



The paradox of primary care

How Saudi Arabia can leapfrog world class primary care systems

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Preface

KPMG conducted an award-winning global study across high, middle and low income countries on trends and innovations in primary care.ⁱ

The research identified an almost universal ‘paradox’ between the critical strategic role assigned to the primary care system and its relative lack of investment, importance or influence. In short, leaders in healthcare saw primary care as key to the transformation they wanted to make across the health system, but did not allow it to be strong enough to achieve this.

This is true in mature health systems whose primary care systems are coming under increasing strain, and in countries currently pursuing universal health coverage, many of which are attempting to implement comprehensive primary care from scratch.ⁱⁱ



More than any other healthcare service, improvements in primary care need to be locally designed and led.

In Saudi Arabia, the healthcare sector is undergoing a huge transformation as part of Vision 2030 and the National Transformation Program: both of which aim to strengthen primary care as a key vehicle for better access and affordability. Will Saudi Arabia be able to escape the paradox of primary care?

As this report outlines, the advent of clusters and accountable care organizations (ACOs) – as well as the new model of care program and other reforms – are creating an ideal enabling environment for a world-class primary care system to develop in Saudi Arabia. But the speed and scale of wider change must be managed in such a way that doesn't stifle ownership, innovation and buy in from frontline staff and communities.

More than any other healthcare service, improvements in primary care need to be locally designed and led. For this reason, in this report we propose a set of design principles and enablers – illuminated with practical examples - rather than a specific model of primary care for Saudi Arabia.

These can be used to initiate reform at sufficient pace but without being prescriptive, and to create models of care that learn from the world's best systems but also leapfrog them through true consumer- and community-centered design.

Throughout the report, we add our own experience of having implemented large-scale primary care reforms in the UK, USA, Canada, India and the Netherlands, amongst other countries.



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Emmeline Roodenburg
Head of Healthcare



Dr. Niti Pall
Global Medical Director

We hope this report stimulates a renewed discussion around the importance of these topics in Saudi Arabia, and how global and local expertise can be combined to make change happen.

Primary care: The foundation of a world class health system

For decades there has been mounting evidence that primary care is not merely another medical service or gatekeeper to specialist care, but rather the foundation on which almost all the world's best health systems are built.

Saudi Arabia still has some way to go in creating a truly primary care-centered model – an ambition central to the reform agenda already underway. Properly stewarded, this unfinished transformation program creates an opportunity to create a unique new way of delivering primary care, fit for the 21st century and for the local assets and needs of the Kingdom.

It has long been known that 'primary care oriented' systems such as Canada, the UK, Spain, Netherlands and Australia deliver better health outcomes at lower cost.^{iii, iv, v} This role is becoming even more powerful over time, as the number of people living with multiple chronic conditions requiring complex, multi-specialty care in the community grows and grows.^{vi}

The recent Declaration of Astana by World Health Organization (WHO) representatives from 120 countries firmly cemented this understanding, affirming that "strengthening primary health care (PHC) is the most inclusive, effective and efficient approach to enhance people's physical and mental health, as well as social well-being, and that PHC is a cornerstone of a sustainable health system for universal health coverage."^{vii}

Like many of its neighbors, Saudi Arabia has lacked a strong history of 'primary care orientation' in its health system.^{viii, ix}



We expect that primary care centers will play a major role in transforming health services and be the first line to provide distinguished health care. Therefore, we have targets to improve the primary care centers in terms of facilities, services and technology

Dr. Tawfiq Al-Rabiah
H.E. the Minister of Health
in an update video earlier this year

This is changing, however, as multiple aspects of the Kingdom’s ongoing healthcare reform program contain significant primary care components. Not least the model of care program and the planned introduction of healthcare clusters and ACOs by 2020 and 2030 respectively.

The impetus behind the need to strengthen Saudi Arabia’s primary care system is clear. The Kingdom already faces some of the highest population health risk factors in the GCC, including one of the worst rates of diabetes in the world.

The population segment most at risk of chronic disease – over 50s – is set to increase rapidly in Saudi Arabia, from around 13 percent of the population in 2015 to 23 percent by 2030.^{xi}

From a healthcare system perspective the country is experiencing rising healthcare costs, increased waiting times for specialist care, and overutilization of emergency departments – all of which are particularly amenable to improvement through a strong “Four Cs” primary care tier.^{xii}

The many ‘Cs’ of a strong primary care system^{xiii}

A seminal framework for understanding primary care, Starfield’s Primary Care Model lists “Four C’s” to identify the strengths and gaps in any given system:



First Contact



Comprehensive



Coordinated



Continuous

Another international group of scholars later expanded this framework, adding a further five ‘Cs’:^{xiv}



Credibility



Career satisfaction



Capacity expansion



Cost-effectiveness



Collaborative learning

Saudi Arabia's primary care system is already noted for a number of successes, not least the impressive gains in maternal health in the 1990s and early 2000s, and improvements in access to care for rural populations.^{xv}

A recent study also highlighted strengths in the supply chains servicing clinics and the availability and use of clinical guidelines for family medicine.^{xiv}

Still, a host of challenges remain:

- The maturity of referral systems operating between primary and secondary care, described by 65 percent of directorates as 'weak', with little to no structured communication or feedback between providers.^{xvi, xvii, xviii}
- The number of fully qualified family physicians – especially Saudi clinicians – due to insufficient training infrastructure and a perception of more limited career progression.^{xix}
- Persistent beliefs and behaviors among patients that lead them to avoid primary care in favor of direct access to hospital,^{xx} with some 74 percent of patients in Riyadh saying they would not attend a primary care clinic as their first choice.^{xxi} This leads to relatively low utilization rates of clinics compared to many leading health systems.
- A payment model that incentivize holistic, integrated care.
- The multitude of ongoing transformation efforts that impact on primary care, which can make local staff feel overwhelmed.

Yet it would be wrong to characterize the relative immaturity of Saudi Arabia's primary care system as unique. Around the world, established health systems are struggling to reshape their traditional models of primary care that, though they have served well in the past, are increasingly out of step with 21st century disease trends and the ways that patients wish to seek care.

At the same time, many low- and middle-income countries are building up their primary care systems from a 'blank slate', and in doing creating entirely new, low cost and flexible ways of delivering services at scale.

Innovation abounds in the way that primary care is being conceived and delivered, making this an ideal time for Saudi Arabia to be planning its future services and models – taking lessons from around the globe and blending them with the unique assets that its communities have to offer and what citizens say they most want.



Aligning efforts between healthcare transformation programs is crucial to enable the enhancement of primary care

There is a need for alignment between the primary care dimensions of the multiple healthcare reform programs ongoing across the Saudi healthcare system, not least:



Corporatization and model of care:

How to integrate primary care with secondary and tertiary care and what are the services that primary care centers should provide?



Healthcare Financing:

How value based healthcare can contribute to improving primary care services



Private Sector Participation:

How privatization could play a role in improving primary care services



Workforce and Leadership Development:

Workforce planning and capability building for multi-disciplinary primary care teams



E-Health:

Adopting the technologies that will enable 21st century primary care



Design principles for primary care transformation

So how could an integrated approach to primary care transformation work as part of Saudi Arabia's existing healthcare reforms? The Model of Care, E-Health and other change programs provide the ideal opportunity to reorient the Kingdom's healthcare system around a foundation of primary care.

As the case studies in this chapter show, we live in a rich time for innovation, with leading systems around the world achieving greater scale, scope, speed and access compared to traditional family medicine clinics.

Yet there are dangers in trying to over-specify what this change should look like, not least the loss of local creativity and ownership by professionals and patients who will be working in and using these new services. Instead of focusing on a specific model, therefore, it is better to work from a common set of "design" principles based on what matters most to patients. We propose four here based on KPMG's global experience of what works.

The key challenge to Saudi Arabia's primary care system is that it is not merely one of explicit service design (number and location of clinics, scope of services etc.) but implicit trust.

Even in areas with modern, high performing primary care services, patients still frequently bypass general practice in favor of hospitals, and there is some evidence that the experience they have when they do attend does not inspire them to come back.

Likewise, professionals across the system require a change in mindset to value primary care on a more equal footing and see collaboration and communication with a patient's family physician as essential to high quality care.



Rather than specify a particular primary care model, it makes sense to determine the key attributes required

With this challenge in mind, the design and implementation of a modern, high performing primary care system will fail if the transformation process involves policymakers coming up with an ‘ideal model’ and imposing this nationwide. Instead, we propose a more participatory approach aimed at long-term, systemic behavioral change:



Identify the design principles that patients and the public would want to see embedded in a new primary care model.



Develop enough specificity to allow these to be applied in practice, but leaving a great deal of room for local creativity.



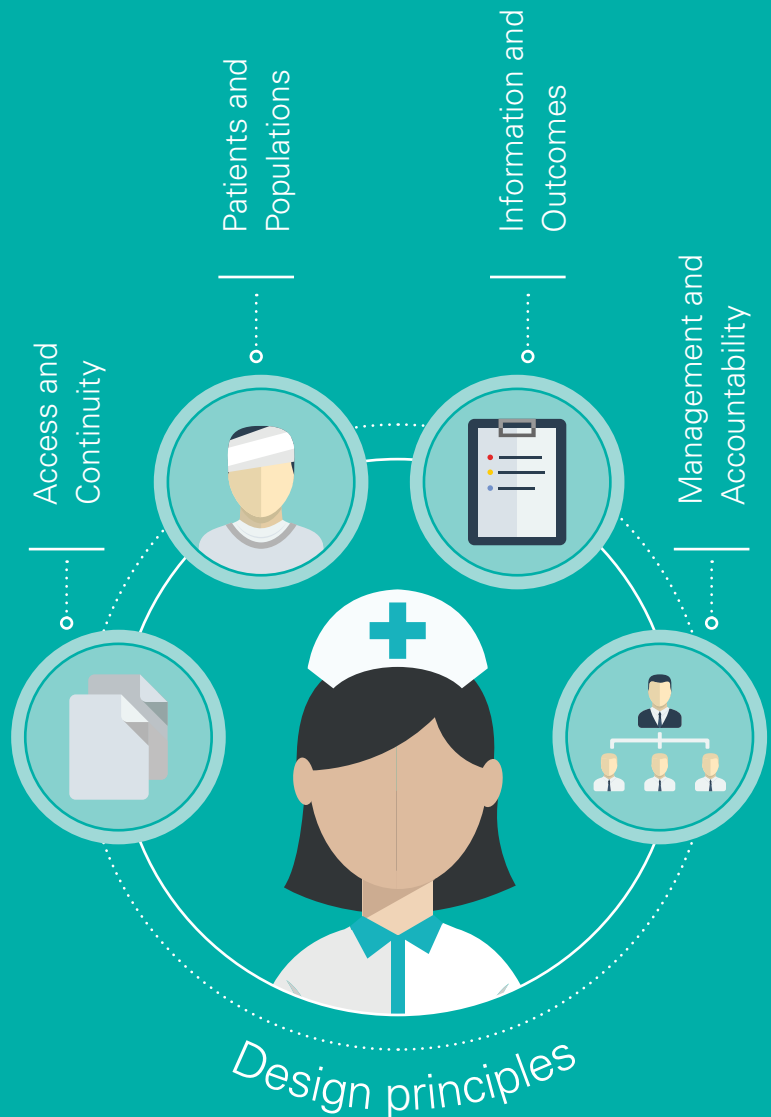
Create incentives, measurements, contracts and rules of behavior that foster the evolution of these new models while managing some of the risks associated with this.



Blend global and local expertise to develop new models of provision, as well as enough central direction to create momentum behind the changes.

KPMG has selected four design principles as a starting point for thinking about what patients, caregivers and communities value most from primary care: **Access and Continuity; Patients and Populations; Information and Outcomes; and Management and Accountability**. We invite these to be discussed, debated and adapted to inform Saudi Arabia’s journey to a primary care centered system.

Towards a better primary care model



1. Access and Continuity

Chief among primary care's 'value-add' in the lives of patients and to the healthcare system are giving rapid access to the right level of information and expertise, and continuity throughout their care journey. In the face of rising complex morbidity and shifting patient expectations, new models of primary care are seeking to enhance how this access and continuity are provided.

There is a growing trend towards:

- Increasing the size and scale of primary care clinics.
- Extending the range of specialist services available, using community specialists, remote consultants and/or point of care diagnostics.
- Tailored clinics for people with multiple conditions.
- Stratifying patients according to those it is important for the most senior clinicians to see immediately.
- A focus on population health management, including investment in non-medical interventions to encourage healthy behaviors and improve the social determinants of health.

One way of achieving this is to bring the primary care clinic itself closer to or even inside the hospital campus, as is the case in King Faisal Specialist Hospital and King Fahad National Guard Hospital.

However, it is also possible to achieve it within the community – most commonly this is done by networking clinics together such that they can make shared investments in new services, as well as creating professional HR, IT, leadership and management teams. This is the strategy employed by the Modality Partnership in the UK (see textbox).

This is also the arena where technology is playing the most revolutionary role in primary care. Platforms to support self-care, such as symptom checkers and medical helplines, are increasingly ubiquitous in high, middle- and low-income countries, from Babylon Health in the UK (and now Saudi Arabia) to Tonic in Bangladesh.

One of the less celebrated, but equally promising areas is the use of technology to expand access to specialists in the community. Examples include point-of-care or wearable diagnostics, and joint teleconsultations with a family physician or nurse present in person and a specialist attending via video link.

Extended primary care through networks:

The Modality Partnership, UK

The Modality Partnership is one of the largest practice groups in the UK, having grown organically from its first two clinics which merged in 2009 to a so-called 'super partnership'



400,000

over 400,000 patients



40

40 site



115

115 GP partners



1,100

1,100 staff across England today.

The scale at which the network now operates has allowed for a wide range of extended services to be offered, including a home visits team, paramedics, virtual consultations and a range of enhanced urology, dermatology, rheumatology and mental health services. Rolling specialist clinics are also provided in areas such as cardiology, respiratory and pain management.

The group has pioneered innovative contracting arrangements with local hospitals and commissioners, to share in the savings generated by reduced unplanned hospital admissions and lengths of stay. Further resources have been released through shared administrative savings.



2. Patients and Populations

The government of Saudi Arabia has been making strenuous efforts to produce more family physicians to build up the required workforce for a fully comprehensive, primary care-oriented health system. Despite considerable success, significant gaps remain and are exacerbated by difficulties recruiting family physicians, and the relatively short tenure of some doctors that take these posts. These challenges hinder progress and compromise the ability to embed primary care in local communities and create ‘cradle to grave’ continuity of care.

While the family physician remains the bedrock of most high-income primary care services, many world class systems have changed their understanding of primary care workforce development in recent years towards more ‘team-based’ model. In the English NHS, primary care workforce planning is moving towards a system whereby doctors, pharmacists, nurses, allied health professionals and new cadres of clinical support roles such as physician and nurse associates are developed together to operate as an integrated team offering a wider array of services.^{xxvi}

This shift towards proactive team-based primary care is one of the key features of a related shift towards population health management and an enhanced role for patients themselves, whereby:

- Patients identify their own goals for their care – which often go well beyond traditional biomedical indicators - and are supported to achieve them.
- Multi-disciplinary teams work together to design and deliver an integrated care plan with the patient.
- Primary care providers think more innovatively about the types of interventions available to them, including the use of so-called ‘social prescribing’.
- Primary care providers work harder to anticipate future health problems that their patients may experience, and proactively try to prevent them.
- Interactions with patients are no longer done through one-size-fits-all appointments, but a blend of short interactions over the phone and, where necessary, much longer consultations to review progress and agree future goals.

Trusting in the patient and clinical team: Buurtzorg, The Netherlands

In the Netherlands, the financing and delivery of home care is highly fragmented with various tasks — such as washing the patient, serving meals and putting on elastic compressions — paid through different reimbursement schemes and, more often than not, executed by different professionals. As a result, patient care tends to be impersonal and lack coordination. At the same time, there has been intense downward pressure on short-run costs as the population ages and spending on care services escalates – resulting in a great deal of task shifting to lower skilled staff.

Bucking this trend is Buurtzorg, a nationwide community care organization of 10,000 community nurses that takes a unique approach through giving greater trust and autonomy to staff and patients.

The model has three key features:



1. Employ experienced nursing staff to deliver all the care that patients need (rather than use nursing assistants or cleaners). Give them time to develop deep relationships with the community to act more like ‘health coaches’ than providers of specific sub-tasks and services.



2. Give them the autonomy to organize their own work and exercise professional judgement through small self-steering teams of up to 12, with the center’s role being to provide the data and IT to allow them to do their jobs



3. Keep administration costs as low as possible – despite a turnover of almost half a billion dollars, there are less than 100 back office staff – none of which are designated as ‘managers’

The results are compelling, Buurtzorg patients have a third fewer hospital admissions than industry average, and regain their independence faster. Staff are also more efficient and productive than other providers, with lower turnover and sickness absence rates, the latter of which are around half the industry average. Although the model is more expensive per hour than most other community care providers, these quality benefits mean that total costs to the system end up being lower.



3. Information and Outcomes

The development of accountable care arrangements is one of the most transformational components of Saudi Arabia's ongoing reforms – and one of the most promising enablers to drive the scale up of primary care.

As the ongoing story of ACOs in the USA shows, however, they are no guarantee of improved outcomes or reduced cost.^{xxvi} A key differentiator is the extent to which they focus on efficiency savings at the margin or, more radically, proactively reconfigure the healthcare value chain to move patients away from high cost secondary care and into more efficient settings.

It is critical that as clusters develop their ACO models they are not distracted by the often staggering technical complexity. The focus should always be on the improvements and innovations that need to be enabled at the front line, and only from this point consider how information, outcomes and money can support this.

Many countries are currently seeking to develop the 'primary care medical home', where a family medicine practice assumes full responsibility for the health and care of its enrolled patients, even when they are referred for diagnosis or treatment beyond primary care.

It is a bold concept that relies on a number of other changes taking place at once, including:

- Integrated electronic health records that bridge across all providers and tiers of care.
- A step-change in support for patients to self-manage their own conditions, often drawing on the growing ecosystem of records-linked, self-management apps, such as MySugar for diabetes.
- Value-based payment models that reward outcomes achieved by different providers working together, rather than 'who did what'.
- A broader understanding of who might be considered a 'health provider' from hospitals and clinics to schools, mosques, food vendors and other community assets.

KPMG has written more extensively on the factors required to develop ACOs in our report *Paths to Population Health*, but it is clear that Saudi Arabia is in the early stages of this. Many of the basics like structured communication between clinicians in primary, secondary and tertiary care have yet to be developed, for example many primary care clinics do not even have referral directories of what types of services are available in different hospitals across the Kingdom.^{xxvii}

Population health



Disease Management



Case Management



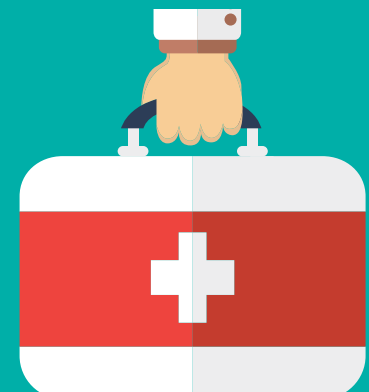
Utilization Management



Clinical Decision Support



Performance Management





Retrospective reporting

Descriptive

Diagnostic

Predictive

Prescriptive

Actionable intelligence

Implementing the Delivery System Reform Incentive Payment (DSRIP) program, New York State, USA

Since 2014, New York State Department of Health – with support from KPMG - has been enacting one of the largest value-based payment reforms in the world: transforming Medicaid's (the scheme for poorer citizens) US\$60 billion budget from almost exclusively fee-for-service to value-based contracting models. The program launched with a 'triple aim' of improving health outcomes, enhancing the quality of care and reducing cost to the State's Medicaid population. Targets include a 25 percent reduction in avoidable hospital admissions and a shift – which is currently on track – to have 90 percent of payments to providers structured as 'value-based' or managed care payments by 2020.^{xxix}

The program launched with a 'triple aim' of



Improving health outcomes



Enhancing the quality of care



Reducing cost to the State's Medicaid population

The wide-ranging program to achieve this involves the clustering of providers into 25 so-called 'Performing Provider Systems', building up of primary care capacity, setting up cross-provider evidence-based protocols, application of behavioral insights, and real-time sharing of data across tiers of care. The program also involves the development of sophisticated data and analytics to detect which populations and patient groups are most amenable to reduced admissions while improving outcomes.

Within four years the program has achieved an 21 percent reduction in potentially avoidable readmissions and a 18 percent reduction in potentially avoidable hospital use, in addition an explosion in collaborative initiatives across providers to improve quality and reduce costs.^{xxx}

4. Management and Accountability

As value-based payment mechanisms are introduced, it is critical that a more primary-care oriented cadre of managers and leaders are developed to support service change. This is a challenge shared by many health systems around the world as they seek to scale up and professionalize the organization of primary care.

Professionalized management of integrated care can be developed within the existing workforce, and is a key feature in the curriculum of the UK's NHS Leadership Academy developed by KPMG. This includes methods to improve the productivity and reduce the variability of primary care, as well as leading a more general shift in mentality among primary care professionals from treating presenting illness to a broader responsibility for the care of populations.

Transparency over the performance of providers and payers is another key ingredient in reducing variation and challenging local health systems to improve. This is an area where Saudi Arabia's health system lags significantly behind – a 2017 index of OECD and G20 health systems by KPMG ranked the Kingdom 29th out of 32 countries for transparency.^{xxx}

Supporting the shift to 21st century person-centred care: The NHS Leadership Academy

Like many Western health systems, the English NHS is facing a huge challenge of developing more sustainable and integrated care services that are better equipped to deal with an ageing population, increasing costs of care and rising patient expectations. As part of this shift, new organizations and roles are being created across England that had never previously existed: family doctors have responsibility for planning and purchasing of local health services under new Clinical Commissioning Groups, and new Primary Care Networks and Integrated Health Systems are being created to fundamentally redesign care pathways.

Leaders recognized that successfully navigating these challenges would require completely new kinds of management within the NHS: focused on whole health systems, rather than individual services, and linking up across primary, community and acute providers. Creating this new cadre required a substantial policy response, and so one of the largest healthcare management and leadership development programs in the world was initiated.

Launched in 2014, the NHS Leadership Academy trained over 50,000 people in its initial years via multiple tiers of full-time, part-time and spare-time programs. By operating at such scale, the Academy was able to develop cutting edge technology platforms that integrated online learning, peer-support and coaching.

The scale of the NHS Leadership Academy also allowed for the creation of tailored programs targeted at the specific priorities groups. Primary care has been at the forefront of these interventions, and in 2018 a dedicated new tier – the Rosalind Franklin Program – was announced to focus on senior and middle-grade nurses working in general practice who aspired to lead large complex change programmes across primary care networks, federations or integrated care systems.

KPMG leads one of the primary consortia responsible for the design and ongoing delivery of the NHS Leadership Academy. The programs have been well received and subsequently, we have successfully led a consortium to deliver the national skills development training program across the entire UK civil service.



To achieve these design principles,
new models of primary care will
need to be professionally managed

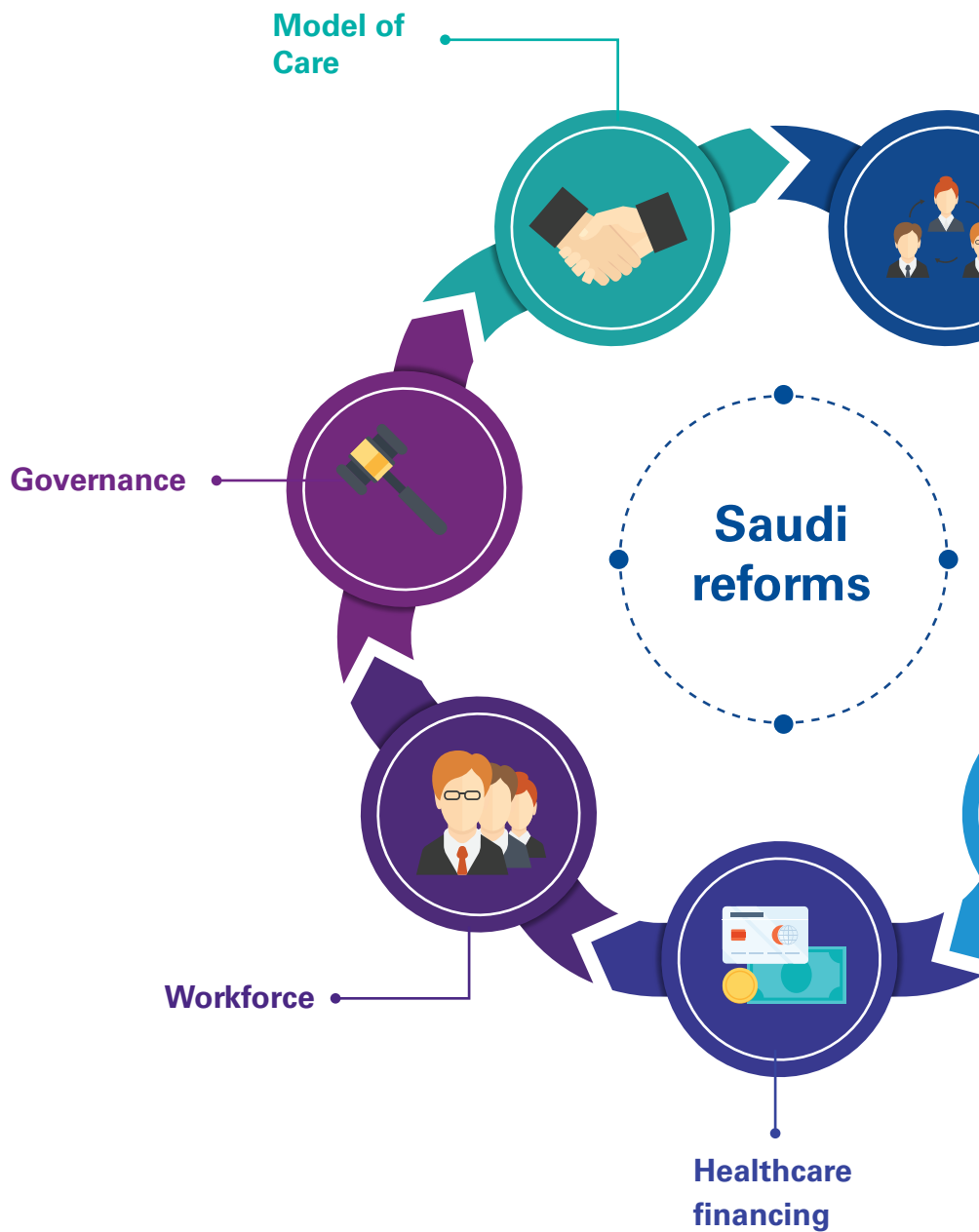


What's next?

Primary care enablers of Saudi Arabia's health care reforms

Applying the proposed design principles involves a constant tension between moving change forward at speed and scale while avoiding constraining local ownership and innovation that are essential to truly changing beliefs and behaviors at the front line.

It is likely that the most impactful change will be achieved by individual clusters taking the lead on this process. At the same time, other primary care related change programs under MOH and the VRO should be rationalized. We propose the following five action areas for them to achieve this. We propose the following five action areas for them to achieve this.



Private sector participation

eHealth

Corporization

Five enablers



1. Citizen-centered design:

The first challenge is to conduct an open and 'out of the box' co-design exercise with citizens in a local area to listen to how they would like to engage with healthcare services and what kind of primary care would change their perceptions and health seeking behaviors. A cohort of engaged citizens can then be selected to be involved in the process that follows.



2. Staff-led change:

Local staff need to be involved in organizing and chairing the citizen-centered design stage to internalize the need for change and start generating their own ideas. Following this, selected champions can be developed and given opportunities to take time out of their front-line roles to help lead the change process.



3. New models and partnerships:

At this point, work can begin on developing the models that will be trialed – this may involve redesign of roles and processes, and rapid-cycle testing of some of the concepts that are easily implemented to see what works. This is also the point in the process where external lessons, models and examples can be introduced – including new partnerships where models from abroad are explored to see if they fit with the service requirements outlined by citizens and staff.



4. Infrastructure:

After determination of the model, a feasibility analysis needs to be conducted to assess the physical and digital architecture requirements of the new local system. At this point it is critical that different local teams working on a change program come together to develop their system requirements together – to benefit from scale.



5. Incentives:

Payment and professional incentives come last in the process – as they are the element that most often lead to over-optimism as to how much they can achieve. Only once momentum for change is set, a model is decided and staff and citizens have taken ownership should the incentives structure for different tiers of the system be put in place. This analysis should go beyond provider payment mechanisms – incentives can be applied across the health system including even to patients: for example in the Netherlands where patients must pay if they attend at an emergency department with a problem that could have been dealt with in (free) primary care clinic.

How KPMG can help

As this report outlines, Saudi Arabia's ambitious reform program to create an equitable, sustainable and high-quality health system for all relies on a transformation of its primary care system. That transformation requires a blend of international expertise and local innovation.

KPMG's global network of over 4,500 healthcare professionals across 50 countries are working on similarly landmark reforms to 'reorient' health systems around a foundation of primary care all over the world, including:

- Help set up integrated care systems in the UK (ongoing)
- The implementation of value-based healthcare and associated transformation of provider systems in New York State from 2014-2019.
- Help to scale up the newly-autonomous public primary care providers in Cyprus, following the introduction of the universal health coverage scheme for primary care in June 2019.
- The introduction of a universal coverage scheme for comprehensive primary healthcare in the Bahamas in 2016, including the introduction of a capitated payment model.
- The creation of 'service delivery networks' model to aggregate and scale up primary health care providers across the Philippines.

At the same time, KPMG in Saudi Arabia has grown to be one of the largest professional service providers in the Kingdom. During the last few years, it has achieved record growth, reaching our current workforce of over 1,300 people across the Kingdom.

Some of the work we have delivered in KSA includes:

- Facilitate nationwide program to establish a sustainable continuous improvement process in public hospitals
- Perform a current-state corporatization readiness assessment on 5 clusters which encompassed 30 healthcare organizations
- Conduct a study on international health systems and redesign the target operating model for the revenue cycle management of a leading hospital

In healthcare our service offerings include but are not limited to:



Performance Improvement & Optimization:

We support the public sector and healthcare providers improve their performance from a clinical, operational, and financial sustainability perspective.



Ecosystem Transformation & Implementation:

We help the regulators, healthcare providers and payers in the development and implementation of target operating models and transformation of the 'ecosystem' of players within the KSA health economy.



Leadership & Workforce Development:

We lead the way in leadership and human resources succession planning, training and change management.



Private Sector Participation & Growth:

We assist clients in the development of deals, transactions, (public / private) partnerships, restructuring, and post-merger integration in the healthcare and life sciences sector.

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