ISSN: 0975-833X

Available online at http://www.journalcra.com

International Journal of Current Research
Vol. 12, Issue, 01, pp.9636-9648, January, 2020

DOI: https://doi.org/10.24941/ijcr.37657.01.2020

INTERNATIONAL JOURNAL OF CURRENT RESEARCH

RESEARCH ARTICLE

COMPARISON OF PRIMARY HEALTH CARE SERVICES IN KSA, USA AND NORDICS WITHIN THE VISION OF 2030

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ARTICLE INFO

Article History:
Received 24th October, 2019
Received in revised form
28th November, 2019
Accepted 29th December, 2019
Published online 30th January, 2020

Key Words:

Health Care Systems, Primary Health Care Systems, USA, Nordics, Saudi Arabia.

ABSTRACT

The purpose of this research paper is to compare health care systems within The vision 2030 of Saudi Arabia .A new primary health care system has been founded and initiatives have been implemented, to make sure we are developing within the right path, we have to compare our healthcare system to those in highly advanced industrialized countries, a comparison will be between the health care system of United States of America (USA) and Nordics countries (Sweden, Denmark, Norway) and Saudi Arabia, it will be formulated by Murray-Frenk framework. The first part of the research paper will focus on the description of health care systems in the above-mentioned countries while the second part will analyze, evaluate and compare the three systems regarding equity and efficiency. We start by providing a general description and comparison of the structure of health care systems in United Statutes of America (USA) and Nordics Countries (Sweden, Denmark, Norway) and comparing within our healthcare system in Saudi Arabia.

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Citation: ***Dr. Abdulhammed Khairalddin, Ahmed Bawazir, Saleh Al-Qhtani, Faisal Al-Humayied, Shoaib Al-Ahmari and Adham Al-Shammari.* 2020.** "Comparison of primary health care services in ksa,usa and nordics within the vision of 2030", *International Journal of Current Research*, 12, (01), 9636-9648.

INTRODUCTION

Health is state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity. WHO definition of health, but we focused our energy and resources to treat rather than prevent infirmity or disease, treatment thrust absorbs more resources without achieve the required goals. Primary health care is necessary to describe the nature of services provided to patients, as well as to identify who are the primary care providers. Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings. Primary medicine assumes longitudinal responsibility for the patient regardless of the presence or absence of the disease. Dentistry is essentially a primary care discipline insofar as the vast majority of patient care takes place in community settings, is restricted to simple procedures and is provided by 'generalists' who in the main hold, or aspire to hold a long-term relationship with their patients.

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In medicine, a key aspect of recent health policy has been to drive the provision of a greater proportion of care in community settings by generalists and thus reduce the referral rate to secondary care. In dentistry, most care is provided by generalists and patients are rarely referred to specialists, though referral rates are reported to have risen greatly in recent years and are likely to continue to do so. Primary health careis usually the first point of contact people have with the health care system. It provides comprehensive, accessible, community-based care that meets the health needs of individuals throughout their life. This includes a spectrum of services from prevention(i.e. vaccinations and family planning) to management of chronic health conditions and palliative care. What we discussed previously was definitions of the ideal way to define health care services, specially the primary health care, because it's the first line of defense and curability of any epidemiological diseases and prevention, but some of the services cannot be included or apply it for many reasons. We have to develop our own primary health care services according to what we need and demand. especially dental health care, and to evolve our health care system we have to start where people ended their progress, and try to duplicate their platforms with our own theme. In this research will highlight comparisons within our healthcare system with USA and Nordics, prediction of the future of our system and how

can develop and fulfill the gaps that we might have. Optimizing our resource will enhance our harvest capability, by inducing new gathering technique.

Nordic and the Welfare Health Care System and OECD: The Nordic countries are well-known for their welfare states. A very important feature of the welfare state is that it aims at easy and equal access to adequate health care for the entire population. For many years, the Nordic systems were automatically viewed as very similar, and they were placed in the same group when the OECD classified health care systems around the world. However, close inspection soon reveals that there are important differences between the health care systems of Denmark, Finland, Iceland, Norway and Sweden. Consequently, it is perhaps no surprise that the Nordic countries fell into three different categories when the OECD revised its classification a few years ago. In this paper, we revisit this issue and argue that the most important similarity across the Nordic countries is the institutional context in which the health care sector is embedded Nordic health care exists in a high-trust, high-taxation setting of small open economies. "The oral health care legislation in each Nordic country emphasises prevention and all services are offered for free." Caries-preventive methods used for children and adolescents in Denmark, Iceland, Norway and Sweden.Källestål C1, Wang NJ, Petersen PE, Arnadottir IB. PMID: 10226725

First of all, in administrative field: In Denmark, the access to health care is the underlying principle 'Health Law' which is a governmental, they promote population health, prevent and treat illness, suffering, and functional limitations, and ensure that they get high quality of care, easy and equal access to care services, so the national government sets the regulatory framework for health services and is in charge of general planning and supervision.

"Denmark's healthcare sector has three political and administrative levels: the State, the regions and the local municipalities." "The Health and Prevention Ministry is in charge of administrative functions related to the organisation and financing of the healthcare system."

Health care systems in the Nordic countries--more similarities than differences?, Kristiansen IS1, Pedersen KM, PMID:11008540

In Norway, the government is responsible for providing health care to the population, the goal of equal access to health care regardless of age, race, gender, income, or area of residence, primary health and social care is the responsibility of the municipalities. So Norway's ministry of health playing an indirect role through legislation mechanisms, they only playing the direct role in specialist care through its ownership of hospitals and its provision of directives to the boards of regional health care authorities(RHAs). "The State is responsible for healthcare policy and capacity issues as well as the quality of healthcare through budgets and laws." "The State is also responsible for hospital services through regional health authorities who organise hospitals as health trusts, municipalities have responsibility for primary healthcare." Health care systems in the Nordic countries--more similarities than differences?, Kristiansen IS1, Pedersen KM,PMID:11008540

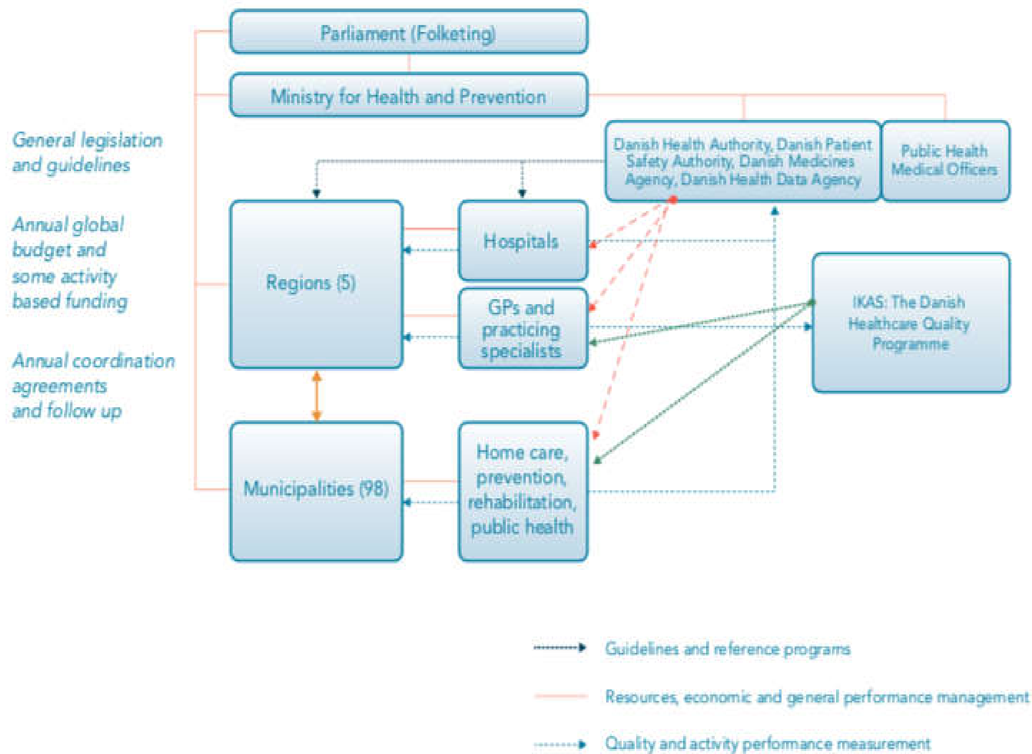
In Sweden, they have three levels of healthcare system national level, regional level, and local level. So the government are involved all of these three levels .At the national, the Ministry of Health and Social Affairs is responsible for overall health and health care policy and other. At regional, they responsible of the financing and delivering health services to citizens. At local 290 municipalities are responsible for care of the elderly and the disabled. So local and regional authorities are represented by the Swedish Association of Local Authorities and Regions(SALAR).

"The Swedish healthcare system is organised in seven sections: proximity or close to home care(this covers clinics for primary care, maternity care, outpatient mental healthcare, etc.), emergency services, elective care, hospitalisation, specialist treatment and dental care." Health care systems in the Nordic countries--more similarities than differences?, Kristiansen IS1, Pedersen KM,PMID:11008540 "primary healthcare centers employ a multidisciplinary workforce." WORK MOTIVATION AMONG HEALTHCARE PROFESSIONALS: A STUDY OF WELL-FUNCTIONING PRIMARY HEALTHCARE CENTERS IN SWEDEN, Kjellström, Avby, Areskoug-Josefsson, Andersson Gäre, Andersson Bäck, PMID:28877624

Second, in finance field: "Health care in the Nordic countries are public financing of health care and that inpatient care is provided by salaried doctors who work as public employees in public hospitals." The core of the Nordic health care system is not empty , Carl Hampus Lyttkens, Terkel Christiansen, Unto Häkkinen, Oddvar Kaarboe, Matt Sutton, Anna Welander, Nordic Journal of Health Economics, Vol. 4(2016), No. 1, pp. 7-27

In Denmark, publicly insurance funded coverage that all registered Danish residents are automatically entitled to publicly financed health care, undocumented immigrants and visitors are not covered but a voluntary, privately insurance funded initiative by Danish doctors, supported by the Danish Red Cross and Danish Refugee Aid and it's financed mainly through a national health tax set at 8 percent of taxable income. For the private insurance complementary voluntary insurance covers statutory copayments are for extended the public insurance mainly for pharmaceuticals and dental care that's not fully covered by the state.

"General practitioners and practicing specialists are privately owned, but operate under general contracts with the regions and receive most of their income from public sources generated by taxation at the state and municipal levels." N. Alexandersen et al. / Nordic Journal of Health Economics, Vol. 4(2016), No. 1, pp. 68-83. In Norway, publicly insurance coverage is universal and automatic for all residents, it is financed through national and municipal taxes, Social security contributions finance public retirement funds, sick leave payment, and, for some patient groups, reimbursement of extra health care costs. For the private insurance it is provided by for-profit insurers and purchased for quicker access and greater choice of private providers and It covers less than 5 percent of elective services like pharmaceuticals and dental care. "The municipalities hold responsibility for primary care while the central government, represented by four regional health authorities, governs specialist care. Both primary and specialized care are tax funded."


Organization of the Health System in Denmark
Parliament (Folketing)
Ministry for Health and Prevention
General legislation and guidelines
Annual global budget and some activity based funding
Annual coordination agreements and follow up
Danish Health Authority, Danish Patient Safety Authority, Danish Medicines Agency, Danish Health Data Agency
Public Health Medical Officers
Regions (5)
Hospitals
GPs and practicing specialists
IKAS: The Danish Healthcare Quality Programme
Municipalities (98)
Home care, prevention, rehabilitation, public health
Guidelines and reference programs
Resources, economic and general performance management
Quality and activity performance measurement

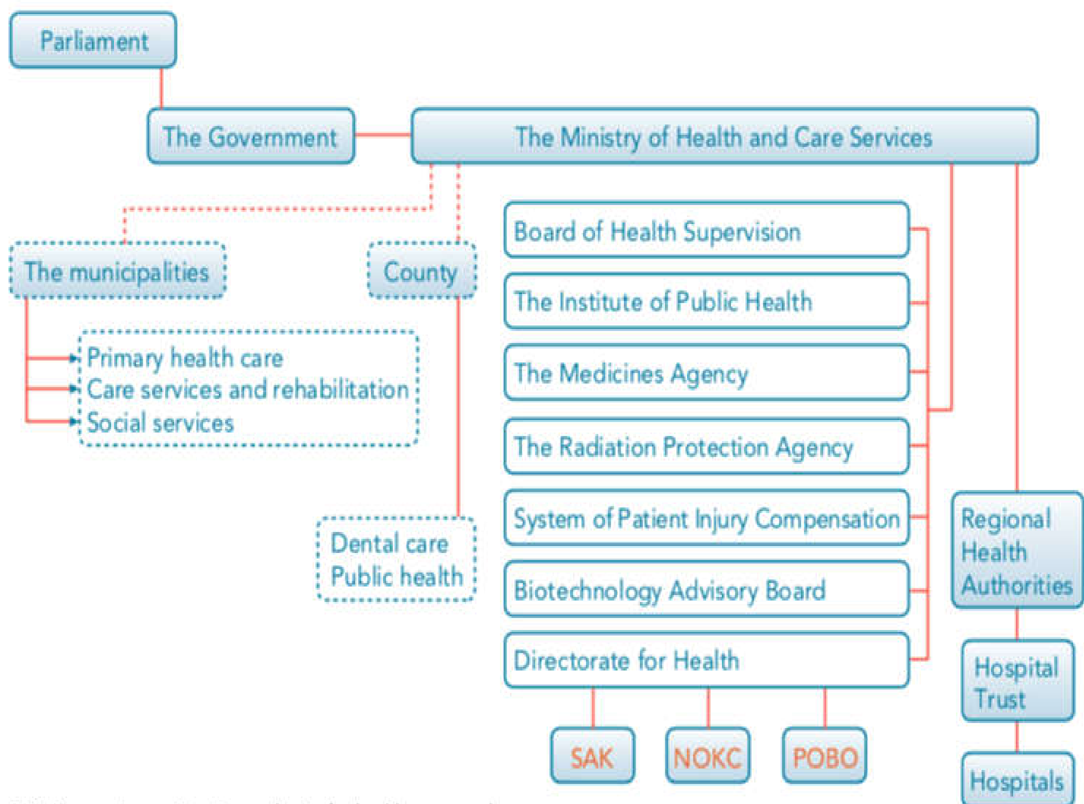
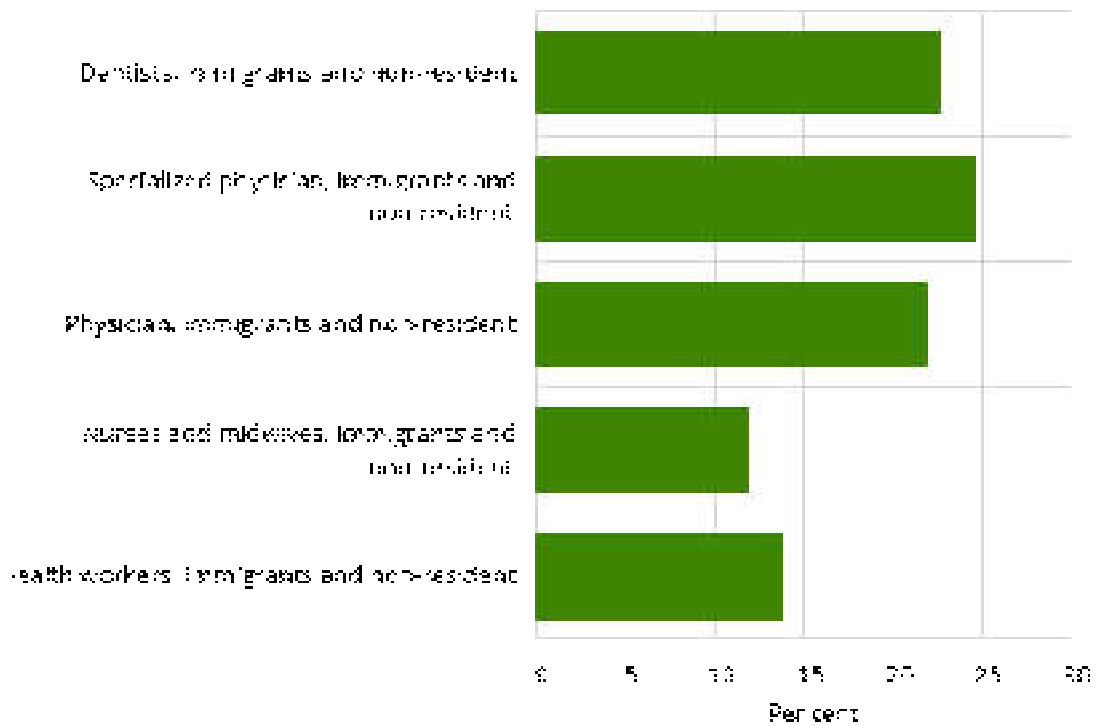
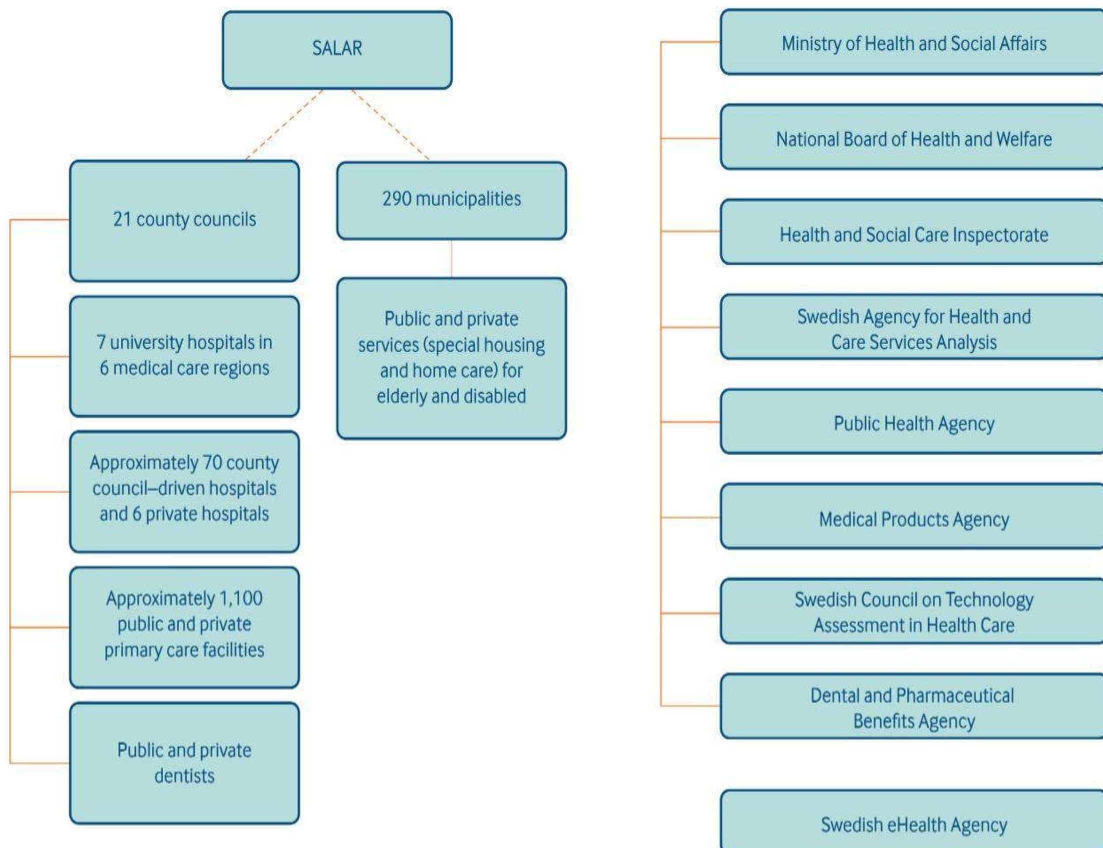

Organization of the Health System in Norway
Parliament
The Government
The Ministry of Health and Care Services
The municipalities
County
Primary health care
Care services and rehabilitation
Social services
Dental care
Public health
Board of Health Supervision
The Institute of Public Health
The Medicines Agency
The Radiation Protection Agency
System of Patient Injury Compensation
Biotechnology Advisory Board
Directorate for Health
SAK
NOKC
POBO
Regional Health Authorities
Hospital Trust
Hospitals
SAK: Norwegian registration authority for health personnel
NOKC: Norwegian Knowledge Centre for the Health Services
POBO: Health and care services ombudsmen

Figure 1. Immigrants and non-resident health personnel 15-74 years in health and social services. Share of selected educational groups. 2015



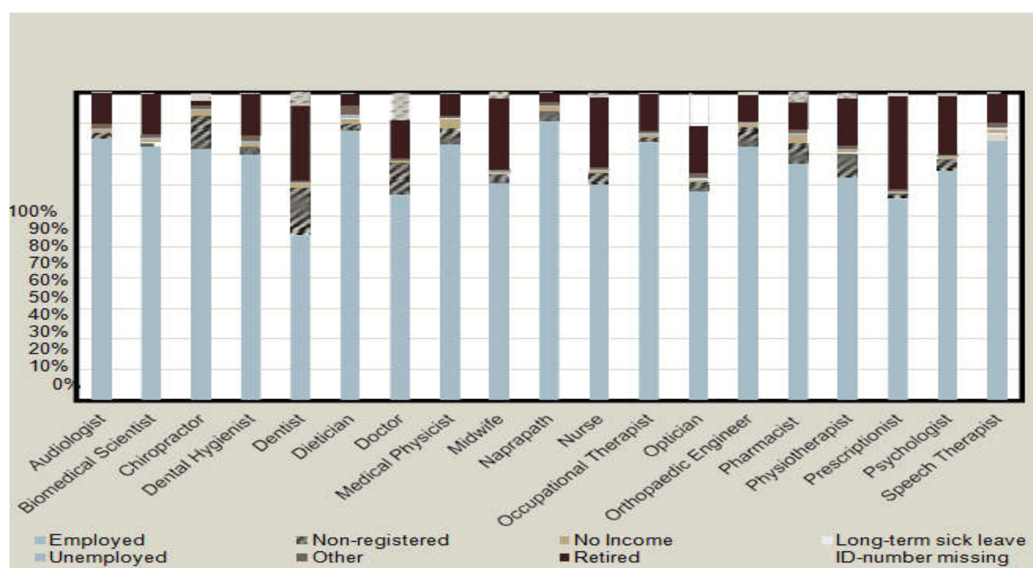
Source: Statistics Norway.



Employed Licensed Personnel by Profession and Percentage Men and Women, November 2014

	Number	Percentage:			Number	Percentage:	
Profession		Men	Women	Profession		Men	Women
Nurse	122 962	12	88	Dental Hygienist	4 837	3	97
Dentist	40 362	54	46	Pharmacist	3 860	26	74
Physiotherapist	16 014	22	78	Optician	2 548	334	66
Occupational Therapist	11 417	6	94	Speech Therapist	1 939	6	94
				Dietician	1 531	5	95
Biomedical Scientist	9 964	10	90	Naprapath	1 174	55	45
				Audiologist	1 129	10	90
Psychologist	9 501	30	70	Chiropractor	688	64	36
Dentist	8 807	45	55	Medical Physicist	512	60	40
Midwife	8 094	1	99	Orthopaedic Engineer	429	62	38
Prescriptionist	5 578	4	96				

Source: National Planning Support's (NPS) register, National Board of Health and Welfare



Source: National Planning Support's (NPS) register, National Board of Health and Welfare

Figure 1. Licensed health care personnel by profession and workforce status in November, 2014

Total health care expenditure in the Nordic countries Euro per capita

	Public consumption	Private consumption	Total costs
Denmark	2 657	469	3 126
Finland	2 231	775	2 986
Iceland	2 227	543	2 769
Norway	5 187	878	6 065
Sweden	2 675	601	3 286

Taxes' share of costs in the health care sector

	Taxes' share of costs in the health care sector
Denmark	85%. (2011)
Finland	75%. (2012)
Iceland	80%. (2012)
Norway	85%. (2012)
Sweden	82%. (2011)

Source: DAMVAD 2014, country reports and OECD stats.

Financial features of the Nordic health care sector

	Denmark	Finland	Iceland	Norway	Sweden
Taxation levels	State and municipality	State and municipality	State	State, coun- ties, munici- pality	State, coun- ties, munici- pality
Out-of-pocket payments	Dental care (adults), pharmaceuti- cals, vaccina- tions	Primary care visits (co- payments), pharmaceuti- cals, dentists, hospital outpatient treatment	Primary care visits (co- payments), hospital outpatient treatment, diagnosis, preventive and screening services, immunization and vaccina- tion programs and pharma- ceuticals	RGPs, special- ist visits / outpatient hospital care, same-day surgery, physiothera- py, prescrip- tion drugs, radiology, laboratory tests, dental care (adults)	Primary care visits (co- payments), dental care (adults), outpatient prescription drugs, special- ist care (co- payments)
Share of popula- tion with private health insurance	Approximate- ly 15%.	Approximate- ly 2%.	Approximate- ly 0%.	Approximate- ly 5%.	Approximate- ly 5%.

Exhibit 1. More Than 16 Million More People Under Age 65 Purchased Coverage on Their Own or Enrolled in Medicaid, 2013–2014

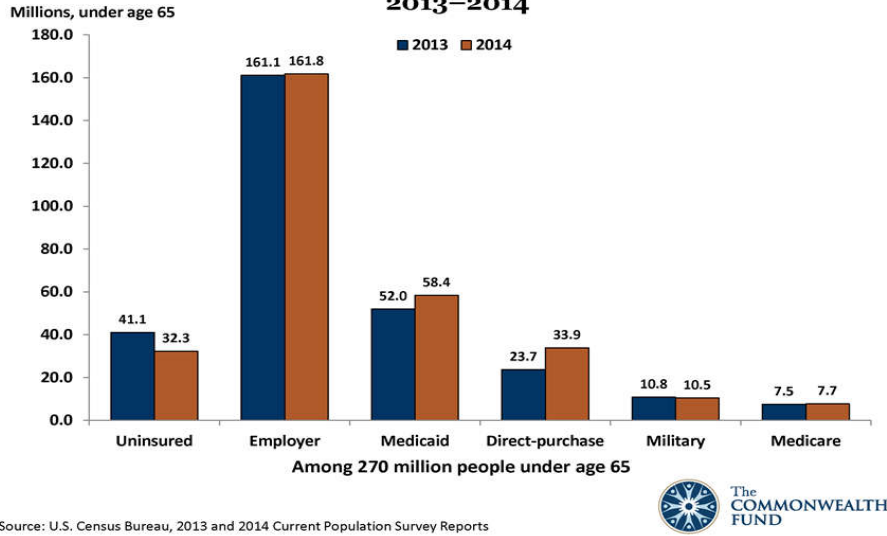
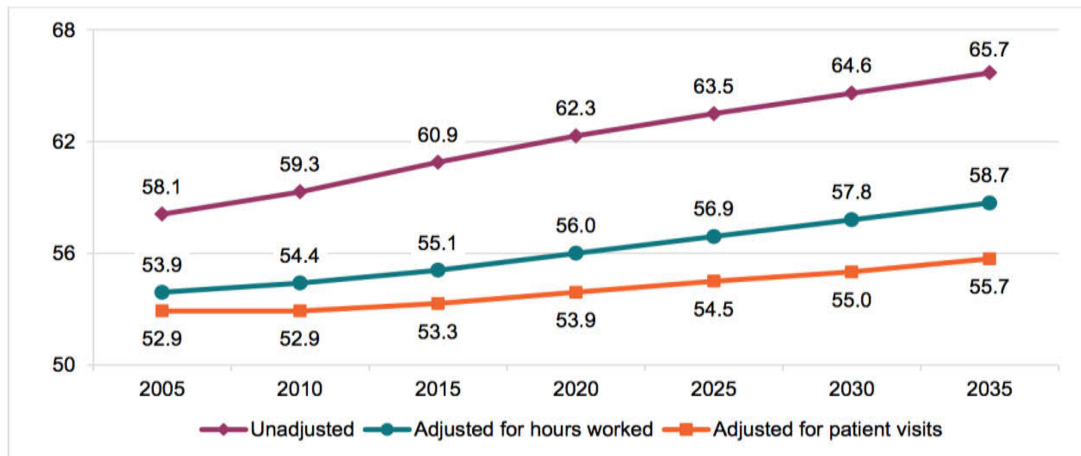
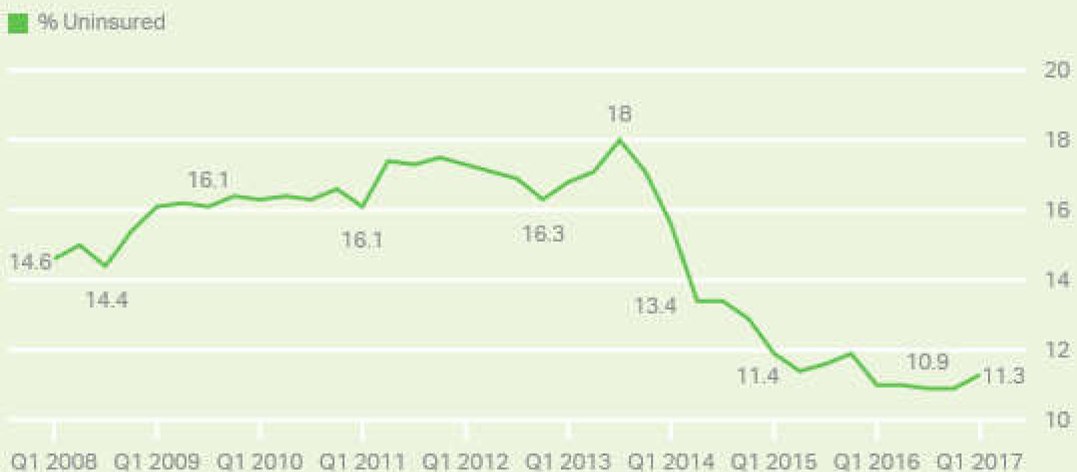
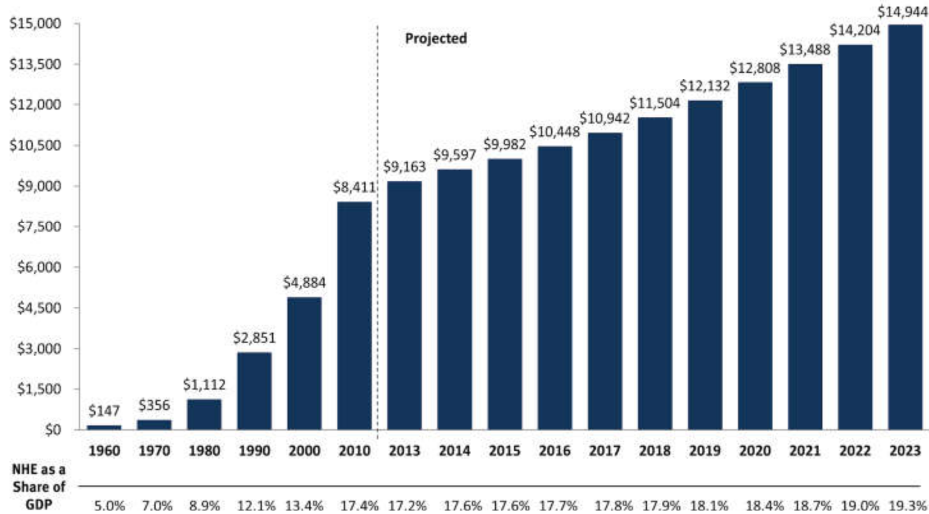


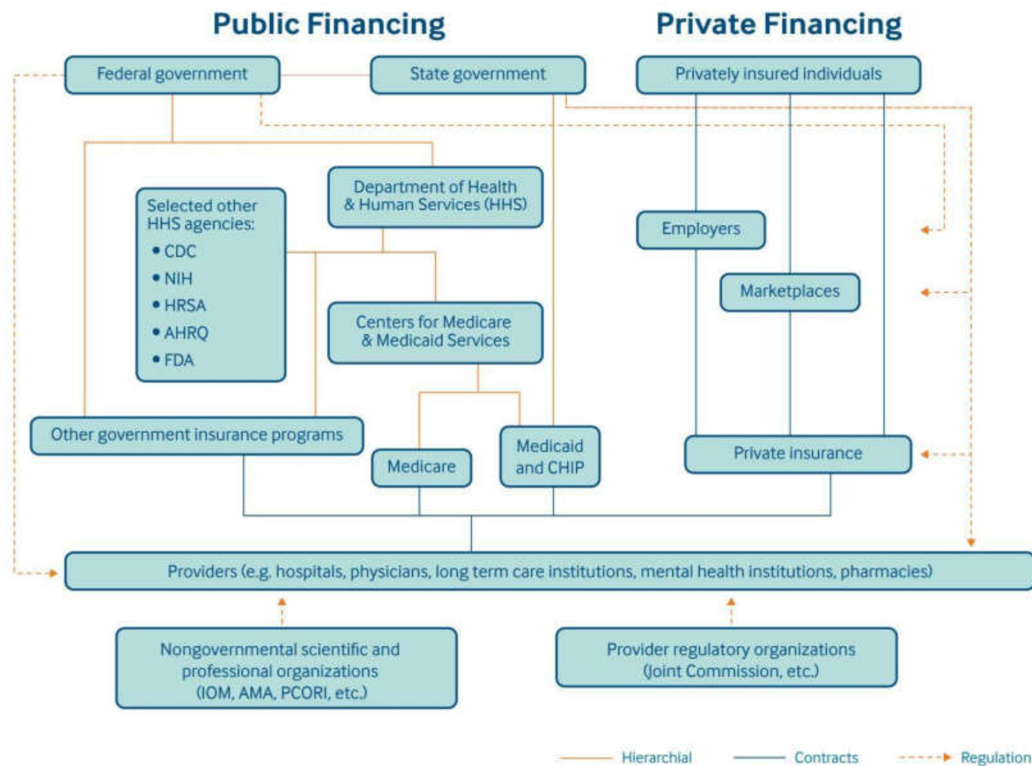
Figure 1: Historical and Projected Dentists per 100,000 Population in the U.S., Baseline Scenario



Sources: ADA Health Policy Institute analysis of ADA masterfile; ADA Survey of Dental Practice; ADA Survey of Dental Education; U.S. Census Bureau, Intercensal Estimates and National Population Projections. **Notes**: Data for 2005, 2010 and 2015 are based on the ADA masterfile. Results after 2015 are projected. Assumes (a.) U.S. total annual dental school graduates will increase until 2020 and then remain constant (b.) future outflow rates are same as 2010-15 historical percentages.







N. Alexandersen et al. / Nordic Journal of Health Economics, Vol. 4(2016), No. 1, pp. 68-83. In Sweden, publicly insurance funded like Denmark coverage that all legal residents and in the emergency is provided to all patients from European Union/European Economic Area countries, and also Asylum seeker children(undocumented) have the right to health care services. For the private insurance it is the form of supplementary coverage it is mainly purchased primarily to ensure quick access to an ambulatory care specialist and to avoid waiting lists for elective treatment.

"Most health care is financed through local taxation, and contrary to Denmark and Norway, county councils have the right to collect their own taxes." N. Alexandersen et al. / Nordic Journal of Health Economics, Vol. 4(2016), No. 1, pp. 68-83

Third, in Delivery of the health system field

"The longer the waiting time is, the lower the quality of care because the benefits of treatment are typically presumed to decrease with waiting"

Gravelle et al., 2003; Propper, 1995.

In Denmark: -Primary care, around 22 percent of all doctors work in general practice, The practice structure are group of practices, typically consisting of two to four GPs and two to three nurses, There are two groups 1st under which GPs act as gatekeepers for secondary care, is required to register with a GP(98% population), 2nd coverage provides free choice of GP and access to practicing specialists without referral.

"Specialist physicians work based on an agreement with a health insurance scheme, and most patients are referred to them by general practitioners."

Health care systems in the Nordic countries--more similarities than differences?, Kristiansen IS1, Pedersen KM,PMID:11008540 "Primary care physicians are mostly private practitioners in Denmark, Iceland and Norway." The core of the Nordic health care system is not empty , CARL HAMPUS LYTTKENS, TERKEL CHRISTIANSEN, UNTO HÄKKINEN, ODDVAR KAARBOE, MATT SUTTON, ANNA WELANDER, Nordic Journal of Health Economics, Vol. 4(2016), No. 1, pp. 7-27. Outpatient specialist care, is delivered through hospital-based ambulatory clinics(fully integrated and funded, as are other public hospital services) or by self-employed specialists in privately facilities it can be full-time or part-time.

In Norway

Primary care, the municipalities provide primary care in accordance with current legislation, government directives, and quality requirements set by the Directorate for Health, " regular GP scheme," whereby people register with one general practitioner, covers 99.6 percent of the population. There was an average of 1,127 patients per GP in 2015 and 2.4 specialists in hospitals or ambulatory care for every practicing primary care physician, after-hours emergency primary care services are the responsibility of the municipalities, whose contracts with GPs include after-hours emergency services on rotation.
"GPs prescribe drugs and provide referrals to specialists and hospitals. They also treat acute and chronic illnesses, and provide preventive care"

Health care systems in the Nordic countries--more similarities than differences?, Kristiansen IS1, Pedersen KM,PMID:11008540

"Denmark and Norway have imposed gate-keeping(GP) on visits to specialized health care for patients in the list patient system, this policy means that a referral from a patient's regular GP is necessary in order for a patient to access specialized health care"

T. Iversen et al. / Nordic Journal of Health Economics, Vol. 4(2016), No. 1, pp. 41-55

Specialist care, the four regional health care authorities(RHAs) that have been mentioned before, which are state-owned corporations that report to the Ministry of Health, are responsible for supervising specialist inpatient and also psychiatric care.

- Outpatient specialist care is provided both by hospitals and by self-employed specialists.
- Long-term care, the municipalities are responsible for providing long-term care and contract also to some extent with private providers.

In Sweden:

Primary care, about 20 percent of all expenditures on health,8 and about 16 percent of all physicians work in this setting, so the team-based primary care, comprising general practitioners(GPs), nurses, midwives, physiotherapists, psychologists, and gynecologists, the average four GPs in a primary care practice, also the providers are required to provide after-hours care practices in proximity to each other(normally three to five practices) collaborate on after-hours arrangements.

"If referred to a specialist by the GP, they should get an appointment within 30 days"

Health care systems in the Nordic countries--more similarities than differences?, Kristiansen IS1, Pedersen KM,PMID:11008540

"One can contact an inpatient or outpatient specialist without first consulting with a GP"

The core of the Nordic health care system is not empty, CARL HAMPUS LYTTKENS, TERKEL CHRISTIANSEN, UNTO HÄKKINEN, ODDVAR KAARBOE, MATT SUTTON, ANNA WELANDER, Nordic Journal of Health Economics, Vol. 4(2016), No. 1, pp. 7-27

Outpatient specialist care, is provided at university and county council hospitals and in private clinics also patients have a choice of specialist. Public and private providers are paid through the same fixed prices.

USA Primary Health Care System: The U.S. healthcare system is unique among advanced industrialized countries. The U.S. does not have a uniform health system, has no universal health care coverage, and only recently enacted legislation mandating healthcare coverage for almost everyone. Rather than operating a national health service, a single-payer national health insurance system, or a multi-payer universal health insurance fund, the U.S. healthcare system can best be described as a hybrid system. In 2014, 48 percent of U.S. health care spending came from private funds, with 28 percent coming from households and 20 percent coming from private businesses. The federal government accounted for 28 percent of spending while state and local governments accounted for 17 percent. Most health care, even if publicly financed, is delivered privately. Currently have a major gap between the number of primary care providers, which they have, and the number that would be needed to deliver primary care to the full population. Indeed, although the recent passage of the Affordable Care Act of 2010 is exciting and has been projected to make coverage available to an additional 32 million of the uninsured, a key issue will be who will deliver primary care to this group.

Midlevel providers will be part of the solution, but primary care is quite complicated, especially for patients with multiple

chronic conditions, and physicians will remain an essential part of the team. Primary care includes general internal, family medicine, and pediatrics, and few medical students have been going into these specialties in recent years for a number of reasons. Regular primary care visits may allow an opportunity to deliver high-value, proactive care. A previous study made using Medicare claims for 378,862 fee-for-service Medicare beneficiaries who received PC at 1328 federally qualified health centers from 2010 to 2014. beneficiaries with fewer regular visits show more ED visits, more hospitalizations, and higher costs [1] Health care in the United States is the world's most expensive, yet America's health outcomes are nothing to brag about. one of the most important appears to be our failure to emphasize primary care within USA healthcare system. Improving Primary care system in USA will improve the overall health care system. Currently, health care system is in crisis, especially because of its costs [2].

USA federal funded health care serves: The NHS serves a large proportion of the national population with seven out of 10 children, and five out of 10 adults, attending primary dental care within a 24-month period. So far, the analysis of NHS data has predominantly been studied to monitor new initiatives, assess value for money, and the longevity of treatments, with much of this research conducted under previous models of care. A more analytical evaluation of dental activity from contemporary NHS primary care has the potential to provide information on how encounters with health care under the current system contribute to addressing oral health needs. Medicaid in the United States is a joint federal and state program that helps with medical costs for some people with limited income and resources. The Centers for Medicare & Medicaid Services (CMS) is the federal agency that runs the Medicare Program. CMS is a branch of the Department of Health and Human Services (HHS). CMS also monitors Medicaid programs offered by each state. In 2011, Medicare covered 48.7 million people. Total expenditures in 2011 were $549.1 billion. This money comes from the Medicare Trust Funds.

The Economics of the Health care in USA:

- **First:** Most the citizen below 65 age have private insurers they get from their own money as individual policy or they get it from their employer.
- **Second:** the citizen above 65 age(seniors) or their income below the poverty line and they get single payer system(Medicare for seniors, Medicaid for the low income).
- **Third:** they have also government hospitals and staff but only for the Veterans.

The Americans in 2013 14.3 % of the citizen didn't have health insurance but in 2014 a 10.4 % the numbers get down they try to solve it, but some of the people they have many jobs as part time jobs or there have full time jobs but there employs didn't offer insurance to them, so they didn't have money to buy insurance or there income is above the poverty line so they can't get benefits from the programs or the system that the government offer it, so they get stuck in the middle this is one of many problems they try to solve it.[4] U.S. health care spending increased 4.3% to reach $3.3 trillion, or $10,348 per person in 2016.The overall share of gross domestic product(GDP) related to health care spending was 17.9 percent in 2016, up from 17.7 percent in 2015.[3]

Health Spending by Major Sources of Funds:

Medicare: Medicare spending grew 3.6 percent to $672.1 billion in 2016, which was lower than growth in the previous two years when spending increased 4.8 percent in 2015 and 4.9 percent in 2014.

Medicaid: Total Medicaid spending decelerated in 2016, increasing 3.9 percent to $565.5 billion.

Private Health Insurance: Private health insurance spending increased 5.1 percent to $1.1 trillion in 2016, which was slower than the 6.9 percent growth in 2015.

Out-of-Pocket: Out-of-pocket spending grew 3.9 percent in 2016 to $352.5 billion, faster than the growth of 2.8 percent in 2015.[3]

Primary Health Care System in Saudi Arabia: Saudi Arabia is a highly income Kingdom and rapidly growing and developing country with alandmass of 2,149,690 km2 with a population exceed 32 million. Facing rapid urbanization(in 2015, 83% of the total population was urban). The rapid urbanization impacts the accessibility, quality and equity of primary healthcare service delivery. Urbanization was focused in some of the Kingdom cities neglecting the small countryside and villages making the population focusing in metropolitan cities were services can be accessible as healthcare.

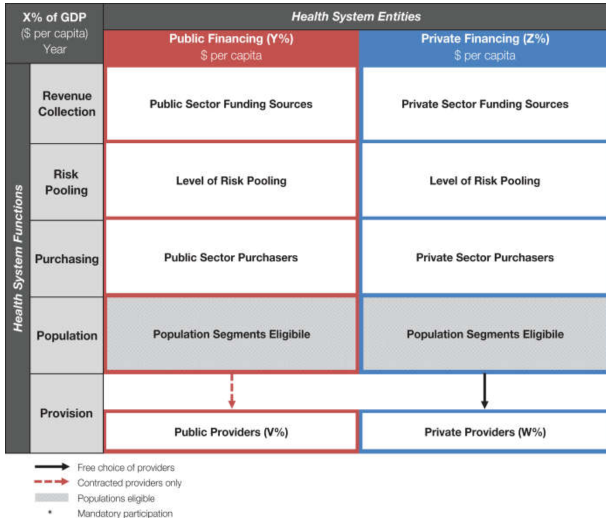
Overpopulation, Education services can lead to urbanization that lead to urban related diseases and infections(Diabetes, Obesity, Dental diseases, cancers) and related psychological problems(bipolarism, schizophrenia, stress, depressions) preventive and education program that was not established with urbanization planning. The prevention at that stage will become unachievable this way we are spending more in curability, that it will eat our resources year after year because of the outdated preventive programs, unfunctional Primary health care interpretation and lack of cohorts and research center.

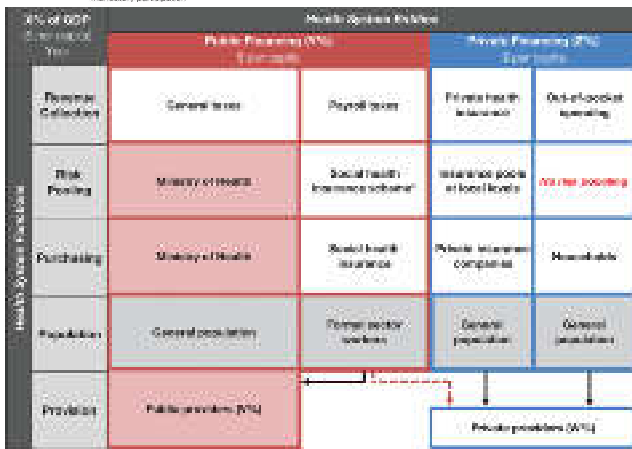
Tackling such a matter need more than ordinary preventive programs .it need a primary healthcare and action centers to address and to improve our health status. That will minimize the future unnecessary disease, infirmity and psychological curability cost. Healthcare services are provided through the public sector [including the Ministry of Health(MOH) and other government agencies] and the private sector with high cost that let the population seeks treatment outside the kingdom our alternative medicine. Plus, the loss of trust of physicians and dentist.

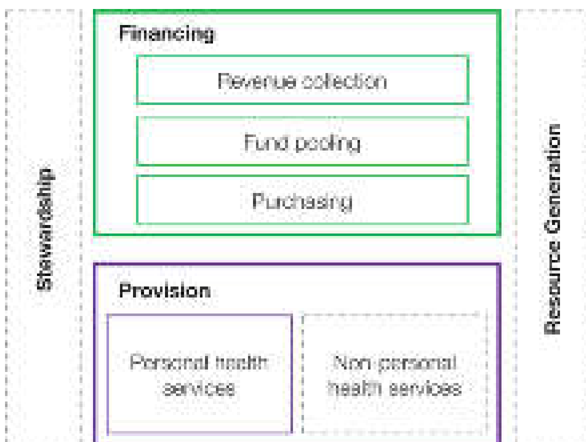
The bulk of healthcare service provision in the KSA is undertaken by the public healthcare sector through the MOH. The MOH, which is funded annually from the total government budget, is the main provider of public healthcare services, operating approximately 60% of hospitals and primary healthcare centers. This cost can be minimized if RND center were active and researches were obtained in periodical matter.

Aims: Actual reading and analysis of what have we achieved, focusing in need and demand, achieving the RND quality control, optimizing the outcomes, privatizing Research and think tanker centers, open the door for university to play a role in providing services.

MATERIALS AND METHODS







RESULTS

DISCUSSION

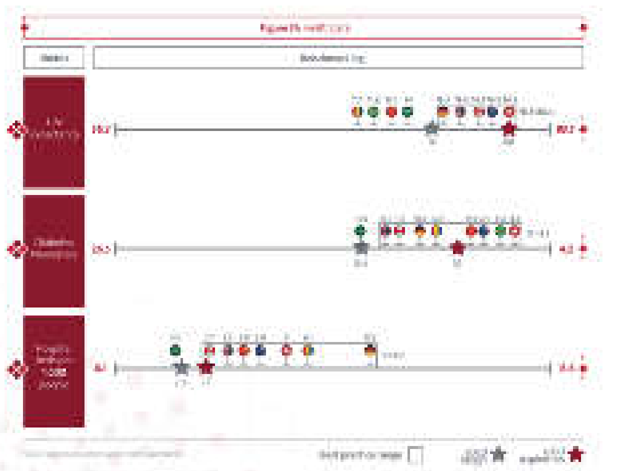
Each country has its own sets of culture and systems that make its nation a whole. What might work in the US might not be able to translate well in our system. The only way we could create a perfect system is to understand our shortcomings and defects and figure out the perfect plan due cohorts centers to understand our multi cultural nation. We need more qualified and certified physician and dentists to serve the population who are hard working and willing to take leadership roles to take the health care standard to the level it should be in.

Table 2-18 : Physicians, Nurses and Allied Health Personnel in Primary Health Care Centers, MOH, 1434-1438 H (2013-2017 G)

Year					Nationality	Category
2017 - 1438	2016 - 1437	2015 - 1436	2014 - 1435	2013 - 1434		
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Saudi	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Non Saudi	
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Total	
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Rate/10000 population	
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Saudi	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Non Saudi	
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Total	
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Rate/10000 population	
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Saudi	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Non Saudi	
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Total	
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Rate/10000 population	
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Saudi	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Non Saudi	
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Total	
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Rate/10000 population	

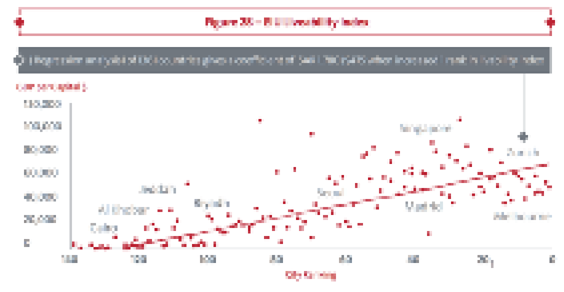
Table 2-20 : Physicians, Nurses and Allied Health Personnel at Private Sector, 1434-1438 H (2013-2017 G)

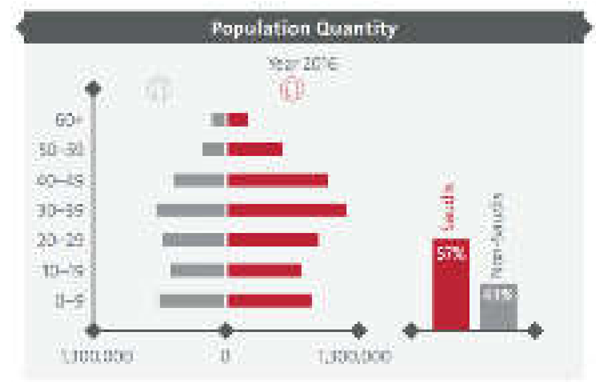
Year					Category	
2017 - 1438	2016 - 1437	2015 - 1436	2014 - 1435	2013 - 1434		
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Saudi	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Non Saudi	
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Total	
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Rate/10000 population	
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Saudi	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Non Saudi	
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Total	
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Rate/10000 population	
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Saudi	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Non Saudi	
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Total	
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Rate/10000 population	
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Saudi	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Non Saudi	
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Total	
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Rate/10000 population	

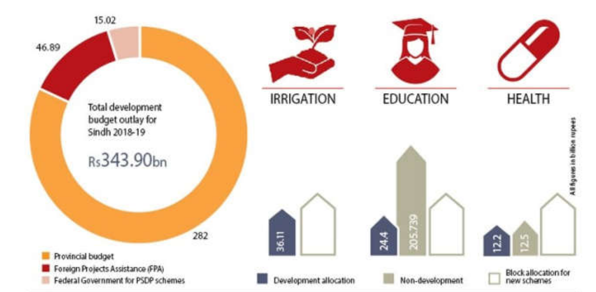


TOTAL OF GOVERNEMT SECTOR EMPLOYEES IN KSA ON 2015

JOBS	Number of employees
GENERAL JOBS	561671
EDUCATION	543466
HEALTH	195094
UNIVERSITY FACULTY MEMBERS	75631
JUDGES	5636
DIPLOMATIC	1390
OTHERS	141,578
TOTAL	1524466







Year	Number of Insured			Growth rate
	Groups	Individual	Total	
2010	8,349,467	0	8,349,467	
2011	7,938,597	0	7,938,597	-4,92%
2012	6,788,970	1,939,597	8,728,567	9,96%
2013	7,199,435	2,655,183	9,854,618	12,90%
2014	7,106,204	2,535,036	9,641,240	-2,17%
2015	6,874,998	3,902,683	10,777,681	11,79%

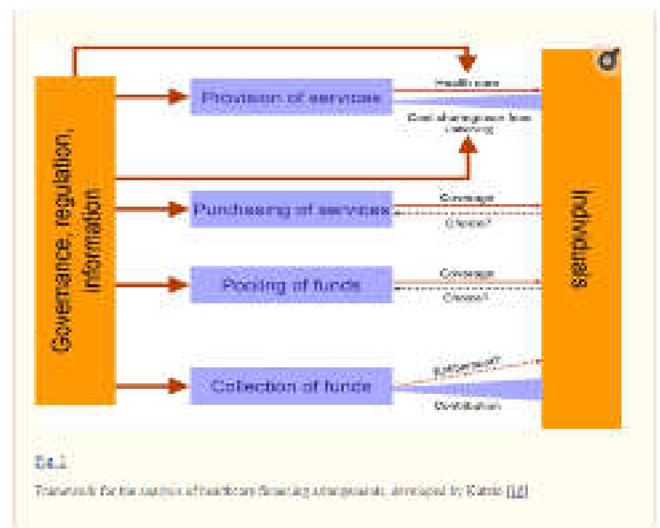


Table 1

Main characteristics of study participants

Characteristics	N	%
Location (urban)	29	80.56
Sex (male)	31	86.11
Marital status		
Single	3	8.33
Married	29	80.56
Divorced	3	8.33
Widowed	1	2.78
Age, years		
18–24	3	8.33
25–34	10	27.78
35–44	12	33.33
45–54	6	16.67
55–64	3	8.33
> 64	2	5.56
Education level		
Illiterate	3	8.33
Elementary school	4	11.11
Intermediate school	3	8.33
Secondary school	6	16.76
Two-years college (diploma)	4	11.11
University degree	13	36.11
Postgraduate	3	8.33
Employment status		
Public sector employee	21	58.33
Private sector employee	5	13.89
Self-employed	5	13.89
Student	1	2.78
Retired	2	5.56
Unemployed	2	5.56
Household average monthly income, SR[a]		
< 6000	4	11.11
6000 to < 12,000	14	38.89
12,000 to < 18,000	12	33.33
≥ 18,000	6	16.67

SR Saudi Riyal

[a]1 Saudi Riyal = $US0.27

Table 2

Reasons for dissatisfaction with the public healthcare services

Reason	N (%) (n = 18)
Waiting times in accessing public hospitals (unavailability of appointments)	17 (94)
Waiting time before seeing the doctor in public hospitals	11 (61)
Lack of hospital beds	11 (61)
Existence of special privileges and favouritism	8 (44)
Attitudes of staff members	7 (39)
Lack of hygiene	7 (39)
Conflicts of interest	6 (33)
Unavailability of drugs	4 (22)
Irregular ward visits by doctors	4 (22)
Weak supervision	4 (22)
Unavailability of specialist doctors	3 (17)
Lack of privacy	2 (11)
No sufficient facilities	2 (11)

Conclusion

Nordics: in the nordic countries, health services are mostly financed by the public authorities, so it's financed primarily by the government or county or municipal taxes for most of the health services and for some of the dental services are covered and they have a complimentary insurance for the services like the dental and the medication as co-payment service and in conclusion they have the best life expectancy and quality, also they fund's much lesser for health services than the countries that mentioned in this research paper. USA has highest healthcare spending in the world but low healthcare outcome. Duo to the gap in the system, there was more than 14% uninsured inhabitants, the numbers of uninsured are decreasing but the system is still not reliable. Health care system is a rapidly develop system that have problems which made a bigger gap that's needed more effort to correct these gaps. doctors is not compatible with population needs, Centers that lack essentials services and equipment, unfair distribution of centers, beds verses population . We must develop our primary healthcare centres and cover the needs of doctors as it will raise the quality of the healthcare provided and reduce the overall healthcare cost.

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