

# Institutional Transformation of the Saudi Health System (2020– 2025): A Qualitative Policy Analysis of Governance, Financing, and System Resilience

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## Research Article

**Keywords:** Health system reform, Institutional governance, Strategic purchasing, Primary health care, Digital health, Health system resilience, Saudi Arabia. [14,15]

**Posted Date:** April 7th, 2026

**DOI:** <https://doi.org/10.21203/rs.3.rs-8957325/v1>

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**Additional Declarations:** No competing interests reported.

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# **Institutional Transformation of the Saudi Health System (2020–2025): A Qualitative Policy Analysis of Governance, Financing, and System Resilience**

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## **Abstract**

### **Background**

Health systems globally are undergoing structural reconfiguration driven by demographic ageing, chronic disease burdens, fiscal sustainability pressures, and post-pandemic governance reassessment. Contemporary reform paradigms increasingly emphasise governance differentiation, strategic purchasing, primary health care (PHC) strengthening, and digital integration as systemic stabilisers. Saudi Arabia's Vision 2030 health sector transformation represents one of the most accelerated centrally coordinated reform trajectories in a high-income context. However, integrated institutional evaluation of governance restructuring and its resilience implications remains limited.

### **Methods**

This study employed a qualitative institutional policy analysis covering the period 2020–2025. Using a structured analytical framework, the Accelerated Centralised Reform Model (ACRM) reform was evaluated across four domains: governance restructuring, financing, and strategic purchasing, PHC strengthening, and digital transformation. Data sources included peer-reviewed scholarship, OECD and WHO governance frameworks, and publicly available reform documentation. Institutional coding was applied across structural differentiation, incentive realignment, accountability consolidation, and adaptive governance integration dimensions.

## **Results**

Findings demonstrate substantial structural differentiation between regulatory, purchasing, and provider functions; expansion of performance-linked financing mechanisms; strategic reorientation towards PHC-based service delivery; and rapid digital platform deployment. Reform design aligns conceptually with contemporary governance paradigms. However, implementation depth varies across accountability standardisation, analytic purchasing maturity, workforce alignment, and adaptive feedback integration.

## **Conclusions**

Saudi Arabia's reform illustrates how accelerated centrally coordinated restructuring can achieve rapid institutional convergence with modern governance models. Long-term system resilience depends on consolidating performance transparency, strengthening analytic purchasing capacity, embedding adaptive governance routines, and institutionalising iterative evaluation cycles. The study contributes to comparative health policy scholarship by conceptualising accelerated centralised reform as a distinct institutional trajectory.

Keywords: Health system reform; Institutional governance; Strategic purchasing; Primary health care; Digital health; Health system resilience; Saudi Arabia. [14,15].

## **1. Introduction**

### **1.1 Global Context of Institutional Health Reform**

Over the past decade, health systems worldwide have confronted intensifying structural pressures driven by demographic ageing, the epidemiological transition towards chronic non-communicable diseases, fiscal sustainability constraints, technological expansion, and rising public expectations regarding transparency and quality [1]. These pressures have exposed limitations in traditionally vertically integrated governance models in which regulatory, financing, and provider roles are concentrated within a single authority [6]. The COVID-19 pandemic further revealed vulnerabilities in governance coordination, surge capacity, supply chain resilience, and financing flexibility [2,3]. Comparative analyses **emphasise** that resilient health systems require institutional preparedness, adaptive governance capacity, and integrated performance oversight mechanisms [4]. Health policy scholarship increasingly conceptualises health systems as institutional architectures rather than collections of facilities [5,6]. Governance structures, financing incentives, regulatory oversight arrangements, workforce governance, accountability instruments, and digital infrastructures collectively shape system performance. Reform therefore entails reconfiguring institutional relationships and incentive logics rather than expanding infrastructure alone [6].

Across high-income systems, four recurrent reform pillars have emerged:

- Governance differentiation and clearer separation between regulator, purchaser, and provider functions [6].
- Strategic purchasing mechanisms linking financing to measurable outputs and outcomes [7,8].
- Strengthening of primary health care to rebalance hospital-centric utilisation patterns [10–12].
- Digital integration enabling monitoring, coordination, and adaptive recalibration [13,19].

These pillars form the structural logic underpinning contemporary institutional reform paradigms.

## **1.2 Saudi Arabia's Reform Context**

Saudi Arabia's Vision 2030 introduced a comprehensive national transformation agenda aimed at enhancing public sector efficiency, financial sustainability, and service quality. Within this agenda, health sector restructuring occupies a central strategic position. Historically, the Ministry of Health functioned simultaneously as regulator, financier, and service provider. While this vertically integrated configuration supported rapid infrastructure expansion, it constrained benchmarking transparency and blurred accountability boundaries [6]. Limited purchaser-provider separation reduced incentive clarity and restricted performance differentiation across facilities [7].

Beginning in 2020, reform accelerated through several major structural initiatives:

- Functional separation of regulatory and service delivery roles.
- Establishment of regional health clusters with operational autonomy under national strategic coordination.
- Introduction of strategic purchasing and performance-linked financing mechanisms [8,9].
- Expansion and reorientation of primary health care as the entry point of care [10–12].
- Rapid deployment of national digital health platforms to support monitoring and integration [19]. [13,17].

These reforms represent a shift from administratively integrated service provision towards a differentiated governance architecture combining central strategic control with decentralised operational management.

## **1.3 Research Gap and Rationale**

Despite the scale and pace of reform, integrated institutional analysis remains limited.

Existing literature often examines individual reform components without situating them within a unified governance and financing framework.

Three analytical gaps therefore persist:

First, limited synthesis of governance differentiation and financing realignment within a structured institutional model [6–9].

Second, insufficient examination of how accelerated reform sequencing influences implementation depth and adaptive capacity [4].

Third, absence of structured comparative positioning within contemporary high-income reform trajectories [5,16].

This study addresses these gaps by applying a theory-informed analytical framework to evaluate institutional transformation between 2020 and 2025.

#### **1.4 Study Objectives**

This study aims to:

1. Analyse institutional restructuring of the Saudi health system between 2020 and 2025.
2. Evaluate governance differentiation, strategic purchasing expansion, PHC strengthening, and digital integration within a unified analytical framework.
3. Assess alignment with contemporary institutional governance paradigms [6].
4. Identify implementation tensions affecting accountability consolidation, resilience, and long-term sustainability [2,4].

## **2. Conceptual Framework: The Accelerated Centralised Reform Model (ACRM)**

### **2.1 Institutional Reform as Governance Reconfiguration**

Contemporary health system reform represents institutional reconfiguration in which authority, accountability, and incentive structures are redistributed across regulatory, purchasing, and provider domains [6].

Institutional governance theory emphasises that system performance depends not solely on financial inputs but on clarity of role differentiation and alignment of incentives across actors [5,6]. In vertically integrated systems, regulatory concentration, financing, and operational authority may facilitate infrastructure expansion but often limits benchmarking transparency and obscures accountability mechanisms [6]. Strategic purchasing frameworks reinforce governance differentiation by linking financing flows to measurable outputs and outcomes rather than historical expenditure patterns [7–9]. Simultaneously, resilience scholarship highlights the importance of adaptive governance, embedded monitoring systems, and iterative policy feedback mechanisms [2,4]. These theoretical strands collectively inform the analytical model applied in this study.

### **2.2 Defining the Accelerated Centralised Reform Model**

The Accelerated Centralised Reform Model is proposed as a structured analytical framework for examining centrally coordinated, high-speed institutional reform in high-income contexts.

Unlike incremental reform pathways observed in many European systems [5,16], the model assumes:

- Strong central political mandate.
- Compressed implementation timelines.
- Simultaneous restructuring across governance, financing, PHC, and digital domains.

- Strategic orchestration rather than negotiated fragmentation.

### **2.3 Structural Differentiation**

Structural differentiation refers to the formal separation of regulatory, purchasing, and provider functions to enhance accountability clarity and benchmarking capacity [6].

Indicators include:

- Independent or semi-independent regulatory oversight.
- Contractual purchaser–provider separation [7].
- Decentralised operational management under national coordination.

Differentiation reduces conflicts of interest and facilitates performance comparison across institutions [6].

### **2.4 Incentive Realignment**

Incentive realignment involves transitioning from input-based budgeting towards performance-sensitive strategic purchasing [7–9].

Effective purchasing reform requires:

- Measurable performance indicators [9].
- Transparent cost-accounting systems.
- Risk-adjusted allocation frameworks [18].

Incentive realignment reshapes organisational behaviour and managerial accountability.

### **2.5 Adaptive Governance Integration**

Adaptive governance integration embeds monitoring systems, digital infrastructure, and evaluation cycles into institutional routines [4,19,21]. Digital maturity enhances

resilience when monitoring outputs inform financing recalibration and policy adjustment rather than functioning solely as reporting infrastructure [2,4].

## **2.6 Analytical Application**

In this study, the ACRM framework is applied to evaluate four reform domains:

1. Governance restructuring.
2. Financing and strategic purchasing.
3. Primary health care strengthening.
4. Digital transformation.

Each domain is assessed according to structural differentiation depth, incentive alignment sophistication, accountability consolidation, and adaptive governance maturity. This structured approach ensures systematic institutional evaluation rather than descriptive narration.

## **3. Methods**

### **3.1 Study Design**

This study employed a qualitative institutional policy analysis to evaluate structural transformation within the Saudi health system between January 2020 and January 2025. Institutional policy analysis is particularly suited to examining governance restructuring, financing reform, and accountability realignment within complex national health systems [5,6]. The study did not aim to measure clinical or epidemiological outcomes. Rather, it assessed institutional architecture, incentive alignment, and reform sequencing using a structured theoretical framework.

### **3.2 Data Sources and Document Selection**

Data were derived from three categories of publicly available sources:

- Peer-reviewed academic literature addressing governance differentiation, strategic purchasing, and health system resilience [6–9].

- International institutional reports (OECD and WHO) providing comparative governance and resilience benchmarks [4,12,19].
- Official Saudi health sector transformation documents published between 2020 and 2025 describing governance restructuring, cluster establishment, financing reforms, and digital integration strategies.

A total of 42 documents were reviewed. Documents were included if they:

- Addressed system-level institutional reform.
- Described governance, financing, PHC, or digital restructuring measures.
- Provided policy, regulatory, or strategic frameworks relevant to institutional transformation.

Documents focusing exclusively on clinical outcomes or disease-specific epidemiology were excluded.

### **3.3 Analytical Procedure**

A structured coding framework based on the Accelerated Centralised Reform Model was applied. Each document was reviewed and coded according to four predefined analytical dimensions:

- Structural differentiation depth.
- Incentive realignment sophistication.
- Accountability consolidation mechanisms.
- Adaptive governance integration.

Coding was conducted manually through thematic categorization. Patterns were then synthesised across reform domains to identify convergence, implementation variation, and institutional maturity levels. To enhance analytical rigour, document triangulation was applied across academic literature, international institutional reports, and national reform documentation. Coding categories were predefined based on the ACRM framework to reduce

interpretive drift. Although primary interviews were not conducted, reliance on formal policy documentation ensured alignment with official institutional design. The objective was institutional configuration analysis rather than stakeholder perception assessment.

### **3.4 Comparative Benchmarking**

To enhance analytical robustness, findings were interpreted in relation to established high-income governance and purchasing models described in OECD and WHO literature [4,6,9]. This comparative lens enabled assessment of the extent to which the Saudi reform reflects structural convergence with contemporary governance paradigms.

### **3.5 Methodological Limitations**

The study relies on document-based institutional analysis and does not incorporate primary interview data or longitudinal quantitative performance indicators. As reform implementation remains ongoing, long-term outcome evaluation requires future empirical research.

## **4. Results**

### **4.1 Governance Restructuring**

#### **4.1.1 Structural Differentiation**

Between 2020 and 2025, governance restructuring introduced formal separation between regulatory oversight, purchasing authority, and service provision functions. The establishment of regional health clusters represents a central structural reform measure. These clusters were granted operational management responsibility while remaining aligned with national strategic direction.

This restructuring reduced direct ministerial operational control and introduced clearer role delineation between central policy formulation and decentralised service management. Such differentiation aligns with governance models emphasising separation of regulator and provider roles to enhance accountability transparency [6]. In addition, contractual mechanisms were progressively introduced to formalise

purchaser–provider relationships. This transition marked movement away from administratively integrated service allocation towards structured governance differentiation.

#### **4.1.2 Accountability Consolidation**

Performance monitoring capacity expanded through the deployment of central reporting dashboards and performance evaluation mechanisms. Cluster-level reporting structures increasingly incorporated key performance indicators linked to financing adjustments. However, indicator standardisation across clusters remains incomplete. Variability in reporting sophistication suggests transitional institutional maturity rather than fully stabilised accountability integration [9].

### **4.2 Financing Reform and Strategic Purchasing**

#### **4.2.1 Transition from Historical Budgeting**

Historically, budget allocations were input-based and linked to historical expenditure patterns. Reform measures introduced strategic purchasing principles, including separation of purchasing authority and provider management structures. Performance-linked contracting mechanisms were progressively implemented to align financing flows with measurable outputs. Budget allocation increasingly incorporated activity-based components and service volume considerations, reflecting alignment with strategic purchasing frameworks [7,8].

#### **4.2.2 Incentive Realignment Maturity**

Cost-accounting systems and performance-linked reimbursement models remain under active development. Risk-adjusted allocation frameworks have been introduced conceptually; however, analytic calibration capacity continues to mature [18]. This reflects a system in transition from administrative budgeting to performance-sensitive allocation. Institutional learning processes remain ongoing, particularly in contract refinement and indicator benchmarking.

### **4.3 Primary Health Care Reorientation**

### **4.3.1 Structural Expansion of PHC**

Primary health care has been repositioned as the first point of contact within the reformed care pathway. Expansion of PHC centres, redesign of referral pathways, and emphasis on preventive care represent structural measures intended to rebalance hospital-dominant utilisation patterns [10–12]. This structural reorientation supports chronic disease management and aims to reduce avoidable secondary-care admissions.

### **4.3.2 Workforce and Behavioural Adaptation**

Institutional rebalancing requires alignment between structural reform and workforce behaviour. Training initiatives and referral governance reforms were introduced to encourage PHC utilisation. However, behavioural adaptation among providers and patients remains uneven. Durable rebalancing depends on sustained reinforcement of PHC gatekeeping functions and performance-linked accountability structures.

## **4.4 Digital Integration and Monitoring Capacity**

### **4.4.1 National Digital Health Platforms**

Rapid deployment of digital health platforms enabled electronic health record integration, central performance tracking, and data exchange across clusters. Digital dashboards support financing oversight and monitoring transparency [19].

### **4.4.2 Adaptive Governance Integration**

Digital monitoring systems increasingly inform financing adjustments and policy recalibration. However, analytic utilisation varies across administrative levels. Institutional integration of digital output into routine decision-making continues to consolidate. Digital deployment therefore represents a foundational enabler of adaptive governance rather than a completed transformation.

## **4.5 Institutional Maturity Assessment**

Applying the Accelerated Centralised Reform Model across domains indicates:

- High structural differentiation coherence.

- Moderate incentive realignment sophistication.
- Transitional accountability consolidation.
- Emerging adaptive governance integration.

These findings reflect accelerated structural transformation accompanied by progressive but incomplete institutional consolidation. The distribution of maturity across domains illustrates differentiated reform pacing, with governance architecture advancing more rapidly than incentive calibration and behavioural institutionalisation.

The overall institutional maturity across reform domains is summarised in Table 1.

**Table 1. Institutional Reform Assessment Using ACRM**

| <b>Reform Domain</b>     | <b>Structural Differentiation</b> | <b>Incentive Realignment</b> | <b>Accountability Consolidation</b> | <b>Adaptive Governance Integration</b> |
|--------------------------|-----------------------------------|------------------------------|-------------------------------------|----------------------------------------|
| Governance restructuring | High                              | Moderate                     | Transitional                        | Emerging                               |
| Strategic purchasing     | Moderate                          | Moderate                     | Transitional                        | Emerging                               |
| Primary health care      | Moderate                          | Developing                   | Transitional                        | Emerging                               |
| Digital transformation   | High                              | Developing                   | Moderate                            | Emerging                               |

## **5. Discussion**

### **5.1 Accelerated Reform and Institutional Sequencing**

Findings indicate that Saudi Arabia's health transformation reflects accelerated institutional convergence with contemporary governance paradigms.

Unlike incremental reform trajectories observed in several high-income systems, restructuring occurred across governance, financing, PHC, and digital domains within a compressed time frame. Accelerated sequencing enhances strategic coherence by aligning reform pillars simultaneously. However, compressed timelines may limit gradual organisational learning. Institutional maturity therefore depends on embedding adaptive evaluation cycles capable of iterative recalibration.

### **5.2 Governance Differentiation Beyond Structural Separation**

Structural differentiation has advanced substantially. However, governance maturity depends on consolidating accountability mechanisms. Formal separation of regulator, purchaser, and provider roles enhances clarity but must be accompanied by standardised performance dashboards and oversight capacity.

Sustainable governance reform requires routinised monitoring processes integrated into decision-making structures.

### **5.3 Strategic Purchasing and Incentive Consolidation**

Strategic purchasing introduces stronger alignment between financing and performance. Nevertheless, long-term effectiveness depends on analytic cost-accounting systems, risk-adjusted allocation frameworks, and contract refinement cycles. Institutional consolidation will require continued technical capacity development to ensure incentive coherence across clusters.

### **5.4 Primary Health Care and System Resilience**

Reorientation towards PHC strengthens absorptive and adaptive capacity by decentralising care and supporting chronic disease management.

Behavioural transformation, workforce adaptation, and continuity-of-care measurement remain essential for durable systemic rebalancing.

### **5.5 Digital Governance and Adaptive Capacity**

Digital infrastructure enhances transparency and monitoring capacity. Its resilience contribution depends on integration within policy feedback loops rather than technological deployment alone. Institutional learning mechanisms must link digital monitoring outputs to financing and governance adjustments.

## **6. Comparative and Theoretical Implications of Accelerated Reform**

### **6.1 Accelerated Centralisation versus Incremental Reform**

Comparative experience across high-income health systems demonstrates that governance differentiation and strategic purchasing typically evolve incrementally over extended reform cycles. European trajectories, for example, often implemented purchaser–provider separation gradually, allowing for pilot experimentation, negotiated stakeholder adjustment, and phased institutional learning [5,16]. Unlike incremental governance reform models described in European contexts, the ACRM framework highlights compressed sequencing under strong central coordination as a defining structural feature, thereby distinguishing accelerated centralised reform from gradual institutional evolution. By contrast, the Saudi reform reflects compressed sequencing under strong central coordination. Governance restructuring, financing realignment, PHC strengthening, and digital integration were advanced in parallel rather than sequentially. This simultaneity enhances strategic coherence and reduces policy fragmentation; however, it also concentrates implementation risk. Incremental reform benefits from extended adaptation periods, whereas accelerated reform requires robust central oversight capacity and rapid institutional learning mechanisms. The Saudi case therefore provides a distinctive empirical example of how central orchestration can substitute for incremental experimentation when supported by political mandate and administrative capacity.

### **6.2 Institutional Learning and Implementation Depth**

Institutional transformation is not solely structural but behavioural. Formal reconfiguration of governance roles must be accompanied by managerial capability, workforce adaptation, and incentive internalisation. Accelerated reform compresses the timeline available for behavioural embedding. Implementation depth can be assessed along three dimensions:

- Technical capacity, including analytic purchasing systems, performance dashboards, and cost-accounting mechanisms.
- Organisational learning, reflecting managerial adaptation to decentralised accountability structures.

- Cultural alignment, including professional acceptance of performance transparency and incentive differentiation.

Where structural reform advances faster than behavioural adaptation, transitional performance variation may emerge. The Saudi reform illustrates the importance of embedding iterative evaluation cycles to consolidate institutional maturity beyond formal restructuring.

### **6.3 Resilience as a Dynamic Institutional Outcome**

Resilience in health systems extends beyond emergency preparedness. It encompasses anticipatory capacity, absorptive flexibility, adaptive learning, and transformative capability [2,4]. Accelerated centralised reform may enhance transformative capacity by enabling rapid structural alignment; however, sustained resilience depends on adaptive governance integration. Digital monitoring systems and performance-linked financing provide foundational tools for adaptive recalibration. Their effectiveness depends on routine integration into policy decision-making rather than technological deployment alone. The Saudi case underscores that resilience is a dynamic institutional outcome contingent on continuous evaluation and recalibration rather than static structural design.

### **6.4 Implications for High-Income Reform Trajectories**

The Saudi experience contributes to broader comparative health policy debates by demonstrating that centrally coordinated accelerated reform can achieve structural convergence with contemporary governance paradigms within a compressed timeframe. This trajectory may be particularly relevant for high-income systems seeking rapid transformation in response to fiscal pressures or systemic shocks. However, the model requires:

- Strong administrative capacity.
- Clear strategic sequencing.
- Transparent performance monitoring.

- Institutionalised policy feedback mechanisms.

Absent these conditions, acceleration may amplify implementation risk.

## **7. Strengths and Limitations**

A principal strength of this study lies in its structured application of the Accelerated Centralised Reform Model, enabling integrated cross-domain institutional analysis. Limitations include reliance on document-based sources and absence of primary empirical interviews or longitudinal quantitative performance data. As reform implementation remains ongoing, long-term outcome effects require future evaluation.

## **8. Policy Implications**

Policy consolidation should prioritise:

- Standardised national performance dashboards to enhance benchmarking transparency.
- Continued development of analytic capacity within strategic purchasing frameworks.
- Measurable continuity-of-care indicators within PHC expansion.
- Strengthened interoperability and cybersecurity safeguards within digital systems.
- **Institutionalisation** of iterative evaluation cycles to consolidate adaptive governance.

These measures will determine long-term resilience and governance maturity.

## **9. Conclusion**

Saudi Arabia's health system transformation between 2020 and 2025 represents an accelerated centrally coordinated institutional restructuring aligned with contemporary

governance models. Structural differentiation, strategic purchasing expansion, primary health care strengthening, and digital integration demonstrate significant institutional convergence. However, durable resilience depends on accountability consolidation, analytic purchasing maturity, workforce alignment, and embedded adaptive governance mechanisms. The study contributes to comparative health policy scholarship by conceptualising accelerated centralised reform as a distinct institutional trajectory capable of achieving rapid structural alignment while requiring sustained evaluative consolidation.

### **Abbreviations**

ACRM: Accelerated Centralised Reform Model

PHC: Primary Health Care

### **Declarations**

#### **Ethics approval and consent to participate**

This study relied exclusively on publicly available documents and secondary literature. No human participants or identifiable data were involved. Ethical approval was not required.

#### **Consent for publication**

Not applicable.

#### **Availability of data and materials**

All materials analysed are derived from publicly available documents and cited literature.

#### **Competing interests**

The author declares no competing interests.

### **Funding**

No specific funding was received for this study.

### **Authors' contributions**

Dr. Soltan J. Algamdi conceptualized the study, developed the analytical framework, conducted the institutional analysis, and drafted and approved the final manuscript.

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