final multi-item scales showed acceptable internal consistency (Cronbach's alpha: services/facilities 0.878; efficiency/staff performance 0.823; treatment cost 0.729). Chi-square tests, independent-samples t tests, and binary logistic regression were performed in SPSS version 27. **Results:** Private hospitals were used by 69.0% of respondents. Hospital choice was associated in bivariate analysis with age, gender, nationality, employment status, health insurance, and family size. Public-hospital users reported higher mean service/facility and efficiency scores, whereas private-hospital users reported higher treatment-cost scores. In the adjusted model, these perception scales were not independent predictors. Health insurance strongly increased the likelihood of private-hospital use (OR=6.269, 95% CI 3.140-12.517; $p<0.001$). Income of at least SR 20,000 was also associated with private-hospital use (OR=6.722, 95% CI 1.072-42.140; $p=0.042$), while government employment (OR=0.147; $p=0.002$) and family size of 12 or more (OR=0.103; $p=0.004$) reduced the likelihood. **Conclusion:** Hospital choice in Jeddah appears to be driven more by structural enabling resources particularly insurance, income, employment-related access, and household size than by subjective perceptions of service quality, efficiency, or treatment cost after adjustment.

Keywords: Hospital choice; public hospitals; private hospitals; health insurance; Saudi Arabia; Jeddah; Vision 2030; healthcare utilization.

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1. INTRODUCTION

Choice of healthcare provider is an important component of healthcare-seeking behavior because it influences access, patient flow, resource allocation, and the performance of health systems. Hospital selection is not simply a consumer preference; it reflects an interaction among individual characteristics, financial resources, perceived service attributes, and the organization of the healthcare system (Oben, 2020; Hannawa *et al.*, 2022). In systems where public and private providers coexist, patients may balance affordability and entitlement against convenience,

responsiveness, perceived quality, and access to technology.

Saudi Arabia provides a particularly relevant setting for studying these decisions. Under Vision 2030 and the Health Sector Transformation Program, the health system is moving toward integrated health clusters, broader insurance-based financing, stronger private-sector participation, and public-private partnerships (Rahman, 2020; Albejaidi & Nair, 2019; Vision 2030 Health Sector Transformation Program, 2024; Mani & Goniewicz, 2024). These reforms are

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intended to improve efficiency, patient experience, and value while responding to demographic change and rising demand for care.

Jeddah, one of Saudi Arabia's largest metropolitan areas and a major economic gateway on the Red Sea, has a diverse population and a mixed market of Ministry of Health facilities, tertiary hospitals, and a growing private healthcare sector. Its role as a gateway for pilgrims and visitors also creates additional healthcare demand. Despite these characteristics, evidence specifically examining hospital choice in Jeddah is relatively limited compared with evidence from Riyadh and other Saudi regions.

Prior studies have identified several determinants of hospital choice. Service quality and patient satisfaction are frequently conceptualized through dimensions such as tangibles, reliability, responsiveness, assurance, and empathy (Han & Nathen, 2022; Bin Libdah & Alqurashi, 2026). Cost also matters, but patients may consider indirect costs especially waiting time and administrative burden in addition to direct fees (Parrado *et al.*, 2024). Socioeconomic variables such as income and insurance can alter the feasible set of hospitals available to a patient, while age, gender, nationality, employment, education, and family size may shape preferences and constraints (Rana *et al.*, 2020; Almosa *et al.*, 2025; Wu *et al.*, 2025).

The present study was guided by Andersen's Behavioral Model of Health Services Use, which distinguishes predisposing characteristics from enabling resources and need-related factors (Andersen, 1995; Albejaidi, 2020). In this framework, insurance, income, and employment-related benefits can function as enabling resources that determine access even when perceptions of quality or efficiency differ. This distinction is especially important in a rapidly changing healthcare financing environment.

The study therefore aimed to identify and analyze factors influencing patients' choice between public and private hospitals in Jeddah. Specifically, it examined associations between hospital choice and demographic characteristics, treatment-cost perceptions, service/facility perceptions, and efficiency/staff-performance perceptions, and then assessed which factors remained independently associated with hospital choice in a multivariable model.

2. MATERIALS AND METHODS

2.1 Study design and setting

A quantitative, cross-sectional, descriptive-analytical design was used. The study was conducted in Jeddah, Saudi Arabia, a large metropolitan center with both public and private hospital services. The cross-sectional design enabled simultaneous assessment of demographic, socioeconomic, and perception variables

in relation to the most recent or typical public-versus-private hospital choice.

2.2 Study population and sampling

Eligible participants were adults aged 18 years or older who had used healthcare services in a public or private hospital in Jeddah within the preceding 12 months. Participants were required to be able to read and understand Arabic or English and to provide informed consent. Individuals younger than 18 years, those without recent experience of hospital services in Jeddah, those unable to complete the questionnaire independently because of cognitive or physical limitations, and those who declined participation were excluded.

The thesis reports use of convenience sampling. The minimum sample size was calculated using $n = (z^2 \times p \times [1-p]) / d^2$, assuming 95% confidence, a 5% margin of error, and maximum variability ($p=0.5$), producing a minimum of 384 participants. The target was increased to 400 to allow for incomplete or non-response. A total of 429 responses were received; 400 complete responses were retained for final analysis.

2.3 Study instrument

Data were collected with a structured, self-administered questionnaire adapted from a previously published study conducted in Riyadh (Almosa *et al.*, 2025). Permission to use the questionnaire was obtained from the original author. The instrument was translated into Arabic for cultural relevance and comprehension, and minor modifications were made without changing its core content.

The questionnaire comprised four sections: (A) nine demographic and socioeconomic items; (B) 14 items assessing service and facility perceptions; (C) nine items assessing staff performance and hospital efficiency; and (D) five items assessing treatment-cost perceptions. Perception items used a five-point agreement scale ranging from strongly disagree to strongly agree. The dependent variable was hospital choice (public or private), based on the hospital type used most recently or the participant's typical preference. Independent variables included age, gender, marital status, educational level, nationality, employment status, monthly income, health-insurance status, family size, and mean scores for the three perception domains.

2.4 Pilot testing, validity, and reliability

A pilot study was conducted among 20 individuals from the target population to assess comprehensibility, cultural appropriateness, survey flow, response options, completion time, and Google Forms functionality. Pilot responses were excluded from the final analysis. Content validity was reviewed by the thesis supervisor, and face validity was assessed through pilot feedback.

Cronbach's alpha was used to assess internal consistency. During scale refinement, three items were removed from the Services and Facilities scale and one item from the Efficiency scale because of negative corrected item-total correlations. The final scales contained 11 Services and Facilities items ($\alpha=0.878$), eight Efficiency and Staff Performance items ($\alpha=0.823$), and five Treatment Cost items ($\alpha=0.729$).

2.5 Data collection

Data were collected online through Google Forms over a 12-week period reported in the thesis as occurring during February-April 2026. The survey was distributed through multiple channels to reach adults with recent hospital experience in Jeddah. Informed consent was obtained electronically at the beginning of the survey. Completed questionnaires were reviewed for completeness and consistency, and substantially incomplete or inconsistent responses were excluded.

2.6 Statistical analysis

Statistical analysis was performed using SPSS version 27.0. Frequencies and percentages summarized categorical variables, while means and standard deviations summarized continuous scale scores. Pearson chi-square tests assessed associations between demographic characteristics and hospital type. Independent-samples t tests compared service/facility, efficiency/staff-performance, and treatment-cost scores between public- and private-hospital users. Normality was assessed using skewness and kurtosis; all reported values fell within ± 2.0 . Binary logistic regression was then used to estimate independent predictors of choosing a private hospital, with demographic variables and the three continuous perception-scale means entered as predictors. Statistical significance was set at two-sided $\alpha=0.05$.

2.7 Ethical considerations

Ethical approval was obtained from the Health Affairs Directorate in Jeddah Institutional Review Board (approval number reported in the thesis as A02409; December 31, 2025). The study was conducted in accordance with the Declaration of Helsinki. Participation was voluntary, informed consent was obtained, no identifiable personal information was collected, and responses were handled confidentially and reported only in aggregate form.

3. RESULTS

3.1 Participant characteristics

Of the 400 complete responses included in the analysis, 276 participants (69.0%) reported private-hospital use and 124 (31.0%) public-hospital use. Most participants were Saudi nationals (80.0%), 55.5% were

female, 60.0% were married, and 74.5% had a college/university or postgraduate qualification. Health insurance was reported by 64.0% of respondents. The majority (61.0%) were younger than 40 years. Detailed characteristics are shown in Table 1.

Table 1: Demographic characteristics of participants (N=400)

Variable	Category	n	%
Hospital type	Public hospital	124	31.0
	Private hospital	276	69.0
Age group	18-29	129	32.3
	30-39	115	28.7
	40-49	76	19.0
	50-59	67	16.8
	60 or more	13	3.3
Gender	Female	222	55.5
	Male	178	44.5
Marital status	Single	124	31.0
	Married	240	60.0
	Divorced	19	4.8
	Widowed	17	4.3
Education	High school or less	102	25.5
	College/University	238	59.5
	Postgraduate	60	15.0
Nationality	Saudi	320	80.0
	Non-Saudi	80	20.0
Employment	Unemployed	61	15.3
	Government employee	59	14.8
	Non-government employee	153	38.3
	Self-employed	27	6.8
	Retired	38	9.5
	Student	62	15.5
Monthly income	< SR 3,000	130	32.5
	SR 3,000 to <5,000	66	16.5
	SR 5,000 to <7,000	78	19.5
	SR 7,000 to <10,000	63	15.8
	SR 10,000 to <15,000	29	7.2
	SR 15,000 to <20,000	20	5.0
	$\geq$ SR 20,000	14	3.5
Health insurance	No	144	36.0
	Yes	256	64.0
Family size	1-3	165	41.3
	4-7	176	44.0
	8-12	46	11.5
	12 or more	13	3.3

3.2 Scale reliability and descriptive statistics

All three final scales exceeded the 0.70 threshold for internal consistency. Across the full sample, treatment-cost perceptions had the highest mean score (3.71 ± 0.77), while service/facility perceptions (2.41 ± 0.75) and efficiency/staff-performance perceptions (2.47 ± 0.72) were lower (Table 2).

Table 2: Reliability and overall descriptive statistics for perception scales

Scale	Final items	Cronbach alpha	Mean	SD
Services and facilities	11	0.878	2.41	0.75
Efficiency and staff performance	8	0.823	2.47	0.72
Treatment cost perceptions	5	0.729	3.71	0.77

3.3 Demographic associations with hospital choice

Bivariate chi-square analysis identified significant associations between hospital type and age group ($p=0.010$), gender ($p=0.033$), nationality ($p=0.013$), employment status ($p<0.001$), health insurance ($p<0.001$), and family size ($p=0.006$). Marital status, education, and monthly income were not

significantly associated with hospital choice in the bivariate analysis (Table 3). Younger participants, insured participants, and non-government employees showed a stronger tendency toward private-hospital use, whereas government employees, uninsured respondents, and members of very large families were more likely to use public hospitals.

Table 3: Chi-square associations between demographic variables and hospital choice

Variable	Pearson chi-square	df	p value
Age group	13.240	4	0.010
Gender	4.564	1	0.033
Marital status	5.617	3	0.132
Education level	1.437	2	0.488
Nationality	6.183	1	0.013
Employment status	25.577	5	<0.001
Monthly income	5.126	6	0.528
Health insurance	30.102	1	<0.001
Family size	12.594	3	0.006

3.4 Perception scores by hospital type

Public-hospital users reported significantly higher service/facility scores than private-hospital users (2.65 ± 0.84 vs 2.31 ± 0.68 ; $t=3.973$, $p<0.001$) and significantly higher efficiency/staff-performance scores

(2.72 ± 0.79 vs 2.36 ± 0.66 ; $t=4.431$, $p<0.001$). In contrast, private-hospital users reported significantly higher treatment-cost perception scores (3.80 ± 0.69 vs 3.51 ± 0.88 ; $t=-3.215$, $p=0.002$). Table 4 summarizes these comparisons.

Table 4: Independent-samples t-test comparisons by hospital type

Scale	Hospital	n	Mean	SD	t	df	p
Services and facilities	Public	124	2.65	0.84	3.973	198.56	<0.001
	Private	276	2.31	0.68			
Efficiency and staff performance	Public	124	2.72	0.79	4.431	203.51	<0.001
	Private	276	2.36	0.66			
Treatment cost perceptions	Public	124	3.51	0.88	-3.215	195.22	0.002
	Private	276	3.80	0.69			

3.5 Multivariable predictors of private-hospital choice

The binary logistic regression model was statistically significant (chi-square[24]=99.384, $p<0.001$), explained 31.0% of the variance in hospital choice by Nagelkerke R^2 , and correctly classified 74.5% of cases. After adjustment, health insurance, government employment, very large family size, and the highest income category were significant predictors. Insured respondents had 6.269 times the odds of choosing a private hospital compared with uninsured respondents (95% CI 3.140-12.517). Respondents with monthly income of at least SR 20,000 had 6.722 times the odds of

private-hospital use compared with those earning below SR 3,000, although the confidence interval was wide. Government employees had substantially lower odds of private-hospital use than unemployed respondents (OR=0.147), and respondents from households of 12 or more had lower odds than those from households of 1-3 members (OR=0.103).

Importantly, the continuous service/facility, efficiency/staff-performance, and treatment-cost perception scores were not significant independent predictors after demographic and socioeconomic adjustment ($p=0.314$, 0.098, and 0.332, respectively).

Table 5: Binary logistic regression predicting private-hospital choice

Predictor	B	SE	p value	OR	95% CI
Health insurance: Yes vs No	1.836	0.353	<0.001	6.269	3.140-12.517
Government employee vs unemployed	-1.914	0.633	0.002	0.147	0.043-0.510
Non-government employee vs unemployed	-0.637	0.601	0.289	0.529	0.163-1.718
Self-employed vs unemployed	-0.157	0.622	0.800	0.854	0.253-2.890
Retired vs unemployed	-0.165	0.543	0.762	0.848	0.293-2.457
Student vs unemployed	0.075	0.570	0.896	1.078	0.352-3.296
Family size 4-7 vs 1-3	-0.231	0.296	0.435	0.794	0.445-1.417
Family size 8-12 vs 1-3	-0.827	0.425	0.052	0.437	0.190-1.006
Family size ≥ 12 vs 1-3	-2.278	0.798	0.004	0.103	0.021-0.489
Income $\geq$ SR 20,000 vs < SR 3,000	1.905	0.937	0.042	6.722	1.072-42.140
Mean service score	-0.257	0.255	0.314	0.773	0.469-1.276
Mean efficiency score	-0.433	0.262	0.098	0.649	0.388-1.084
Mean cost score	-0.227	0.234	0.332	0.797	0.503-1.261

Note: The thesis states that age group, gender, nationality, and non-significant intermediate income categories were included in the full model but omitted from its summary regression table for readability. Reference categories are shown in the predictor labels above.

4. DISCUSSION

This study provides evidence on patient choice between public and private hospitals in Jeddah during a period of major healthcare transformation. The central finding is the contrast between bivariate and multivariable results. Perceptions of service quality, efficiency, and treatment cost differed significantly between public- and private-hospital users when examined separately, but none independently predicted hospital type once demographic and socioeconomic factors were controlled. In the adjusted model, the strongest determinants were structural: health insurance, income, employment status, and family size. This pattern supports the proposition that access-enabling resources may be more influential than subjective service perceptions in determining where care is obtained.

Health insurance was the most prominent predictor. Insured respondents had more than six times the odds of choosing a private hospital compared with uninsured respondents. This finding is consistent with the enabling-resource component of Andersen's Behavioral Model and with evidence that insurance expands the feasible use of private healthcare by reducing the direct marginal cost faced by patients (Rana *et al.*, 2020; Almosa *et al.*, 2025). In the Saudi context, the expansion of compulsory and employer-linked health insurance may therefore function not only as a financing mechanism but also as a gatekeeper to the private sector. The finding is particularly relevant to Vision 2030 reforms that aim to increase private-sector participation and improve system efficiency.

Income and household size further illustrate the importance of financial capacity. Respondents in the highest income category had substantially greater odds of private-hospital use than those in the lowest category. This direction is consistent with studies showing that higher income increases access to private-sector convenience and choice (Rana *et al.*, 2020; Wu *et al.*,

2025). However, this estimate should be interpreted cautiously because only 14 respondents were in the highest income category and the 95% confidence interval was wide. Conversely, respondents from families of 12 or more had markedly lower odds of using private hospitals. The cumulative financial burden of healthcare in large households may make public hospitals a practical necessity, consistent with the role of family size as a determinant of healthcare utilization (Albejaidi & Nair, 2019).

Government employment was associated with lower odds of private-hospital use compared with unemployment. The thesis interprets this as reflecting access to public healthcare benefits among government-sector employees. This result emphasizes that employment status may capture more than income: it may also represent entitlement, institutional coverage, and established pathways to care. Accordingly, employment-related access should be considered an enabling resource in analyses of hospital choice.

An unexpected result was that public-hospital users rated services/facilities and efficiency/staff performance more favorably than private-hospital users. This contrasts with literature that commonly reports better perceived service quality in private facilities (Almosa *et al.*, 2025; Bin Libdah & Alqurashi, 2026). Several interpretations are possible within the thesis framework. Public-hospital users may begin with lower expectations and therefore report greater satisfaction when services meet or exceed those expectations. Higher-paying private-hospital patients may have higher expectations and evaluate care more critically. The pattern may also reflect genuine improvements in public-sector quality associated with health clusters, patient-centered reforms, and investment under Vision 2030 (Rahman, 2020; Mani & Goniewicz, 2024). Because this was a cross-sectional self-report study, these explanations cannot be distinguished empirically and should be tested in future research.

Treatment-cost perceptions also differed between hospital groups. Private-hospital users reported higher cost scores, which is intuitive given direct private-sector fees; however, the cost scale included items relating to the willingness to pay for timely care and to the indirect costs of obtaining public-sector appointments. The significant bivariate difference therefore may reflect perceived value and time costs rather than price alone. This interpretation is consistent with work suggesting that patients may bypass lower-cost public services when waiting time and administrative burden are valued as important indirect costs (Parrado *et al.*, 2024). The disappearance of the cost effect in the multivariable model suggests that financial structure particularly insurance and income may account for much of the observed group difference.

The bivariate associations with age, gender, nationality, employment, insurance, and family size indicate that hospital use is socially patterned. Younger adults showed a greater preference for private hospitals, women showed greater private-sector preference than men, and non-Saudi respondents were more likely to prefer private facilities. Similar patterns have been described in Saudi and international studies (Almosa *et al.*, 2025; Rana *et al.*, 2020; Wu *et al.*, 2025). These findings may reflect differences in eligibility, insurance coverage, privacy preferences, familiarity with digital services, and expectations of convenience, although the present study did not directly test these mechanisms.

From a theoretical perspective, the findings refine the study's conceptual model by indicating that predisposing and enabling factors are not equally influential. The adjusted results place the greatest weight on enabling resources insurance, income, household financial burden, and employment-linked access. The thesis describes this cluster as a form of "healthcare capital": the financial and institutional resources that determine which healthcare options are realistically accessible. The finding supports Andersen's model while warning against interpreting service-quality correlations as independent determinants without controlling for structural access factors.

For healthcare policy, the findings have two parallel implications. Expansion of insurance coverage may facilitate use of private hospitals and reduce pressure on public facilities, but it may also widen disparities between insured and uninsured populations if private-sector access becomes increasingly dependent on coverage. At the same time, the strong public-hospital use among very large families confirms the continuing role of public hospitals as essential safety-net providers. Policy should therefore combine insurance expansion with sustained investment in public-sector capacity, patient flow, service quality, and equitable access.

5. STRENGTHS AND LIMITATIONS

The study achieved the planned analytical sample of 400 participants, used a structured instrument adapted from prior Saudi research, and incorporated both bivariate and multivariable analyses. The use of logistic regression was particularly important because it demonstrated that associations observed in simple comparisons did not necessarily remain independent after adjustment. The final service and efficiency scales showed good internal consistency.

Several limitations affect interpretation. Convenience sampling and online recruitment limit generalizability to the entire Jeddah population. The sample overrepresented private-hospital users (69.0%), highly educated respondents (74.5% with college education or higher), and insured participants (64.0%). Self-reported hospital use and perceptions are susceptible to recall, response, and social-desirability bias. The treatment-cost scale had comparatively weaker, although acceptable, reliability ($\alpha=0.729$). The highest income category contained only 14 participants, producing a wide confidence interval for the income estimate. The study was cross-sectional and therefore cannot establish temporal or causal relationships. It also did not measure several potentially important influences, including physician recommendation, family influence, cultural norms, clinical severity, diagnosis, hospital reputation, or treatment-specific preferences.

6. IMPLICATIONS FOR POLICY AND PRACTICE

Healthcare planners should treat insurance design and coverage as central determinants of public-private patient distribution rather than assuming that service-quality improvements alone will shift utilization. Policies expanding insurance should be accompanied by safeguards for uninsured populations and by monitoring of equity in access. Public hospitals should continue to receive investment in staff development, patient-centered care, waiting-time reduction, and service organization because they remain especially important for uninsured people, government-linked users, and large households. Private hospitals, meanwhile, need to maintain service standards sufficient to justify higher direct costs and the expectations associated with paid care.

Future studies should use probability-based or stratified sampling where feasible, follow patients longitudinally as Vision 2030 reforms progress, and include clinical need, diagnosis, physician referral, digital-health access, hospital reputation, and family decision-making. Qualitative work could clarify why public-hospital users reported higher service and efficiency perceptions and how insurance changes the decision process. Focused research among older adults and lower-income or very large families would also address groups that were relatively underrepresented in the present sample.

7. CONCLUSION

Among adults with recent hospital experience in Jeddah, private-hospital use was common, but the strongest independent determinants of hospital choice were not patients' perceptions of service quality, efficiency, or treatment cost. Instead, health insurance, income, employment-related access, and family size were the key predictors after adjustment. Insurance markedly increased the likelihood of private-hospital use, while government employment and very large family size reduced it. These findings indicate that hospital choice in Jeddah is fundamentally shaped by enabling resources and structural access. As Saudi Arabia continues healthcare transformation under Vision 2030, policies seeking balanced public-private utilization should address financing and equity alongside service-quality improvement.

Declarations: Ethics approval and consent to participate: Ethical approval was obtained from the Health Affairs Directorate in Jeddah Institutional Review Board (approval number reported in the thesis as A02409; December 31, 2025). Electronic informed consent was obtained from all participants.

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