National Health Programs and Policies

Objectives :

- **To understand the difference between the old and new healthcare system in the kingdom.**
- **To highlight the drives for the national healthcare transformation.**
- **To list the aims of the national healthcare transformation.**
- **To understand the difference between the different bodies for the new saudi healthcare system.**
- **To be familiar with concepts important for developing the new healthcare system approach (e.g. population health management).**

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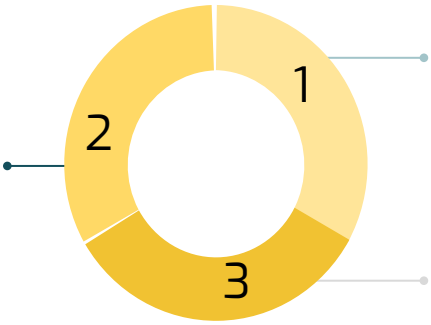
History of Saudi Healthcare System

History of MOH:



1925 (1343H): Public Health Department, in Makkah

1925 (1344): Public Health and Ambulance Services

1950 (1370): Ministry of Health established by a royal decree from King Abdul Aziz

MOH Mission:

· Provision of healthcare at all levels (levels are: primary care: prevent the disease from happening, secondary care: early detection of the disease to avoid complications, tertiary care: the disease has already progressed so we try to make the patient functional and not disabled)
· Promotion of general health and prevention of disease
· Developing laws and legislations regulating both governmental and private health sectors
· Monitoring performance in health institutions
· Monitoring research activity and academic training in field of health

Legislators, regulators and providers

Legislation	• Executive bodies: The King, The Council of Ministers • Judicial body: The Saudi court • Legislative body: Shariah
Health regulators	• The National Health Council, Ministry of health (الأساسي) • The Saudi Commission for Health Specialties, • Council of Co-operative Health Insurance • The Saudi Food and Drug Authority • Public Health Authority => new!
Healthcare providers	Governmental: 1-MOH 2-Other ministries (MOE, MOD...etc) Non-governmental (private): These are regulated by the council of cooperative health insurance (مجلس الضمان الصحي التعاوني) (The regulator for private health provision)

Legislators, regulators and providers

Providers (public providers):

Prior to 2016, almost 60% of the healthcare provision was provided by MOH and free

Other Government bodies include:

- Referral hospital (KFSHRC)
- Security Forces
- Army Forces
- National Guard
- ARAMCO hospitals
- Royal commission for Jubail and Yanbu
- MOE hospitals (teaching hospitals)
- School health units
- Red Crescent Society

Provide services to defined populations (employees and dependants)

Healthcare Delivery Structure in 2011

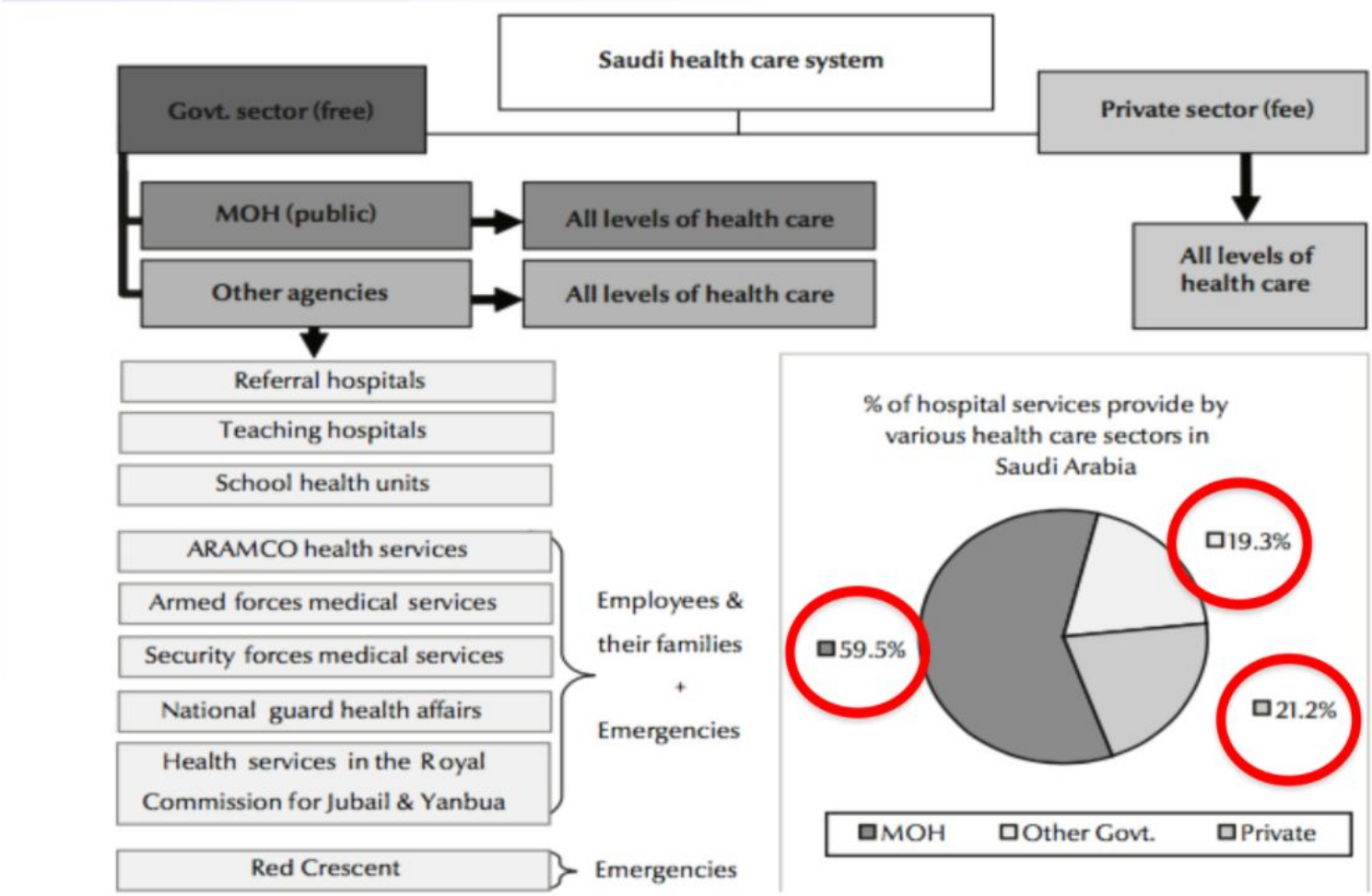


Figure 1 **Current structure of the health care sectors in Saudi Arabia (MOH = Ministry of Health). Source of data: [4]**

MOH Milestones in Prevention and Control

1. 1950: ARAMCO collaborated with WHO to MOH control malaria in Eastern region.
2. 1978: The country adopted concept of Primary Health Care "most imp milestone".
3. 1983: Primary health care was implemented in healthcare system.
4. 1997: Successful immunization program where 90% of children were immunized.
5. 2016: National Healthcare Transformation begins..

Challenges to healthcare systems worldwide

1. Resources for healthcare are limited
2. Populations are getting older
3. Changes in the epidemiology of diseases
4. Healthcare systems are fragmented

These are causing a shift in healthcare

Why does the MOH need to change its model?

1. The population is aging (life expectancy is expected to rise, and so would the need for services for the elderly to meet demands).
2. Rates of avoidable non-communicable diseases and injuries are getting higher (current prevention measures are not sufficient).
3. Primary care is not adequate. (they are not acting as gatekeepers and people are accustomed to accessing secondary and tertiary care for things that can be treated in primary care setting
4. There is significant gaps in quality of services).
5. There is disparity in access to care
6. Organizations are institution and staff-centric (not population-centric).
7. Gaps in workforce capacity and capabilities.
8. A lot of waste in resources and medical spending.

The Saudi population is changing

- 35+ Million in 2020 -> 39.5 Million by 2030.
- People between ages 60 – 70 y will increase by 136.2% by 2030.
- Latest annual growth rate as per GSTAT was approximately 2.5%.
- The current youth (child and adolescent populations) will be of childbearing age soon, and will require obstetrics and pediatric services -> increased demand for these services.
- The increase in aging population -> would mean that we should expect a higher prevalence of the different chronic diseases and more frequency of “mild disability” in elderly population; as in other parts of the world -> increased demand for coordinated care, assisted self-care and home-care services.

The Saudi National Health transformation

- As part of the Vision 2030 Transformation Programs, Saudi Arabia has established a national health transformation program.
- This is based on a national shift in “governmental” healthcare services to “value-based care” services.

Aims of this transformation

1. **Improve health outcomes**: Increase the length, wellbeing and quality of life of Saudi citizens, which includes the Vision 2030 goal of increasing the life expectancy of citizens to 80 years by 2030.

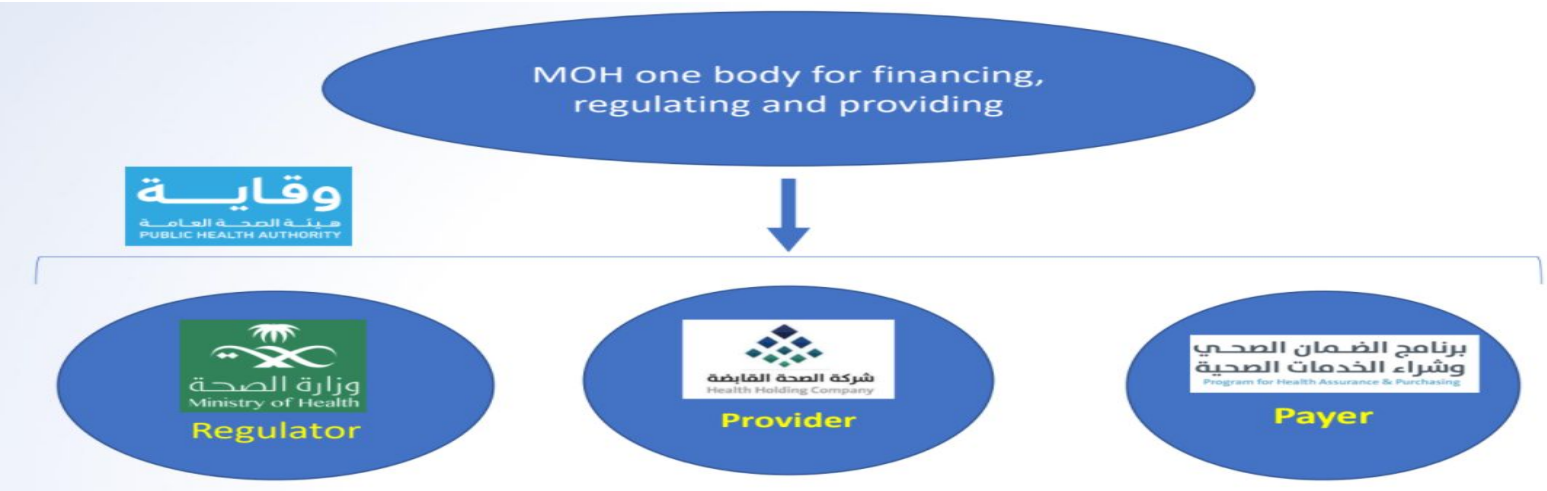
2. **Improve quality of care and patient experience**: By improving the quality and consistency of services and the performance and accountability of healthcare organizations and staff to deliver care that is safe, effective, person-centered, timely and equitable.

3. **Reduce costs**: by containing costs, improving outcomes, controlling public healthcare expenditure and guiding new investment.

- Improve quality + reducing costs will improve value!
- This is called the "Triple Aim"; first developed by the Institute for Healthcare Improvement.

Change in governance structure

Previous model vs. new model



The provider decides the quality of services and outcomes then report that to the health ministry, while the payer decides who is eligible for ministry of health services to decrease the load.

What will the new healthcare system offer?

1. Provide services by specified healthcare networks (health clusters) to specified populations designated in demarcated geographic locations.

2. Funding for these services would be based on an quality-incentivized system, such that these health-networks would be rewarded for favorable population health outcomes and would be penalized for improper allocation of services and resources.

3. Each health network would be accountable for the population it is supposed to serve (accountable care organizations).

4. Some services not available in the health-network can be outsourced to private sectors, and networks with specialized services can provide them for a fee, to individuals outside of their network (privatization).

5. Primary care services will be better allocated.

6. Distribution of MoH secondary and tertiary care centers will be improved across different regions in the country (in each health network).

7. A better approach to prevention services (public health programs).

How will healthcare services be provided?

Through health-networks called “Health Clusters”

A total of 21 health clusters to be launched

Each health cluster has a defined population (ranging from 800 K to 1.6 M); at least 4 hospitals and specialized centers; and a number of PHCs under its organization

These will act as “accountable care organizations” and will need to operate as such

Health clusters need to establish the following:

- Build a good population health management model
- Integrate electronic health records from different systems to unify the electronic health record system used in the cluster
- Develop public health and community participatory programs
- Repurpose of resources and projecting future budgets
- Implement 42 planned interventions (as part of the Model of Care)
- Evaluate quality of care and making improvements

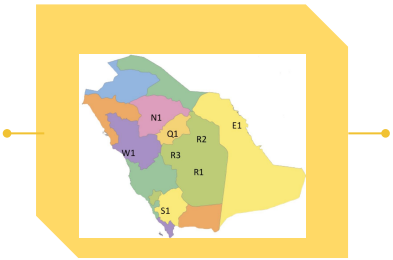
Types of ACO Models

The type adopted by the Kingdom

ACO Model	Description
Integrated Delivery Systems	Based on a common ownership of hospitals, physician practices and insurance plan (single insurance company)
Multispecialty Group Practices	Multiple practices (specialty clinics) that are affiliated to one hospital, in which patients are funded through multiple payers (multiple insurance companies)
Physician Hospital Organizations	A subset of hospital staff who coordinate care together for the purpose of improving quality of care and health outcomes, and reducing costs
Independent Practice Associations	Individual physician practices that come together for the purpose of contracting with common health plans, and evolved into organized network
Virtual Physician Organizations	Physicians integrate their services together virtually; this is usually provided for rural settings

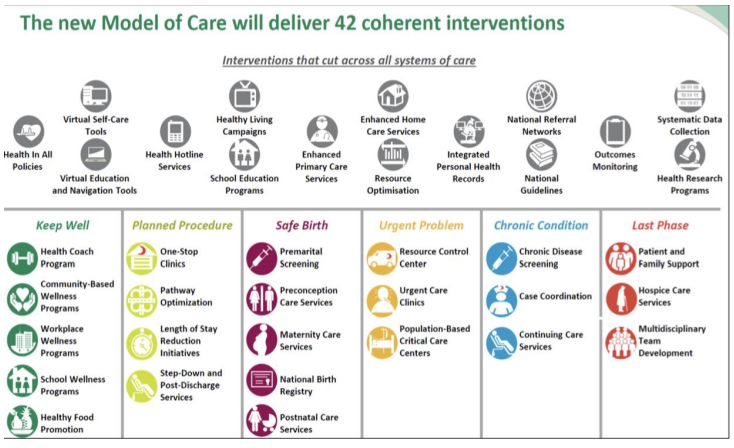
Health clusters (التجمعات الصحية)

- All ministry of health governmental facilities in the Kingdom will be grouped and then divided into 21 clusters, distributed by geographic regions
- Not all have been activated yet

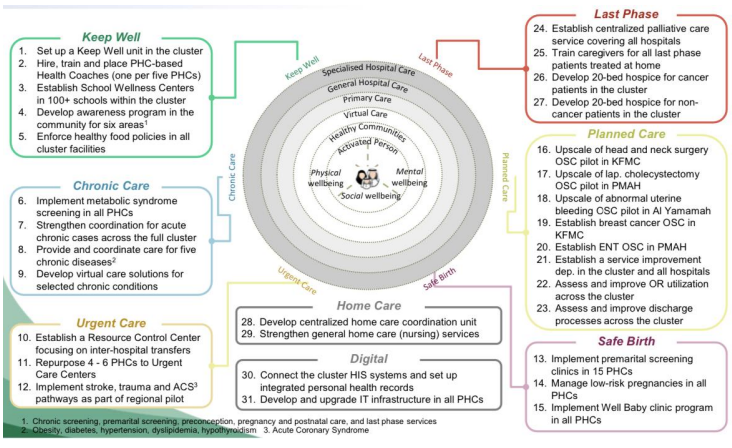


- Each health cluster is responsible for a specific population
- It has primary care centers
- Hospitals
- Specialized care centers

Interventions for the model of care



Model of Care Initiatives and Programs

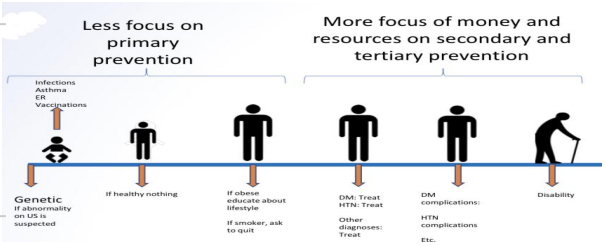


The healthcare system is moving from a “reactive to proactive”

- Reactive => only caters the individuals health when the individual has a problem or comes to the healthcare facility

No continuity of care

Patient has multiple files in different hospitals



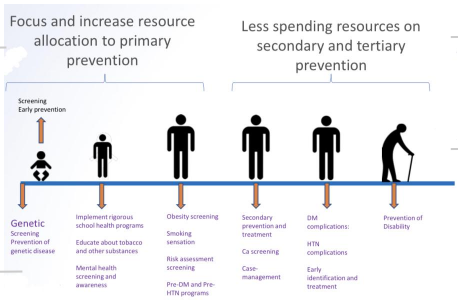
Scattered replicated services

Poor community outreach

- Proactive => reaches out to the individuals before they come to the healthcare facility; go to them in their community;

Continuity of care

Focused services designed and directed to targeted risk-group across entire health continuum

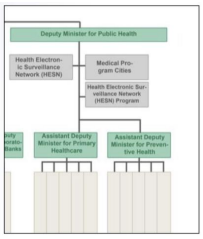


Uniform care delivery

Engagement of the community

Integrated health recording system

Public health policies and guides



وقاية
هيئة الصحة العامة
PUBLIC HEALTH AUTHORITY

وزارة الصحة
Ministry of Health

Giving attention to everyone across the health spectrum

To be proactive....

We need an approach that:

- Understands the need of each individual
- Integrates data about them from different sources
- Allows to male decisions about person-centered interventions
- Monitor the quality of care; apply continuous improvements
- Predicts future outcomes for better planning
- Maneges healthcare resources with minimal waste
- Reduces the cost of care

Population Health Management Is the solution!

Many definitions for PHM

- A proactive, organized, and cost-effective approach to prevention that utilizes newer technologies to help reduce morbidity while improving the health status, health service use, and personal productivity of individuals in defined populations
- A systematic approach to ensuring that all patients receive appropriate preventive, chronic, and transitional care
- Accountability and management of the health of an entire community, regardless of system membership or insurance status
- A community-based, patient- centered, provider-led approach that has evidence behind it, can be measured, and can not only improve health status, but also reduce cost.
- An approach designed to improve consumer health and increase quality of care with an eye toward managing medical costs

Population Health Management (PHM)

PHM is an organized, proactive and multidisciplinary approach for a healthcare delivery system that provides cost-effective health interventions (at all three levels of prevention) that are targeted to the respectable risk-groups in a defined population, using evidence-based approaches, making use of the latest advancements in health information technology, and through engaging the community in the healthcare process

What PHM is not!

- PHM is NOT synonymous to community health
- PHM is NOT synonymous to public health
- PHM is NOT a healthcare system, but rather an approach to one
- PHM is NOT synonymous to primary care delivery

PHM is approaching your healthcare system to deliver person-centered care with better quality, to improve health, and to reduce costs!

Public Health vs. Community Health vs. Population Health

Public health

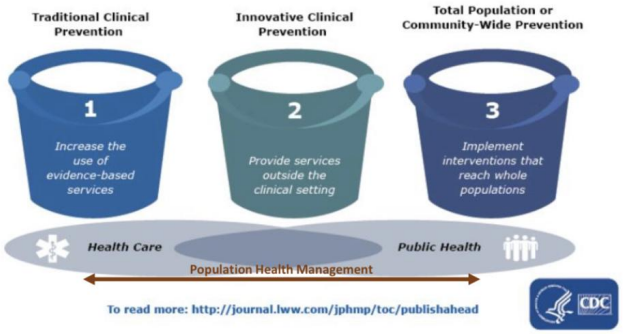
Community health

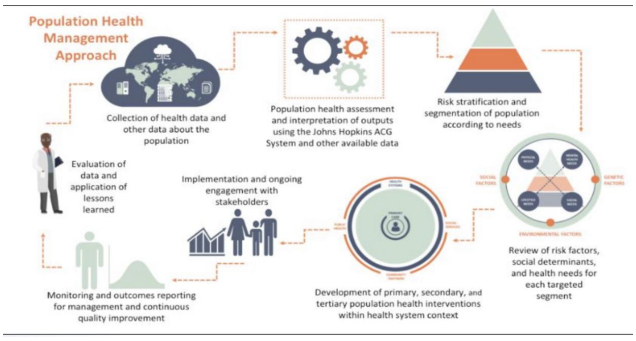
Population health

None are population health management

All are needed for population health management, but are NOT in themselves population health management

PHM Bridges the gap between public health and traditional healthcare delivery





What PHM will help us identify?

=> 50% of the population But use 3% of costs

Healthy majority

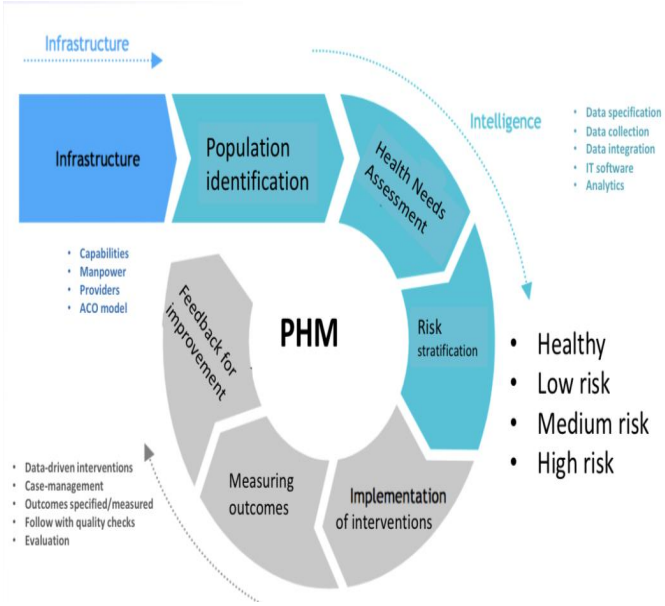
Medium-risk people (chronic conditions stable)

Low-risk people.

High-risk complex (Chronic condition complex)

1% of the <= Population but use 20% of costs

PHM framework



An organization with a PHM model

Well defined population

Datawarehouse (PHM indicators)

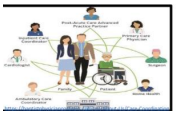
Risk group 1: Healthy

Risk group 2: low risk

Risk group 3 : Medium risk

Risk group 4 : High risk

Identify these risks Enroll each risk group into



Ensure continuity of care

The Saudi health transformation is a long journey

- This is just the beginning
- Only the MoH facilities are involved now -> could it expand to other
- health sectors?
- It requires:

1. Patience
2. A lot of determination
3. Alignment and collaboration with stakeholders
4. Good funding
5. Good IT support
6. Well trained labor force

Summary

- **Worldwide the population is growing, and a big part of this can be contributed to aging.**
- **Focus should be on prevention, because it is less costly and more effective in decreasing chronic disease burden.**
- **The Kingdom of Saudi Arabia has taken this into consideration in their planning of their transformed healthcare system.**
- **The MOH will be transformed into three bodies: provider; payer; regulator.**
- **Public health policies and guidelines will also be transformed.**
- **The aims of this new system are to improve health; reduce, costs, and improve quality of care and patient experience.**
- **Population health management is an important building block for this transformation.**

Practice Questions

Q1: Ministry of health is

A. healthcare provider	B. health regulator	C. legislator	D. both A & B

Q2: Non-governmental (private) healthcare providers are regulated by

A. the national health council	B. ministry of health	C. the council of cooperative health insurance	D. Public health authority

Q3: What is the aim of The Saudi National Health transformation program ?

A. improve health outcome	B. improve quality of care and patient experience	C. increase costs	D. both A & B

Q4: "Physicians integrate their services together virtually; this is usually provided for rural settings." is a description of which ACO Model?

A. Virtual Physician Organizations	B. Multispecialty Group Practices	C. Independent Practice Associations	D. Integrated Delivery Systems

Q5: Which of the following is not included in the Last phase of the interventions for the model of care?

A. Patient and family support	B. Hospice care services	C. Continuing care services	D. Multidisciplinary team development

Q6: Group 4 of the PHM model is known to be

A. Medium risk	B. High risk	C. Low risk	D. Health

Answer key:
1 (D) , 2 (C) , 3 (D) , 4 (A) , 5 (C) , 6 (B)

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سوف ترتكبون العديد من
الأخطاء، فلا تخجلوا من
أخطائكم، وسوف يلتهم الفشل
أمانيكم الغالية، فلا تنصرفوا من
مطاردة الأمانى إلى مطاردة
الفشل.

- غازي القصيبي رحمه الله -