مؤسسة الملك خالد
KING KHALID FOUNDATION

KSA CARE ECONOMY

Choices for Transformation and Growth Prospect

Policy Report | 2023

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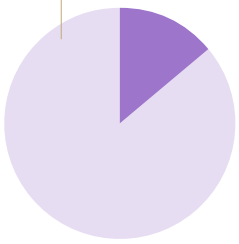
Decision-Maker Summary

Care sector

14%
of labor market
Represents
2,000,000
employees



The Saudi care economy accounts for 14% of the labor market, with 2 million male and female employees in the education, health and social services sectors. It is expected that the Saudi care economies, if appropriate investments and policies are in place, will contribute to the growth of the national gross domestic product, increasing of tax revenues, and provision of new jobs ranging between

1.5-1.6 million
direct jobs

500,000+
indirect job
by 2030

becoming one of the largest growing sectors in the future, reaching a total number of jobs that exceed the number of targeted jobs in **the tourism and culture sectors combined by 2030**.

Since the launch of the KSA Vision 2030, Saudi Arabia has been able to move forward with structural reforms that led to the development of the social protection system, including the issuance of a number of pivotal laws and legislation, a review of the social benefits system, and the adoption of financing tools and social spending. In light of these pivotal changes, the opportunity has risen to discuss the structure of the care economy in the Kingdom, in a way that ensures maximizing the economic return, governs the process of providing vital services to beneficiaries, and achieves economic and social empowerment for the beneficiaries of care services. This report discusses the foundations of the care economy in KSA in their current form, including the social, health and educational care services markets, to keep pace with the expected global growth of this economy.

In the first chapter, the report provides a reading of the local as well as globsl economic indicators of the care economy, and highlights the current components of this economy and the existing regulatory framework by reviewing national policies and the huge efforts led by the KSA Vision 2030 and its executive programs that build on the principle of improving health, social and educational services, and making the Kingdom a world leader in quality of life. The kingdom targets at least three cities to become on the list of the most liveable cities. The report then reviews the reality of care services in the Kingdom, based on field research carried out by King Khalid Foundation (KKF) throughout 2021 in 18 cities, provinces, and villages across the Kingdom, and ways to improve the social reality of these groups most in need.

Through this report, KKF presents a bundle of recommendations that together constitute two option packages that the decision-maker can consider adopting in order to reach a radical and comprehensive transformation in care economy. Adopting any of the two options would have a positive impact on the gross domestic product and tax revenues, and would provide new direct and indirect jobs ranging from 1.5 to 1.6 million direct jobs in the Saudi care economy and 500,000 indirect jobs by 2030, based on forecasts of economic models.

Through the first option, KKF proposes the establishment of a new ministry to lead the care system under the name "Ministry of Care", which can be responsible for the organization of the health and social care sector due to the need to re-establish the system, by regulating practitioners and the profession, registering beneficiaries and safekeeping their records reliably, as well as ensuring equal provision of services by establishing service delivery alliances at the national level. The second proposed option provides coordination solutions to regulate the current state of service provision between a number of operators and ministries. It is expected to improve the beneficiary's experience, support complementarity in service provision, provide new frameworks for regulating care professions and protecting their practitioners, and pave the way for building a care economy that supports job growth and achieves comprehensive economic growth. However, its financial cost is greater, as this option requires the creation of new entities concerned with social care, while the first option relied on considering care in all its specializations and expanding the scope of existing agencies to support the organization of the care sector in terms of services and work force.

Content of the Report

Report Terminology

Care Economy: Care economics (or the so-called purple economy) refers to the market of services and goods, jobs, investments, infrastructure, technology, government spending, private and nonprofit sector final consumption, as well as all the money consumers pay to care for others—from the day they are born until they die. This includes health, social care, education, unpaid home care, domestic work and volunteering. This report focuses on the official sectors of health, social care and education, without concentrating on the areas of domestic workers, volunteering and unpaid care work due to their different contexts.

Care System: All existing plans, initiatives, programs, centers and agencies concerned with organizing or providing care services (health, social, educational), governmental, non-profit or private sector.

Beneficiary: An individual who receives or is entitled to care services; Whether in the government, private or otherwise non-profit sector, including (the elderly, people with disabilities, survivors of violence, orphans, juveniles, people with limited income, orphans with special conditions, patients, addicts).

Beneficiary Relatives: The family of a beneficiary, such as parents, children, brothers and sisters, and others.

Practitioner: A practitioner who provides service to the beneficiary directly, such as a health practitioner, special education teacher, social researcher, and others.

Respondent(s): the person who voluntarily participated in the research and was included in the research sample (the beneficiary, the beneficiary's family, the practitioner).

Caregivers: Persons concerned with providing care services to those in need.

People in need of care: individuals or groups in need of a type of care, such as patients, children, the elderly and others.

Midway House: A facility equipped to receive individuals recovering from addiction who are in the transitional phase between the care setting and the community environment. They stay there for a specific period, to learn the necessary skills, to gradually reintegrate into society, and to provide better support and care for themselves.

Care Services: means the social, health and educational services provided by governmental, private and non-profit agencies through residential or non-residential centers or directly at home to the beneficiary.

Social Spending: Expenditures and investments that countries spend on social fields such as health, education, subsidies, developmental housing, and social development, primarily by the public sector, and by the private and social sectors alternately.

Social Protection: All the programs and systems provide protection for the citizen in all his life stages. It is usually distributed on three main pillars: cash and in-kind aid programs that form a social protection network, insurance programs in which the person contributes by paying part of the contributions, such as retirement and health insurance, and labor market programs such as the job search, training and qualification program.

Social Subsidies: These are the cash and in-kind benefits and aid that the government provides to needy groups of its citizens, such as: low-income people, the elderly, people with disabilities, the unemployed, and job seekers.

Introduction

Over the past ten years, the King Khalid Foundation has worked to support the development of integrated social protection policies, from proposing the necessary national measures to measure poverty in its various forms[1], proposing regulatory frameworks to tighten the social protection system, recommending the development of financing tools for the social care system by following up on social spending allocations[2] and calculating its financial multiplier[3], to exploring ways to monitor the prosperity of society members, especially those in need by proposing a national framework for indicators of prosperity[4]. With the remarkable progress in all of these prgrams and inititatives in previous years, KKF saw that the opportunity had become ripe for maximizing the impact of the returns of this progress. Through this report, KKF presents its vision of the structure of the care economy in Saudi Arabia, and how we can maximize the social and economic effects of developing social, health and educational care services, in parallel with achieving social and economic empowerment for the beneficiaries of these services.

The care economy is one of the most promising economies globally, as it is expected to outperform all other economies like the digital economy and the green economy, as the research will show. The care economy includes health, social care, education, early childhood, domestic employment, volunteering and unpaid care work. However, this report will focus on the formal sectors of health, social care and education. The report is designed to reflect in its first chapter the significant economic benefits of regulating the care economy, including jobs, wages, assets and services. The second chapter of the report deals with the reality of health, social and educational care services from the perspective of the beneficiary, his family, and the practitioner, according to the results of the qualitative field research conducted by KKF throughout 2021 in 18 cities, provinces, and villages around the Kingdom.

Building a comprehensive and integrated social protection system is one of the solid foundations and principles guaranteed by the Basic Law of Governance, and its impact extends to the Kingdom's ambitious Vision 2030. The most prominent of these foundations and principles is what the Law stipulated in terms of the state's keenness to **"strengthen the bonds of the family, preserve its Arab and Islamic values, take care of all its members, and provide appropriate conditions for the development of their talents and capabilities,"** as well as what the Law stipulated that the state guarantees **"the right of the citizen and his family in a state of emergency, illness, disability, old age, supports the social security system, and**

1. King Khalid Foundation (2017), **"Development of Government Support System: Determine the Poverty Line and the Limit of Sufficiency"**

2. King Khalid Foundation (2017), **"Social Spending and Consumption Tax Policy Paper"**

3. King Khalid Foundation (2021), **"Social Subsidies in the Kingdom of Saudi Arabia: A Financial Analysis of the Horizon of Multiplying the Effect Against Spending"**

4. King Khalid Foundation (2019), **"Justice Across Generations: Towards a National Framework for Prosperity"**

encourages institutions and individuals to contribute to charitable works." This provides every individual with the opportunities and programs necessary to protect him when he falls into a state of destitution and need, as all members of society are equally likely to fall into a state of vulnerability at some point in their lives.

KSA Vision 2030 has been developed to emphasize the centrality of the citizen and his quality of life, and to set the executive mechanisms to bring about a fundamental transformation in the health, social and developmental service system through a package of vision realization programs that devote their efforts to maximizing the impact of the social and economic development system. It strengthened its ambition in providing services to be the leader in the region and the world in the field of quality of life for citizens and residents, as it aims to have at least 3 cities be among the top livable cities in the world. In addition, the Vision and its executive programs paid a great attention to the support and social benefits system, and to ensuring that citizens and residents enjoy access to efficient health services through the "Health Sector Transformation" program. The program aims to restructure the health sector in the Kingdom to be a comprehensive, effective and integrated health system, based on the health of the individual and society (including the citizen, resident and visitor), and depends on promoting public health, preventing diseases, and improving access to health services through optimal coverage, comprehensive and fair geographical distribution.

His Royal Highness Prince Mohammed bin Salman bin Abdulaziz, Crown Prince and Prime Minister chairs the "Human Capability Development" program committee, reflecting the ambition of wise leadership in the education sector and seeking to develop the capabilities of all citizens to prepare them for the future, and seize opportunities provided by the renewed and increasing local and global demand. The program focuses on making a shift in the stages of early childhood education, lifelong learning, and the training and skills system so that its interest is not limited to primary and university education only.

رؤيـــة VISION 2030
المملكة العربية السعودية
KINGDOM OF SAUDI ARABIA

برنامج تحـــول القطاع الصحي

برنامج تنميـــة القدرات البشرية

Despite the availability of studies and research that have accurately and carefully examined aspects of improvement in the health, social and educational services system, KKF seeks, through this report, to provide a new vision for these services in line with the ambition of the related vision realization programs by introducing the concept of the care economy, so there is interdependece between all social and health services rooted-under the umbrella of care services; as is recognized internationally. This is in response to the beneficiaries' need for the integration of these services; to become active participants in inclusive economic growth rather than continuing to be dependent on receiving services. In its research, KKF relied on the qualitative research methodology, which bases its understanding and review of the care system on the experience of the main stakeholders in the system; where it carried out the method of in-depth field interviews with more than 374* beneficiaries, parents, social and health practitioners, and educators working in the care system in governmental, private and non-profit agencies.

In order to answer the research question: **"How does the beneficiary, his family, and the practitioner deal with the challenges of the care system in the Kingdom?"**, KKF took upon itself the obligation to start from the experience of the beneficiary, the experience of his family, and the experience of practitioners in the field, and end by reaching an understanding and perception of their journey in life, work, access to service, and its provision, completion or failure.

This report reviews the research results and answers the main research question, through four topics:

1. How the care system accommodates the beneficiary;
2. Workforce readiness;
3. Access pathways to care services;
4. Costs and adaptation mechanisms.

These contain the results and qualitative explorations based on mechanisms of objective analysis of the experience of the beneficiary, his family and practitioners in dealing with the challenges of the care system. The report reviews the concept of the care economy, its reality in the Kingdom, its future aspirations, and global trends around it. It also reviews the key national efforts, laws and practices, and concludes with a set of recommendations that together constitute two packages of options that the decision-maker can consider adopting to reach a radical and comprehensive transformation in the care economy.

* Unlike quantitative research, the qualitative research methodology depends on **investigating the density and depth of data and diving into the journey of the respondents for long hours**.
(Total 77 hours of data recorded for this research).

Chapter 1

What is Care Economy?

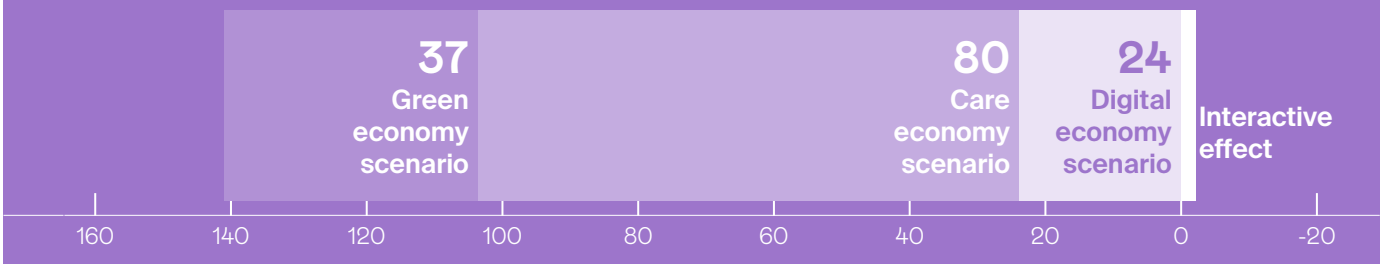
Care Economy

Care economy is one of the most promising growth sectors in the global economy. It is possible, if appropriate policies are in place, that it will have the largest share of the expected growth in the labor market until 2030, along with other emerging sectors such as green jobs (in environmentally friendly sectors, industries, services, and clean energy) and jobs in the digital economy.

Figure 1

Global job growth forecasts by 2030* (million jobs)

In the case of adopting a scenario of investment priority in achieving the goals of sustainable development 2030



* Estimates of the International Labor Organization using the economic model (E3ME model of Cambridge Econometrics) of 2022. **Global Trends in Youth Employment Report. pg. 66.**

Care economics refer to the market of goods and services, jobs, investments, infrastructure, technology, government spending, private and nonprofit sector end consumption, and the money consumers pay to care for others—from the day they are born until they die. This includes health, social care, education, unpaid home care, domestic work and volunteering. This report will focus on the official sectors of health, social care and education, without concentrating on the areas of domestic workers, volunteering and unpaid care work due to their different contexts.

The care economy **(or the so-called purple economy)** is internationally witnessing steady growth due to the shift in demographics around the world. The number of people in need of care reached 2.1 billion globally in 2015. This number is expected to increase to 2.3 billion by 2030 as a result of the increase in the number of elderly people by 100 million and the increase in the number of children (between 6 to 14 years old) by 100 million children. In addition, an estimated 100-190 million people with severe disabilities worldwide may need care throughout their lives. This is in addition to the growth resulting from the demand that is currently not covered in the global markets due to the absence of modern care services that meet the needs of consumers and the incomplete geographical coverage of care services around the world.[5]

The care market is an investment opportunity estimated at $648 billion in the United States of America alone, comparable in size to the hotel sectors, automobile manufacturing, and social media platforms combined. A group of international investment companies and stakeholders have made available packages of market studies and future forecasts that show growth prospects in the care markets. The market includes home care services, extended care services outside the home (such as nursing homes and day care centers for people with disabilities), home care services (such as care for the elderly and sick in their own homes), and child care services, in addition to a newly emerging segment of caregiver services, excluding care services in health facilities and public education.[6]

As a market, the care economy is financed by buyers, either consumers, government, private insurance companies or employers. It is possible to imagine latent consumption in the social care market according to the data of the American Consumer Survey, as 54% of clients with care responsibilities reported their willingness to spend part of their income in exchange for providing social care services that help them, whether in caring for children, home or the elderly, which constitutes around 54,000,000 consumers. Some family caregivers are reluctant to seek or purchase assistance to provide care for their loved ones, either because of the lack of innovative products that meet their needs, or more because of the stigma surrounding purchasing care services.[7]

The number of employees in the care economy in the sectors of education, health and social work around the world is estimated at 215 million people, 67% of whom are female. This global labor force accounts for 6.5% of all jobs around the world. The education sector accounts for the largest share of jobs in the global care economy with 123 million jobs, followed by the health and social work sector with 92 million jobs. The share of the care economy, in its broadest sense, around the world could reach 11.5% of the total jobs around the world if domestic workers (70 million male and female workers), workers in care tasks outside the care sectors (24 million male and female workers), and supportive jobs in care sectors (72 million male and female workers) are accounted for.[8]

5. **Care Work and Care Jobs: For a Decent Work Future** - ILO Report (2018), Executive Summary.

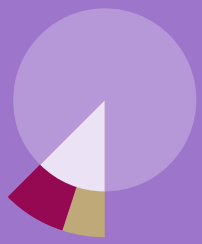
6. **The Investor's Guide to the Care Economy** – Investing.care/The Holding Company

7. **The Potential Market for Care Services Study -** Holding Company

8. **Care Work and Care Jobs: For a Decent Work Future** - ILO Report (2018)

Saudi Care Economics Dashboard

Jobs



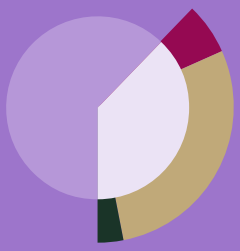
2,000,000 employees

1,200,000 employees
in education sector

800,000 employees
in health and social work sectors

Together, they make up 14% of jobs in the labor market, with nationalization ratio 76%

Need



8,200,000 citizens need care

700,000 disabled people

6,200,000 children

1,300,000 elderly

not including

1,600,000 citizens
diagnosed with chronic diseases

Growth prospect

Government social spending equals

10% of the gross domestic product at a value of
393 billion riyals

Spending

Making

1.5-1.6 million
direct jobs available by 2030

+500,000
Indirect jobs by 2030

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Major Non-commercial Assets

Kindergarten schools

2,295

Public education schools

27,235

Literacy and adult education centers

2,860

Universities

29

Technical and vocational training facilities

260

Primary health care centers

2,390

Hospitals

284

Elderly care homes

12

Social observation homes

17

Comprehensive rehabilitation centers

38

Day care centers for people with disabilities

199

Nonprofit organizations providing social services

850

Nonprofit organizations providing health services

241

Nonprofit organizations providing educational services

95

Nonprofit scientific and health organizations

253

A

Reality of KSA Care Economy

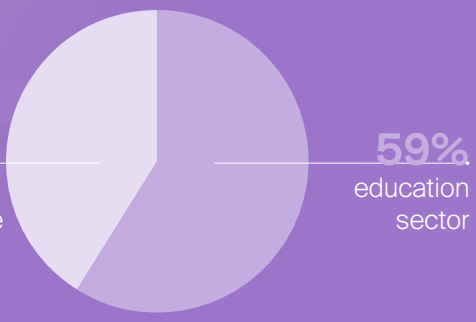
halfway through 2021, about 2 million male and female employees worked in the Saudi care economy, constituting 13.7% of the total jobs in the Saudi labor market. Males account for 58% of care jobs in the Kingdom. the rate of Saudization in the kingdom's care sectors was recorded at 76% of jobs occupied by Saudi men and women[9]. There are 16,000 graduates seeking jobs after attaining specialization in health and walfare[10], and 118,000 job seekers among Saudi graduates in education specializations.

Jobs of Care Economy

1

The workers

Figure 2
Saudi Care Economy Employees



In detail, the Saudi education sector contains more than 1.2 million jobs, while the health and social work sector in the Kingdom contains more than 800,000 jobs. The demand for care professions is expected to rise in various sectors, institutions and industries of the economy.

9. Based on the research team's analysis of the results of employment rates published in the **Labor Market Survey Q2 2021** and based on **mid-2021 population estimates** by the General Authority for Statistics.

10. **International Standard Classification of Education**, UNESCO (ISCED-13) and the **Unified Saudi Classification for Educational Levels and Specializations**

Types of specializations, professions and jobs in the care economy

Care professions include different and branched areas and activities. They belong to more than one main group in the lists of professions, ranging in their job levels, professional careers, technical competencies, and necessary qualifications:

Managerial group
Such as managers of health services, social care and education

Specialists group
Such as doctors, surgeons, nursing and midwifery specialists, pharmacists, teaching and university and general education professionals

Technicians group
Such as laboratory technicians, eyeglass lens fitters, medical records technicians, and ambulance attendants

Office support workers group
Such as patient receivers, data entry and stock keepers

Service workers group
Such as childcare specialists, teacher's assistants, care assistants for the sick, elderly and disabled, personal care workers and first aid assistants [11]

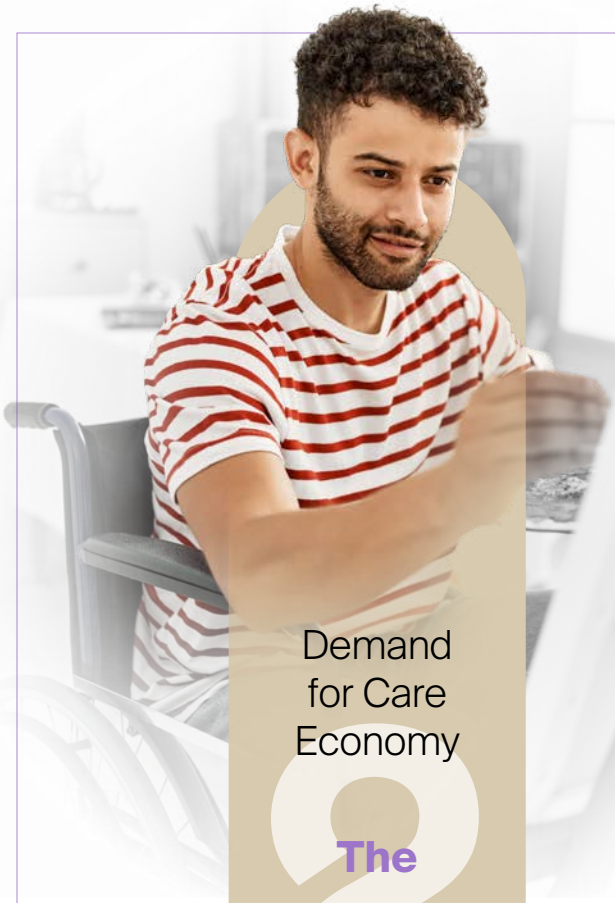
Health and welfare specialties include:

- Dental studies
- Medicine
- Nursing and midwifery
- Medical diagnosis and treatment technique
- Therapy and rehabilitation
- Pharmacy
- Traditional and alternative medicine and treatment
- Caring for the elderly and adults with disabilities
- Child care and youth services
- Social service and counseling
- Interdisciplinary programs and qualifications
- Social policies
- Psychological health

Education specialties include:

- Educational sciences
- Teacher training
- Curriculum and teaching methods
- Educational measurement and evaluation
- Education technologies
- Learning resources
- Early childhood
- Special education
- Early intervention
- Learning difficulties
- Multiple disabilities
- Applied behavior analysis
- Primary education
- Adult and continuing education
- Socials
- School activity
- Physical and artistic education
- Science
- Islamic culture and studies
- Languages
- Preparation of school laboratories

11. **Saudi classification of occupations,** General Authority for Statistics.



Demand for Care Economy

2 The beneficiaries

The number of people in need of care in the Kingdom would be estimated at approximately 8.2 million males and females - with varying degrees of urgency. The most recent survey of persons with disabilities in the Kingdom for the year 2017 indicates that there are 700,000 Saudi persons age (15 to 59 years) with disabilities who face at least one difficulty, regardless of its severity. In order to understand the total number of Saudis in need of care, we must take into account the number of children (under 15 years old), totaling 6.2 million, and the elderly (60 years and over), totaling 1.3 million[12]; these are the categories that are usually classified as needing one aspect of care. This is without counting the number of sick people diagnosed with one of the chronic diseases such as diabetes, cancer, hypertension, and cardiovascular diseases, totaling 1.6 million male and female citizens (15 to 50 years old)[13]. This demand for care may be temporary, as is the case with children, victims of violence, and juveniles (until puberty, recovery, or the end of the period of implementation and independence on their own), but it may be permanent for life, as is the case with some persons with disabilities and the elderly.

It is expected that the number of consumers in the care market and those in need of care around the Kingdom will grow steadily during the coming decades, especially in the health and social service sector, constituting a favorable economic opportunity. Demographic trends indicate that the Kingdom has one of the highest population growth rates in the world[14]. This may put pressure on social infrastructure, health and education assets, and care services in the event that no proactive investments are made to meet the upcoming demand for care markets.

12. **Population Characteristics Survey** 2017 and the **Persons with Disabilities Survey** 2017, issued by the General Authority for Statistics.

13. Family Health Survey 2017, General Authority for Statistics.

14. **The State of Saudi Cities Report** 2019 issued by the Ministry of Municipal and Rural Affairs (formerly) and the Future of Saudi Cities Program in cooperation with the United Nations Human Settlements Program (Habitat), p.3.

The Kingdom is expected to face significant changes in the demographics that will have a huge impact on the economics of care, especially the accelerated growth rate of the elderly population (65 years and over). The elderly population is expected to rise from 3.1% of the population in 2015 to 6.6% of the population in 2030, and then to 16.7% of the population in 2050.[15] Therefore, it can be predicted that the demand for care economies and the health, rehabilitation and social services sector will increase rapidly during the coming decades.

This is in addition to the investments expected to be made as part of the health sector transformation program to achieve the target of reaching 88% of residential communities covered by basic health care services, including remote areas, by 2025.[16] As well as the investments expected to be made as part of the human capacity development program to raise the level of quality in public and university education, training and lifelong learning programs, and improve equal access to education. The program aims to double the enrollment rate in kindergarten education from 21% to 40%, and raise the percentage of students with disabilities enrolled in educational institutions from 1.4% to 20% by 2025, and reduce the disparity in student performance and quality of education between the regions of the Kingdom.[17]

15. The State of Saudi Cities Report 2019 issued by the Ministry of Municipal and Rural Affairs (formerly) and the Future of Saudi Cities Program in cooperation with the United Nations Human Settlements Program (Habitat), p.5.

16. The State's General Budget Statement for the fiscal year 2022، issued by the Ministry of Finance, p.68.

17. Targets of the **Human Capacity Development Program**, KSA Vision 2030 website.

Financing of Care Economy

3 The consumers

With respect to financing, the largest spender on the care economy is the kingdom's general budget, due to the kingdom's government prioritizing its citizen's enjoyment of the right to development, education, and health. The Basic Law of Governance stipulates that "the State provides public education and is committed to combating illiteracy" and that "the State is concerned with public health and provides health care for every citizen."

The latest forecasts for the end of the fiscal year 2022 indicated a total government spending of 393 billion riyals on the education, health and social development sectors[18], constituting approximately 10% of the expected nominal GDP for 2022[19] - without counting the huge spending on health and education services in other sectors, such as hospitals and health services in the Ministry of Defense, the Ministry of the Interior, the Ministry of National Guard, and others, as detailed data about it is not available.

According to the outcomes of the Human Capacity Development Program, "The Kingdom spends a high percentage of its GDP on education, but the rate of spending on early childhood represents only 0.3% of GDP, while the average spending on early childhood education in the OECD countries is 0.8% of GDP, nearly three times the spending in the Kingdom. In addition, kindergarten schools in the Kingdom encounter challenges related to the quality of infrastructure and support services."[20]

The contribution of the private sector and the non-profit sector in investments directed to the care sectors is still below expectations. Therefore, the KSA Vision 2030 has allocated a set of initiatives in the vision realization programs to facilitate, support, motivate and attract investments in health, social and educational services from non-governmental sectors.

18. **The State's General Budget Statement for the fiscal year 2022,** issued by the Ministry of Finance, p.68.

19. By calculating the ratio of spending to the estimates of the Ministry of Finance for the expected nominal GDP indicator for 2022, previous reference, p. 21.

20. **Human Capacity Development Program Implementation Plan Document,** p. 29.

The private sector contribution to total social spending was 1.4% at the end of 2020. The National Transformation Program aims to raise it to 1.8% by 2025.[21] The percentage of private sector participation in spending on education is 1.1%. The Human Capacity Development Program aims to raise it slightly to 1.2% by 2025.[22] The Health Transformation Program works on a private sector partnership initiative in nine key areas of care, including rehabilitation, long-term care, home care, and extended care.[23] The Health Insurance Council aims to double the volume of insurance coverage in private health insurance from 9.8 million beneficiaries in 2021 to 21.7 million beneficiaries by 2030.

The King Khalid Foundation's initial estimates indicate that the total expenditure of non-profit sector organizations in 2021 has exceeded 30 billion riyals[24]. At least half of it can be classified as care economy expenditures—more than 15 billion riyals. Where non-profit organizations working in the field of social services, health and education account for almost half of the activities of the non-profit sector (51% of volunteers, 45% of revenues, 44% of expenses, and 39% of beneficiaries)[25] - without counting non-profit organizations that provide social services and classified under "development and housing" due to the lack of detailed data.

As for consumer spending, the average out-of-pocket purchasing of care services in the kingdom accounts for 4.3% of a household's monthly expenditure; Divided between 2.9% on education expenditures, 1.4% on health expenditures, and less than 0.2% on social services. In order to enable the demand for care services, the Custodian of the Two Holy Mosques King Salman bin Abdulaziz issued in 2018 a royal order requiring that the State bear the value-added tax on citizens benefiting from private health services and private education.[26]

According to data from the Saudi Central Bank, sales of points of sale in the Kingdom exceeded 35.3 billion riyals in the health sector, and 6.5 billion riyals in the education sector during 2021 (data for the social services sector is not available). Consumer payments for education services via SADAD amount to 788 million riyals for the same period (as it exceeds 160 million riyals per month in the back-to-school seasons) – without counting the transfers of the SADAD system for health and social services due to the lack of detailed data.[27] This data provides an incomplete picture of the volume of household spending on the care economy due to the lack of detailed data and the difficulty of estimating cash payments for those services.

21. National Transformation Program Annual Report 2021, p.130.

22. Human Capacity Development Program Implementation Plan Document, p.25..

23. Health Sector Transformation Program Implementation Plan Document, p.69.

24. Non-Profit Sector Prospects Report 2023, KKF, under publication

25. Based on the relative distribution of these variables according to the classification of non-profit organizations based on the non-profit organizations survey 2018, issued by the General Authority for Statistics.

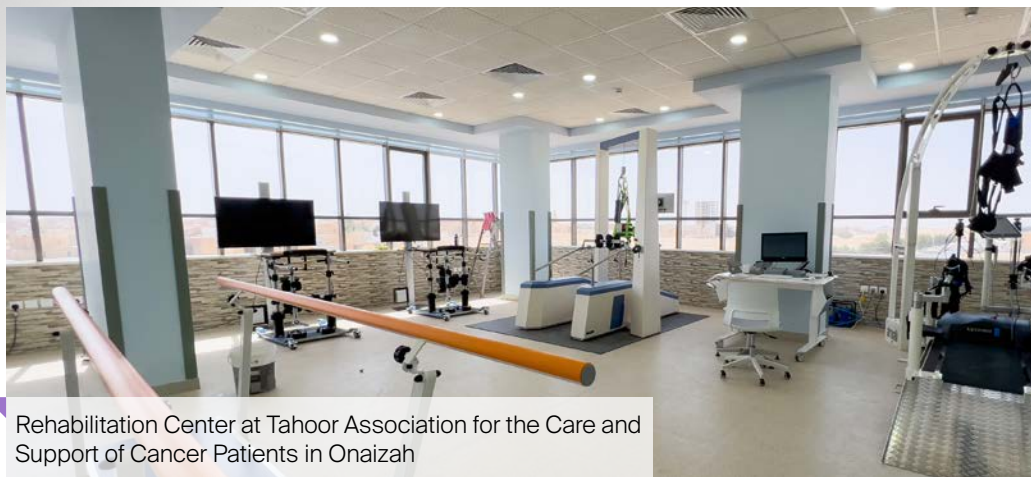
26. Royal Order No. (A/86) dated 18 Rabee II 1439 AH.

27. Monthly Statistical Bulletin November 2022, tables 26-30, 1439 AH

The components of the care services system in its current condition in the Kingdom are complex and difficult to enumerate, in addition to the ambiguity and dispersion that afflicts the researcher about existing or prospective government plans and initiatives to develop the care system. It is noted that there is no programmatic or organizational umbrella to lead the care system with the diversity of its educational, social and health services. This may be due to the distribution of treatment plans between the Health Sector Transformation Program (for the health aspect), the Human Capacity Development Program (for the educational aspect), the National Transformation Program (for the social aspect), and the Privatization Program (for the operational aspect). Ministries and government agencies related to the care economy have worked on national and institutional strategies that translate the important care economy into initiatives, projects and plans.

Organizations of Care Economy

Servicer providers and supervisors



Rehabilitation Center at Tahoor Association for the Care and Support of Cancer Patients in Onaizah

However, the prevailing trend in government programs, strategies, and policies under development is to tighten organizational roles, reduce operational roles, and shift towards assigning the process of service provision to the private and non-profit sectors, thus making government assets available to them; with the aim of improving the quality of services and reducing costs for the government. This trend is in line with the focus of the KSA Vision 2030 on concentrating the government's efforts on legislative, regulatory and oversight roles, and opening the way for the private and non-profit sectors to assume service-providing roles.

The privatization program identified the sectors of education, health, human resources and social development as sectors targeted for privatization. The program introduced and studied a number of health and education initiatives for privatization. For example, the initiative of the hemodialysis program to serve 7,000 beneficiaries of patients with chronic kidney failure, the operation of radiology departments in partnership with the private sector to meet 50% of the demand, and the expansion of Al-Ansar Hospital in Madinah to 244 beds, in cooperation with the Ministry of Health. This is in addition to allocating medical services to Saudi Airlines, in cooperation with the Ministry of Transport and Logistics; and financing the design, construction and operation of 60 schools in partnership with the private sector, in cooperation with the Ministry of Education. It also launched a social case management tender in cooperation with the Ministry of Human Resources and Social Development.[28]

In addition, organizational arrangements have already been made to convert King Faisal Specialist Hospital and Research Center, as well as King Saud University, the Capital Model Institute, and Al-Thaghar Model Schools, into non-profit institutions. It is expected that in the coming years, more educational and health facilities and services will be converted to a non-profit business model.

In terms of social services, the Ministry of Human Resources and Social Development has assigned the services of fostering orphans to the Al-Wadad National Association, as the association will assume the responsibility of fostering all orphaned children who have lost parental care across the Kingdom. The Ministry also launched a tender to assign the services of comprehensive rehabilitation centers to the private and non-profit sectors, and opened the first club for the elderly with the Wahat Al-Wafaa Association to support the elderly, and launched the first two projects to establish and operate a social club for the elderly in Riyadh and Jeddah. This is in line with what was stated in the Ministry's social development strategy that "over the next ten years, these services will be increasingly provided by non-governmental organizations, with the Ministry assuming the role of supervisor of the sector. The main beneficiaries were identified as orphans, juveniles, people who are subjected to domestic violence, people with disabilities, the elderly, and beggars."

The Ministry aimed to build the capacities of non-governmental organizations to become the main service providers, focus on individuals' access to a decent life free from abuse and violence, and enable individuals to be self-reliant as much as possible and access support when they need it, while ensuring equal opportunities for economic and social engagement.[29] The strategy demonstrates that the decision-maker feels the deficiencies in the current service system, some of which we will review in the next chapter from the point of view of the beneficiary, his family and practitioners, and the need to shift towards the beneficiary's centralization, independence, inclusion and protection from abuse and negligence.

The strategy will face the challenge of testing the hypothesis that the non-profit sector and its organizations are ready to assume huge operational roles, especially with the current growing demand for social care services. This will mean the necessity of searching for innovative and serious mechanisms for capacity building, qualifying non-profit competitors, encouraging the formation of alliances between the private and non-profit sectors, and applying the policy of project separation so that small and medium non-profit organizations with limited geographical scope and limited technical and financial capabilities can compete to provide services within their local community.

28. **Privatization Program Document,** p.32.

29. **Social Development Sector Strategy Document,** Ministry of Human Resources and Social Development

5 Assets of Care Economy

Infrastructure

King Abdullah Center for Oncology and Liver Diseases, King Faisal Specialist Hospital and Research Center, Riyadh

Saudi Arabia has huge resources such as facilities, buildings and establishments dedicated to providing care services, most of which are managed by the Ministries of Health, Education, Human Resources and Social Development. It is difficult to count these assets and institutions, due to the disparity of their data, the difficulty of accessing them, and their obsolescence. The research team was unable to access adequate data on the assets of the privately owned and non-profit care infrastructure. This section reviews the data obtained from its published sources on the assets of government care.

Health, educational and social care facilities

under the Ministry of Education, the Technical and Vocational Training Corporation, the Ministry of Health and the Ministry of Human Resources and Social Development in 2019, including day care centers that fall under the Ministry, charities, and social development committees

More recent data has not been accessed[30]

Kindergarten schools **2,295**	Primary schools **12,271**	Intermediate schools **7,044**	High schools **3,490**	Literacy and adult education centers **2,860**	Special education programs **3,007**
Secondary courses **4,430**	Universities **29**	Technical and vocational training facilities* **260**	Primary health care centers **2,390**	Hospitals **284**	Cardiology centers **11**
Oncology centers **4**	Diabetes centers **39**	Dialysis centers **204**	Dental centers **42**	Medical rehabilitation centers **14**	Central laboratories **13**
Forensic centers **20**	Anti-smoking clinics **494**	Preventive health control centers at the ports **28**	Social education homes for boys and girls **21**	Orphanages (model education institutions) **1**	
Social guidance facilities **5**	Social care homes for elderly care **12**	Social nurseries **6**	Social observation facilities **17**	Family protection **34**	
Social hospitality **2**	Girls' welfare institutions **9**	Vocational rehabilitation centers and departments **7**	Comprehensive rehabilitation centers **38**	Social follow-up and anti-beggary offices **12**	
Day care center for people with special needs **199**	Medical and social health services **43**	Social development centers and social service centers **41**			

30. Source: **Open Data Portal and Statistical Yearbook of the General Authority for Statistics,** separate tables, 2019. It does not include health facilities affiliated with the Ministry of Education, nor the medical services of the Ministry of Defense, the Ministry of National Guard, and the Ministry of Interior, nor the facilities of King Faisal Specialist Hospital and Research Center, nor the Royal Commission Hospitals of Jubail and Yanbu, nor Aramco hospitals, nor the health facilities of the Ministry of Sports, nor the medical services of Saudi Airlines.

* Note: Technical and Vocational Training Corporation data is updated for the year 2020, according to the **Introductory Guide**.

A number of non-profit organizations that are active in the field of Care Economy and serve its practitioners and beneficiaries operate in the Kingdom, including Prince Sultan City for Humanitarian Services, the Health Endowment Fund, King Salman Social Center, the National Charitable Foundation for Home Health Care, the Saudi Association for Social Studies, the Association of Social Workers, Momarydhoon Association, and the Association for Safety and Facilities Management in health facilities (FEMSA). In addition to 850 non-profit organizations providing social services, 241 non-profit organizations providing health services, 1183 non-profit organizations working in the field of social development, and 95 non-profit organizations working in the field of education and research. In addition to 253 scientific societies and health specialization societies.[31]

Examples of some non-profit initiatives in the field of providing care services:

Jaleesa

An innovative solution model that provides support in providing in-home care services, a digital platform that connects parents who want a certified and trained babysitter to take care of their child or who are looking for a nursery near their home or workplace. In addition, in coordination with the Ministry of Human Resources and Social Development, the Jaleesa Company provides job opportunities and then works to rehabilitate and train the babysitters.

Onaizah Association for Development and Human Services (TAHEEL)

A system of specialized, non-profit centers, integrated to provide rehabilitation, care, education and empowerment services for different groups of people with disabilities from early childhood to adolescence.

HELP CENTER

A non-profit organization that takes care of its beneficiaries with intellectual disabilities, starting from childhood, and provides continuous development services for them and their families, and gives them a better opportunity to play, learn, and work in a safe environment.

31. **Non-Profit Organizations Directory,** National Center for the Development of the Non-Profit Sector

6 Regulatory framework

Legislation of Care Economy

It is noted that the legislative and legal system for the beneficiaries of care services has been completed in terms of issuing regulations for the beneficiary groups. The last of these was the system of elderly rights and care. However, the research team did not find studies that examined the quality of implementing these systems or the services provided to beneficiaries of care after their issuance. The problem, when it comes to government programs and policies, is the failure to investigate the needs of these less fortunate groups and to include them directly in the strategic objectives of the programs, projects and plans of government agencies. It is also noted that there are no inquiries or surveys of the beneficiaries' opinion about the design of the services provided to them, and the absence of measuring the impact of these projects and changes, as well as the absence of what is known as a participatory approach with beneficiaries in developing programs and interventions.

The current regulatory framework for the care system contains a number of Saudi laws that provide protection, ensure that the population enjoys rights, and take care of the interests of the beneficiaries of the care system. These include the system of care for the disabled, the system of protection from abuse, the system of mental health care, the system of child protection, the system of juveniles, the system of rights and care of the elderly, the health system, and the education system. In addition to the issuance of a set of laws and regulations that set the organizational, institutional and operational frameworks for the care system, including the Saudi Commission for Health Specialties Law, the Education and Training Evaluation Commission Regulation, the Health Professions Practice Law, the Saudi Center for Accreditation of Healthcare Facilities Regulation, the Health Jobs Regulation, and the Educational Jobs Regulation.

A license was also granted to establish the Health Holding Company, to be the health care provider for the beneficiaries, after transferring the employees and workers specialized in providing health care services to the company and its health complexes. In light of this, the regulation of the National Health Insurance Center was issued, reaffirming the role of the Ministry of Health as a regulator, supervisor and control body for public and private health institutions. The jurisdiction of the Health Sharia Board to consider professional errors and to ensure the professional liability (civil and criminal) of the health practitioner was transferred to the general judiciary, with the expansion of the application of compulsory cooperative insurance against medical professional errors by health practitioners.

However, the regulatory framework for social care services has not kept pace with this level of maturity. There is still an absence of a system for practicing social professions, and the absence of a professional body specialized in regulating social professions. This limited the development of human resources in the social field, and caused the absence of licensing, follow-up, professional examinations, and continuous learning requirements for social practitioners, and consequently led to a decline in service quality. The Saudi Commission for Health Specialties currently provides classification services for the degree of "assistant specialist, specialist, senior specialist, and consultant" based on bachelor, master's, and doctoral degrees in the fields of sociology, social work, and psychology. However, the Commission mainly targets workers in health facilities.

The Council of Ministers recently issued a decision to establish a unit for social specializations, which proposes the foundations and criteria for practicing social professions, coordinates with educational sectors, studies licensing applications, evaluates professional social qualifications, and encourages and supports the preparation of social and human scientific research. The Ministry of Human Resources and Social Development, five years after the unit assumes its duties, shall submit a report to the Council of Ministers to consider transforming the unit into an independent organizational entity or continuing to work through it.

Mobile clinics of the Hayat Charity Association in Medina

The implementation of the professional license for educational positions has begun by the Education and Training Evaluation Commission, after its regulatory arrangements stipulated its authority to "prepare and approve professional standards for the practice of teaching and training professions, and follow up on their application" and "build and apply tests for the professional competence of teachers, and the like, in Education, trainers, and the like, in training, and the issuance of special certificates. The introduction of professional standards, tests and licenses will raise the level of professionalism in the education and training professions.[32]

There is no specialized center for the accreditation of facilities providing social care services, nor clear mechanisms for insurance against (and accountability for) professional errors by social practitioners. In addition, a wide number of non-health social care services are not covered by the mandatory health insurance policy from the Health Insurance Board, but acute psychological conditions are covered during the policy period by a maximum of 15,000 riyals, and 5,000 for non-acute psychological conditions for four sessions with medications during the policy period.

Care facilities have translated these regulations, rights, policies, plans, and programs into projects, work mechanisms, and technical, administrative, and medical protocols that take into account the beneficiary's enjoyment of appropriate and comprehensive care services. This includes policies and procedures for protecting and caring for vulnerable patients (who are subjected to violence, neglect and abuse) in most government hospitals, and procedures for admitting cases and beneficiaries and treating them in social homes. Despite the absence of specialized studies on the impact of applying these policies and procedures, and the extent of their enforcement on the ground, the results of the qualitative research that we will review in this report requires deliberation, consideration, and care, and urges putting the experience of the beneficiary, his family, and practitioners under scrutiny.

32. **Professional Standards and Practices for Teachers in the Kingdom of Saudi Arabia",** Education and Training Evaluation Commission, 2017.

B

Future Aspirations of Care Economics

1 Outlook for growth prospects

Today, the world stands at a crossroads. The care system, with its health, social and educational systems, is under high pressure as a result of the increasing demand for services compared to high costs, the scarcity of specialized manpower, the low quality of jobs, and the increasing burdens of care on families and individuals. Foresight of the prospects for demand for care services also indicates that it is trending towards growth, due to the accumulated gaps in the qualitative geographic coverage, and due to the changing global demographics with the increasing number of the elderly.

It is expected that the increasing pressure on health and social services will lead to a decrease in the quality of jobs for workers in care professions, which necessarily leads to a decrease in the quality of care, and then a decrease in the quality of life of care recipients, caregivers and their families. For example, increased business volume and tight nursing schedules lead to a higher risk of patient death.

Nurses and midwives constitute the largest percentage in the group of health care professions. Nursing is the most feminine job, but their wages are low, and they are forced to work for more than one daily period, to work additional hours, or to obtain an additional job. Consistently around the world, women do 76% of all unpaid care work; 3 times more than a man.

When working hours in income-generating jobs and unpaid care times are calculated together, it turns out that the working day for women (7 hours and 28 minutes), on average, is longer than the working day for men (6 hours and 44 minutes). Therefore, women suffer from what is called “time poverty”; women devote more time to unpaid care work than men in all regions of the world.[33]

33. The report **"Care Work and Care Jobs: for a future of decent work"** - ILO Report 2018, p.53.

Figure 3

The number of working hours per day for women and men around the world between paid jobs and unpaid care

Estimates based on time use surveys in more than 64 countries indicate that the total number of hours used for unpaid care is 16.4 billion hours worked per day. That equates to an estimated two billion full-time employees every day without pay. When estimated at the minimum wage rate, hours worked equal 9% of world GDP; i.e. equivalent to 11 trillion US dollars.

In sum, the arduous and exhausting work of unpaid care leads to substandard levels of care that harm those in need of care such as infants, children, people with disabilities, and the elderly. In addition to their harm to the caregivers themselves. Experts expect pressure on job growth in the future, and the replacement of some of them due to technology developments and artificial intelligence; Care jobs will be an opportunity to create good and stable jobs in the future that artificial intelligence will not be able to do, due to the emotional connection and human interaction between the recipients of care and its beneficiaries.

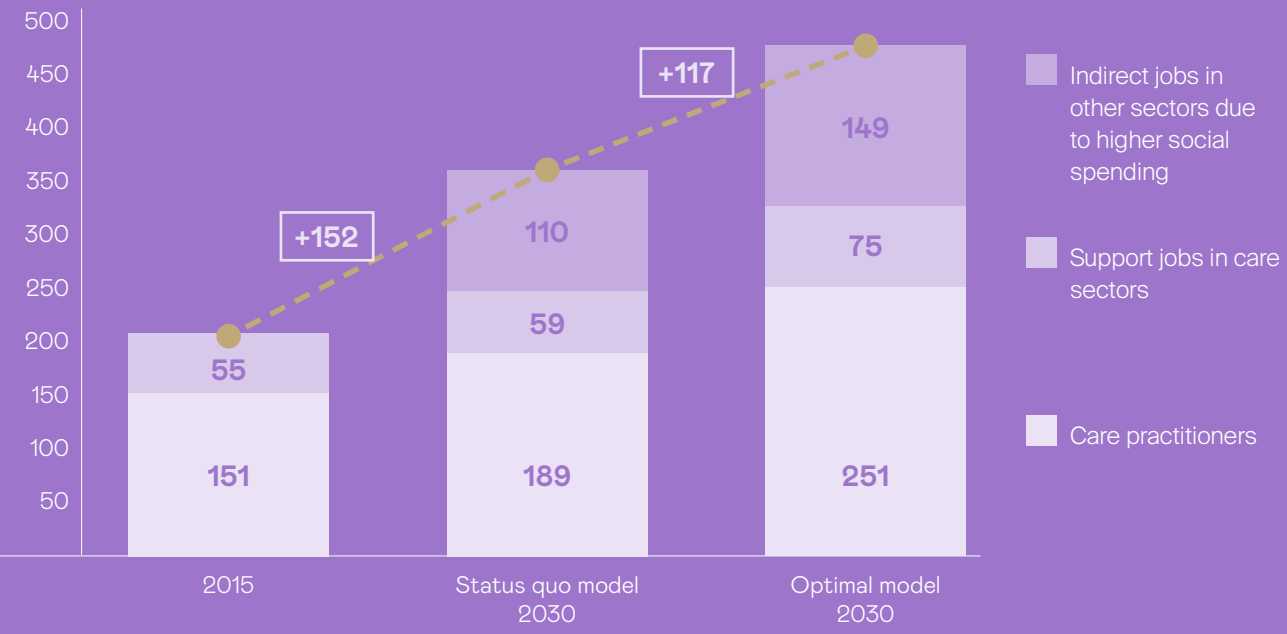
In order to anticipate future prospects, the International Labor Organization[34] (ILO) worked, after examining the numbers and facts above, on two economic modeling. The first model anticipates the effects of maintaining the status quo as it is. The other anticipates the effects of adopting bold reform steps for care economies, by improving policies, services and infrastructure related to care. This means directing resources to recognizing, reducing and redistributing unpaid care work (through money, services and time).This includes:

- Improving public services provided by the state to care for children, the elderly, social subsidies, benefits for those with family care responsibilities, and benefits for unpaid care workers and those in need of care.
- Investing in social infrastructure such as hospitals, schools, extended care homes, and other buildings and facilities that reduce the burden of care on families.
- Adopting family-friendly labor market policies that balance employee hours between working hours in the job and hours of caring for the family and taking care of its members in need of care.
- Changing society's impressions and perceptions about the appropriate distribution of time between work and family responsibilities between women and men.
- Adopting a huge investment package that puts us on the right track to achieve the Sustainable Development Goals: Goal 3 (Good Health and Well-being), Goal 4 (Quality Education), Goal 5 (Gender Equality), and Goal 8 (Decent Work and Economic Growth). These investments are essential to achieving overall access to health and educational services.
- Taking care of caregivers and extending social and labor protection to them, encouraging the professionalization of social professions, avoiding reducing the skills required to practice professions, and avoiding austerity policies that lead to reducing salaries or reducing the duration and quality of service.

34. The report **"Care Work and Care Jobs: for a future of decent work"** - ILO Report 2018, p.53.

Figure 4

Projected job growth between 2015 and 2030 in the care economy and related jobs, a comparison of two technical models.



The optimal model calls for spending the equivalent of 18.3% of GDP on providing care services by 2030, which will result - God willing - in creating 269 million new jobs globally, bringing the total number of care jobs around the world to 475 million jobs. While the status quo model will lead to less ambitious growth figures.

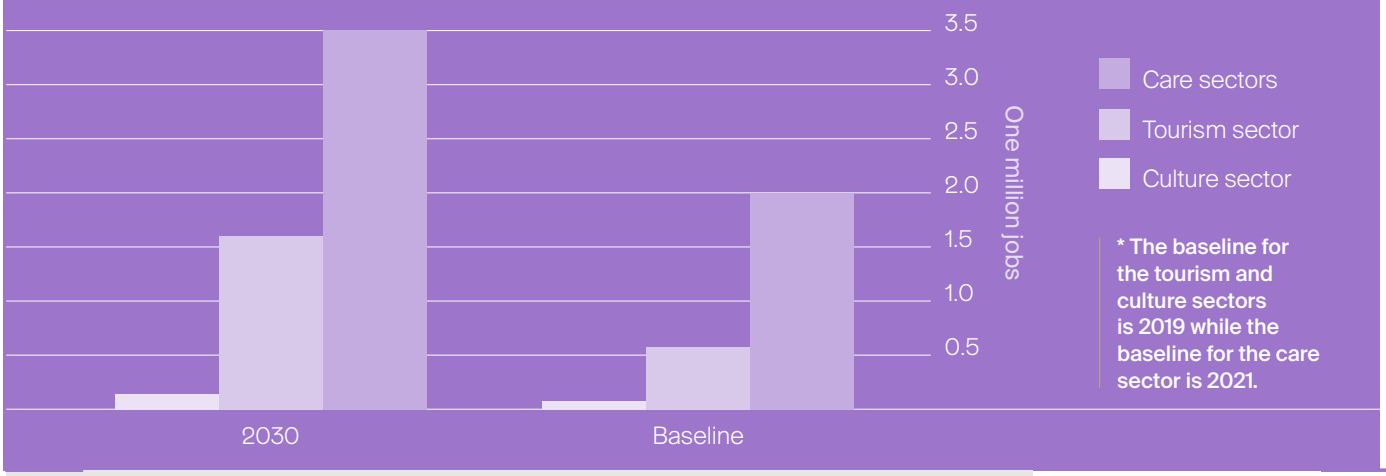
Using the same assumptions of the ILO's economic model and the observed growth trends, the "optimal path" option is expected to create at least 1,500,000 new jobs globally in the Saudi care economy, driven by the increase in government social spending, the coverage of health services for the population (especially extended care centers, home health services and community care), the growth of early childhood care services and pre-primary education, the growth of care services for the elderly and people with disabilities, research and innovation activities in social entrepreneurship, and the increase in the private and non-profit sector's contribution to social spending and non-oil GDP, increased consumer spending by individuals and families on care products and services, increased spending by employers on comprehensive insurance coverage expenses for social and health care services for their employees, and the possibility of the Kingdom becoming a destination for teaching care specialties and for therapeutic and rehabilitative tourism.

In a recent working paper on analyzing the gains and costs of adopting transformative government policy packages in the care sector and their impact on the macroeconomy in 82 countries (including the Kingdom of Saudi Arabia), a researcher estimated the need to inject new investments equivalent to 1.5% of GDP annually in early childhood care and education (ECCE), and investments equivalent to 2.5% in long-term care (LTC) by 2035. This will result in the creation of 300 million jobs worldwide by 2035, with returns expected to be recovered through the expected increase in tax returns. The paper estimates for the Saudi care economy mean that the Kingdom needs to spend the equivalent of 4.4% of the gross domestic product on ECCE and LTC by 2030.[35] The paper estimates that this will result in the creation of 1.5 million direct jobs and 500,000 new indirect jobs in the Kingdom by 2030.[36]

When comparing the above technical models that attempted to anticipate economic benefits from adopting expansionary policies in care economics and their effects on the Saudi economy, it can be concluded that economic forecasts predict a net positive impact on GDP, tax revenues, and the creation of new direct and indirect jobs between 1.5 and 1.6 million direct jobs and 500,000 indirect jobs by 2030. As such, the Saudi care economy will be one of the largest growing sectors in the future, with a total number of jobs (3.5 direct jobs) that exceed the number of targeted jobs in the tourism and culture sectors combined in 2030 (1.6 million targeted jobs in the tourism sector and 150,000 targeted jobs in the culture sector).[37]

Figure 5

Expected growth in the Kingdom until 2030 in jobs in the care sectors, the tourism sector, and the health sector*

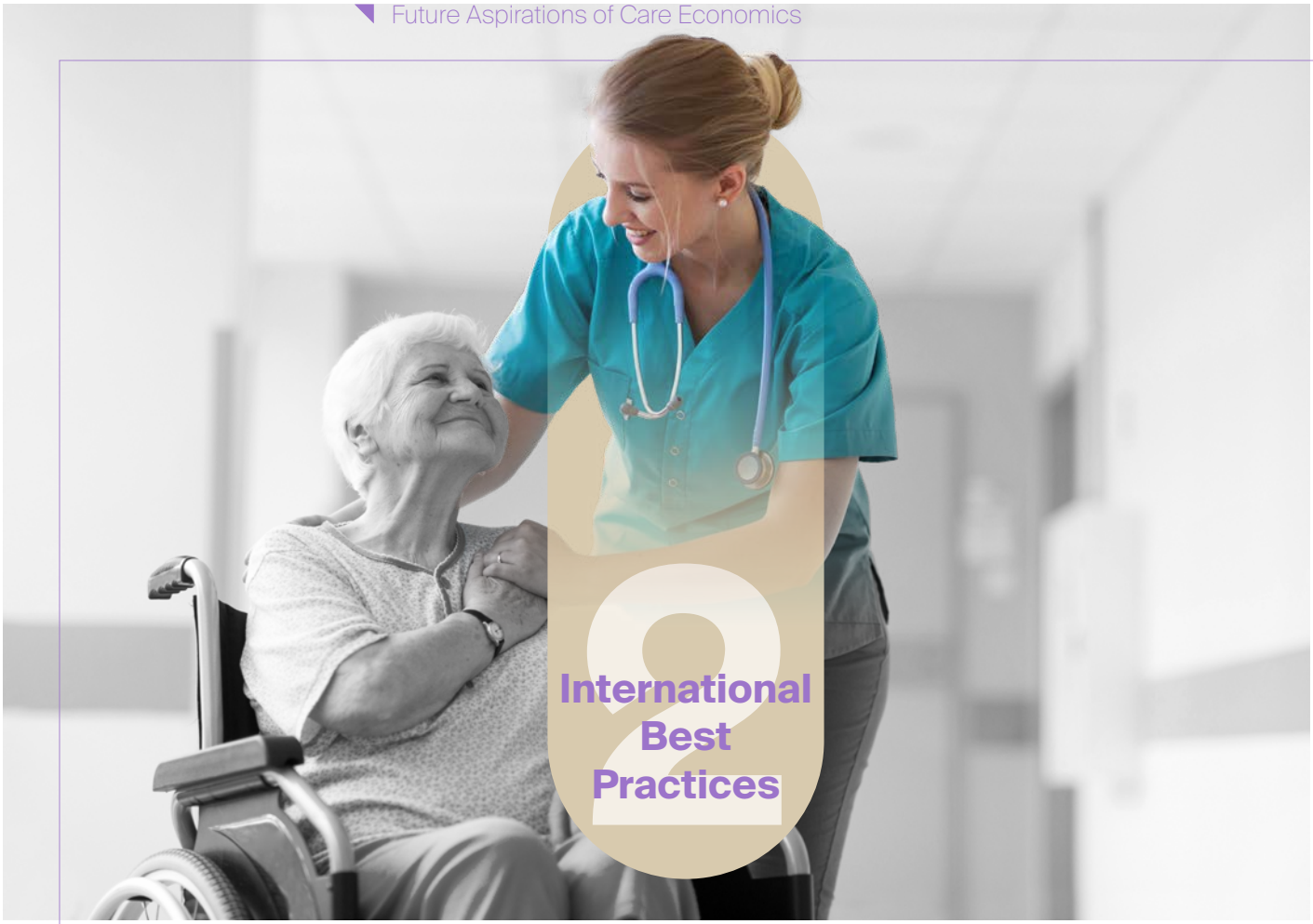


* The baseline for the tourism and culture sectors is 2019 while the baseline for the care sector is 2021.

35. 1.85% on ECCE and 2.58% on LTC

36. ILO Working Paper **"Costs and Benefits of Investing in Transformational Care Policy Packages: A Macroeconomic Modeling Study for 82 Countries"** by Jerome de Henao, 2022.

37. According to the 2030 targets for the tourism and culture sectors, contemplated in the **"Quality of Life Program Document"**.



2 International Best Practices

Several countries have sought to change some public policies and adopt a package of reforms, after observing the division of responsibility for supervising the health and social care sectors between a number of ministries. This led to duplication of service, dispersion of the beneficiary, and increased costs. Among the most important of these trends is striving towards integrating care and health systems, developing strategic plans for the workforce in the areas of care, enacting regulations for practicing and protecting care professions, and doubling investment in social infrastructure.

A number of countries regulate the provision of social and health care services through a single executive body or a single ministry. As in Finland[38], England[39] and Austria[39]. The United Kingdom is considered one of the most advanced countries in integrating health and social care services into one entity that supervises the provision of services, sets controls and guidelines, and exercises regulation and oversight functions, with the presence of a Ministry of Health and Social Care, and a minister with the same title. In Scotland, it has a Department of Health and Social Care with a desire for a long-term transition to the National Care Service by 2026.

38. Ministry of Social Affairs and Health, Finland

39. Ministry of Health and Social Care, England

40. Ministry of Social Affairs, Health, Care and Consumer Protection

The following is a summary of the practical measures and steps taken by Scotland to pave the way for the establishment of the Ministry of Care to transition to an integrated model for providing care services:[41]

1. **Develop guidelines for the merger process:**
   - Integration of services from the perspective of service users
   - Taking into account the needs of different service users
   - Taking into account the needs of service users in the different places where the service is provided
   - Including the characteristics and circumstances of different users of the service
   - Respecting the rights of service users
   - Enabling service beneficiaries to engage in supporting their communities in which services are provided
   - Improving service quality
   - Adopting planning and guidance based on local conditions and through community engagement (particularly those who care for service users and those involved in service delivery)
   - Reducing the skills required to practice professions, and avoiding austerity policies that lead to lower salaries or reducing the duration and quality of service.
2. **Develop a strategy for the workforce in the field of health and social care: The strategy emphasizes developing the functional and specialized areas of social care services, making these jobs attractive and attractable, in addition to developing new paths.**
3. **Conduct a review and audit of the level of provision of social and health care services. The audit was specific to the care services provided to the elderly (because the number of beneficiaries from this category is very large). One of the most important outcomes of the review was the establishment of a Ministry of Care Services**
4. **Develop the National Law for Care Services: Submitting it to Parliament for discussion in mid-June 2022, as it is still under study and discussion**
5. **Conduct consultations at multiple levels including practitioners, beneficiaries and their families**

Among the most prominent experts' diagnoses of the defects of care systems around the world is the beneficiary's transformation into a number, the inflation of the cost by calculating the inputs (such as the hours of attendance and leave) without calculating the outputs (such as interaction with the beneficiaries), and the absence of communication outside the service provision facilities, where the work of social practitioners is focused in modern systems on the need to fill electronic forms and systems with the absence of the support and sympathy that the beneficiary and his family need, and to use duplicate solutions without caring about designing appropriate interventions that ensure participation with the beneficiary and his centrality in the program development process.[42]

A number of developed countries provide cash subsidies for family caregivers under the name of Carers Allowance, which helps them bear the costs of care and contributes to limiting the decline in income resulting from increased expenses or loss of paid working hours, including Canada and the United Kingdom.[43]

41. Health and Social Care Strategy

42. For more on this phenomenon, read researcher Hilary Cottam's book on the need to redesign welfare systems around relationships (Radical Help - Hilary Cottam)

43. For more, **see the UK Government's dedicated page to ensure beneficiaries are eligible for the service**

One of the most apparent challenges of contemporary care systems is the absence of the principles of community protection and public interest in the bodies supervising care specialties. The organizations lack a compass, do not always seek the principles of protecting vulnerable groups from abuse and bad service, and do not seek the principles of the public interest. Rather, they are often biased toward bureaucratic systems that focus on prevention and prosecution, discreet practitioners of abuses, and recording inputs (such as hours of training) that are sufficient to measure the continuity of professional competence. Therefore, the Professional Standards Authority in Health and Social Care in the UK carried out a comprehensive review of the professional regulations, which relied on the concept of the right touch approach, which does not flatter at the expense of the beneficiary and does not suffocate the practitioner.[44]

Appropriate care requires efficient social facilities (in planning, building, space and services, operation and maintenance, and meeting the social needs of individuals and families) as well as professional practitioners to operate these facilities and provide services to beneficiaries with professionalism, reliability and honesty. Some experts describe the assets of social infrastructure as being inclusive of flexible facilities and equipment, of social practitioners and motivated employees with appropriate wages, and of institutional capacities that are highly prepared to work under pressure.

The COVID-19 pandemic has highlighted the uneven resilience of social infrastructures under pressure due to the shock of the increasing demand for services, with the weak equipment, plans and capabilities needed to deal with crises in a flexible and sustainable manner. The pandemic also demonstrated the inability of many social infrastructure assets (such as the sufficiency of intensive care services in hospitals) even in developed countries. It is the result of the retreat from investment to expand and maintain the social infrastructure and ensure the adequacy of its services and capabilities over the years, due to the fiscal austerity policies that affected government spending around the world on social protection and health items during the global financial crisis.[45]

Experts point out that social infrastructure (through which citizens access care services such as education and health) is usually compared to economic infrastructure (linked to economic assets such as energy and transportation facilities). However, this classification is limited, in their view,

44. For more on the reassessment of the processes for regulating social care professions, see the UK's experience **titled Right-touch Regulation**

45. Panel discussion on **"Resilient Social Infrastructure"** from the C20 Civil Society Summit 2020.

to the quality of facilities only. Instead, the infrastructure can be viewed from a more comprehensive perspective by categorizing it into soft infrastructure and hard infrastructure. Soft infrastructure includes all of the policies, systems, procedures, and social and cultural relations surrounding hard infrastructure (which are those that are limited to buildings, establishments, and facilities on the ground). Residents are usually closely associated with social infrastructure assets by virtue of their proximity to their daily lives (such as a school, a clinic, and a social care home), compared to economic infrastructure assets that are usually far from their place of residence (such as ports, power generation and water desalination plants). The non-solid aspect of the social infrastructure is more pivotal due to its need for systems, mechanisms, work procedures, professional practices, and institutional capacities to operate social services and provide them efficiently, professionally, and fairly to citizens and beneficiaries.

The social protection system requires the greatest impact: Outstanding and adequate health and social facilities, adequate cash and non-cash benefits, and efficient health and social services provided by professional social workers in dealing with the beneficiary professionally, ethically, and with empathy.

It is a good practice to view the practice of social care professions (not only health care professions) as critical professions that affect public health, the development and integrity of the community. Therefore, their practice globally is subject to oversight conditions that guarantee the public interest. Therefore, each state of the United States of America appoints a supervisory board to monitor the work of social workers, determine the necessary competencies for them, impose professional examinations and continuing education, and license their work. The supervisory boards also meet in a national assembly (ASWB) (which includes them and provides guides and guiding standards, including the Model Social Work Practice Act).

Social practitioners in the United States meet at the National Association of Social Workers (NASW) to build capacity, advocate for practitioner positions in national policies, and disseminate ethical codes and best practices in social work in the areas of aging, behavioral health, childhood care, and clinical, school, and specialized social work such as leadership and social supervision, addiction management, mental health, criminal justice and law enforcement fields and in the courts.

A specialized regulatory body in England (SWE) is also working to regulate the work of social practitioners through registration and accreditation tools, setting professional standards and continuing professional development practices, as well as hearing grievances against social practitioners. The SWE works to ensure the implementation of six professional standards concerned with 1) promoting the rights, strength and well-being of individuals, families and communities, 2) building and maintaining people's confidence in the profession, 3) ensuring accountability for the quality of practices and decisions made by social practitioners, 4) the commitment of social practitioners to continuous professional development 5) Safe, dignified and respectful practices, and 6) Encouraging ethical work and reporting malpractice.[46]

46. For more, see the policy paper **"Social Benefits: A Financial Analysis of the Prospect of Doubling the Impact Against Spending"** by King Khalid Foundation, 2021.

It is a good practice to collect data on beneficiaries of care services through what is known as the "National Social Register", an electronic system that keeps data of beneficiaries of care services in all its forms, especially beneficiaries of government social benefits. In many countries, this electronic system constitutes the starting point for anyone who needs social protection services in all its forms. According to the description of the World Bank, this system is "the basic guarantee for the provision of these services." Through this register, applications for care services are submitted, the beneficiaries' eligibility is determined and verified, and then the beneficiaries' case is managed and subsidies and programs are provided to them through it. This register is made available to all governmental and non-governmental care providers.[47]

From the discussion of the best standards and experiences, it can be concluded that there is a tendency to reconsider the organization of care professions, and raise their level in a way that serves the centrality of the beneficiary and his needs when formulating its policies, and that there is a great economic growth prospect for the care economy as an essential component for achieving comprehensive sustainable development and raising living standards. In addition to the Kingdom's excellence in the regulatory frameworks available through programs to achieve the Kingdom's Vision 2030 to serve all target groups of the care system, there is a need to manage the regulation of the professions of this system, and to identify more about the needs of the beneficiaries. This is what the second chapter of the research will present, through reviewing the results of the field research for each of the beneficiaries of the social, health and educational care system in the Kingdom, their families, and practitioners working in the care professions.

Before going into the details of the results of the qualitative field research, the general consensus was that the beneficiaries and their families felt a deep sense of gratitude for the efforts made by all care givers and their sincere desire to provid them with the necessary help they need. The beneficiaries' families enthusiastically responded to the request to participate in the research, hoping to help those who care for them, and in gratitude to the organizations that provided them with services. On the other hand, all those working in the field of providing care services expressed their great love for their work, and the "blessing and satisfaction" that their service brings to the beneficiary, according to their description, as the moral return from their work greatly exceeded the material return. The qualitative analysis lists some quotes from the beneficiaries, their families, and practitioners, as data presented to the reader to bring the picture closer. The research team concealed the identity of the participants and their geographical location in order to preserve their privacy and the privacy of the information they provided. The diversity of the beneficiaries, the diversity of the services provided, and the service providers were a great addition in clarifying the common denominators in the service delivery processes. The data analysis did not address issues related to a specific category of beneficiaries, and the focus was on the recurring circumstances that all beneficiaries of the care system faced continuously. We find that there is a need to conduct in-depth research for each group of beneficiaries of care services, to understand the needs of this group, and with the aim of developing programs and interventions that support the economic and social empowerment of these groups.

47. For more information, see the **World Bank Group's Guide to National Social Registries**

Chapter 2

Reviewing the Results of the Field Research

A

About the research method*

The need for care is an inherent human need, regardless of one's standard of living as community member are vulnerable at any point in their lives[47]. This field research showed that all people of all income levels have benefited from the Care System at some point in their lives. Everyone is vulnerable to weakness and debilitation as a result of the human's biological nature that always exposes him to disease or age changes, or due to environmental, social or economic factors that are beyond the individual's ability of control. This confirms the centrality of the Care System to ensure the quality of life of individuals in the society.

This Report adopted the qualitative field research methodology to answer the research question about the experience of the beneficiary, his family, and the practitioner within the Social Care System, to identify the organizational and operational challenges confronting these three groups, as they are the main parties concerned with the Care System. The research team met up with a total of 374 beneficiaries, family of beneficiaries, and practitioners in 18 cities, governorates, and villages in the KSA during the past 11 months of 2022 G. The team asked them a set of questions through individual or group interviews. The resulting data (77 hours of audio-recorded research interviews) were processed through pivotal qualitative analysis, whereby all texts of interviews from different regions of the KSA were reviewed, and the text was encoded with codes expressing the behavior, opinion, or participation of the participant throughout the individual interviews. Some group interviews were held with practitioners working in the same entity and beneficiaries of the same organization. The respondents were contacted through the foundations that provided care in various regions of the KSA, in addition to communicating directly with government social and health care associations. The codes varied in number, there was between 1 to 5 codes for each text in the analysis process, referring to the diversity of the semantics of the experiences that the respondent goes through. The codes and observations of the field research team were collected to formulate an "aspect/theme" and, in some areas, a "sub-aspect/sub-theme" and the corresponding codes, totaling 142 descriptive codes. The explanations of the codes and details of the methodology can be found in the Appendix to the Methodology at the end of the Report.

47. To learn more about the King Khalid Foundation's concept of vulnerability, kindly see the **"Reflection Paper: Redefining Vulnerability"**

*** The publication contains a detailed appendix of the research methodology and tools.**

B

Aspects of Qualitative Analysis

1 Care System's Absorption of Beneficiaries

This section recounts the journey of the beneficiary, his family, and the practitioner as they enter the Care System, starting the journey from identifying the available services, the way to access them, and ending with the various entities' following up on delivering these services to the beneficiaries. The results of this section discuss the challenges that the Care Economy faces in being able to handle the need of the beneficiary when it comes to providing services. Similarly, it discusses the system's understanding and adoption of the beneficiary's identity and characteristics, diagnosing his condition accurately, and classifying him clearly.

The beneficiaries' need for the Care System is clearly reflected since their attempt to access the service. The participants talked about a recurring difficulty they face, namely the 'starting point', as per their description: From where does a person needing care services should begin? regarding this issue, there are several stories told by the beneficiaries and their family. The respondents from both groups expressed the need for guidance and direction as some of them described their journey in the Care System as having to chase the entities needed to be able to properly document the beneficiary's status and conditions until he obtains the service. In many cases, the beneficiary finds himself repeatedly begging for the service rather than having a right to it. Some of the beneficiaries, after discovering the "starting point", face the problem of not being diagnosed accurately, which leads to their not obtaining the service they need. Some social workers talked about the same problem of being confused when they attempt to instruct the beneficiaries:

> "Sometimes I, sadly, overlook some cases. I do not offer them service as I do not know where to direct them. I mean, there are some cases I see that they need the service and those cases are with me, but I do not know how to offer the service, so I ignore it. I do not offer them the service. I say, for example, that you can benef[redacted] another party …"

Female social worker

Beneficiaries' knowledge-base

The Care System faces a weak knowledge base about the characteristics of their beneficiaries. The practitioners reported the absence of records, figures and data on the beneficiary from the Care System, resulting in weak reports available on the beneficiaries. The beneficiary's first challenge is often about his attempt to prove his eligibility for these services. Practitioners mentioned several difficulties they face in obtaining these services. These difficulties can be summarized under two major challenges. The first is the centralization of decision-making; i.e. the service provider needs to refer to a higher authority outside the city or institution providing care (such as referring to the office of the Ministry) and to wait for a long time to obtain a decision. The second is the lack of fulfillment of the service provision at one entity, and the beneficiary's need to resort to another entity to benefit from a complementary service. This requires the beneficiary's opening of a file in more than one entity (for example, another hospital), which leads to duplication of efforts due to the absence of a unified file for the beneficiary, and exposes the beneficiary to obtaining more than one diagnosis.

One of the challenges affecting the beneficiary is the absence of an accurate national classification system based on scientific criteria generalized to all caregivers. For example, some caregivers still refer to the beneficiaries using imprecise and often inappropriate names to the beneficiary and his family.

> "My son is with Down [Down Syndrome], and it would bother me if they said 'Mongolian', especially if said by the doctors. My ex-husband wanted me to give up on this, but I insisted on treating my son. Now my ex-husband only contributes to the expenses."

A beneficiary mother of a Down syndrome child

> "My son is studying in a public school now and his everything is going well with him, but the specialist there told me not to be happy about my son as he is with autism."

A beneficiary mother of an autistic child

On another note, the practitioners also noted the frequent misdiagnosis of cases, which changes the beneficiary's future and ability to improve his life. For example, the practitioners dealing with the category of people with multiple sclerosis stated that this category is not classified among people with disabilities in the KSA; i.e. they are not benefiting from the services provided to the category of people with disabilities. The same is applicable in the case of Alzheimer's patients, as they are not classified in the first stage of the disease as patients with disabilities. This poor classification limits the beneficiary's ability to benefit from the services and aspects of support available, which increases the costs and the burden of care incurred by the beneficiary's family. Furthermore, there are no review and audit procedures for diagnostics.

With regard to residential care centers, the research found that the caregivers mix up the beneficiaries, especially in the care centers, which leads to serious consequences for the quality of service delivery and opportunities for improvement of the beneficiaries, and affects the beneficiary's experience and quality of life (for example: sheltering addicts with mentally ill people, or elderly with people of disabilities).

A number of social workers working in non-profit organizations shared their opinion that the lack of linkage with government entities that provide care creates additional challenges facing the associations that provide care, represented in checking on the beneficiaries' eligibility for care services, as well as completing the information on the beneficiaries. Those practitioners stated that they had to communicate all the time by phone, or they or the beneficiaries even had to visit the government entities to obtain reports, numbers, or evidence proving the beneficiaries' eligibility to receive the government services. All of these procedures can be avoided and the service delivery period for the beneficiary can be reduced if there is an electronic link with government entities and their records.

There is a major assumption that all government caregivers have reliable, up-to-date and fully classified digital records. By reference to the observations of the research team that visited a number of government care institutions, many of them document the cases and their information on paper, in addition to the creation of multiple files about the beneficiaries (social file, health file, educational file, internal file) distributed among various departments within the entity. The problem with dealing with non-profit organizations lies in the absence of clear procedures for government entities that provide care about integration with non-profit organizations in providing services or even with the private sector, to complete the beneficiaries' needs for care of all aspects. The beneficiaries stated that the lack of clarity of their diagnosis and eligibility sometimes leads to persistent questioning of the beneficiary's credibility, and to some practitioners' inaction and indolence to research and carry out more investigation.

"Yes there is c[redacted]tion between us and them, but it is paper coordination, which means that if I want to know whether the family is following up with me or not, and does it benefit [redacted] from the service, I have [redacted] them [redacted] to sign somewhere in order to get specific amount. The coordination would be better if it electronic. I sought for that, and I was assigned by the administration to be in charge of the same, and I sent them [redacted] the website, but without receiving any response."

Social worker at an association

"As a specialist in the association, I am a mediator between you and the entities. But if such entities don't find solution, what can I do? I mean, I really suffer because of this, and I wish I can give a hand of help. I hope to reach a solution with them, but I am not able because there are entities with specific procedures and mechanisms that I can't bypass."

Social worker at an association

Several social workers mentioned the lack of government reports on the beneficiaries, and lack of accurate and adequate information about the beneficiary's condition. For example, a number of practitioners reported that medical reports do not identify the need for care beyond its traditional (medical) scope, nor provide the details needed by other caregivers.

There is a need to move from the centralization of decision-making on the beneficiary to centralization on the beneficiary in the Care System. There must be a single record for each beneficiary that all caregivers from different sectors (governmental, private, and non-profit) can access to facilitate the beneficiary's journey throughout the Care System. According to the social workers participating in this research, the absence of an integrated plan for the care services needed by the beneficiary around which caregivers are integrated under the supervision of an integrated team of caregivers, has led to the beneficiaries' dispersion and loss among caregivers, and sometimes to their lack of benefit from the Care System. In addition, some beneficiaries reported and some practitioners noticed that some practitioners hasten to pass judgment on the beneficiaries and give random unscientific diagnosis due to the absence of a reference for classification in many cases.

It should be noted, in this context, that practitioners and their family expressed their resentment at the practitioners' failure to explain the diagnosis and educate the beneficiary about the options offered by the Care System, in addition to the failure of some of the practitioners to maintain confidentiality and privacy.

Help Center - a non-profit organization helping persons with intellectual disabilities to develop their lives.

Many nonprofit caregivers rely on conducting case studies of beneficiaries. Social workers in association state, for example, that the reports (such as medical reports) do not fulfill all the information that the social worker needs to conduct a study on the case of the beneficiary, in addition to the difficulty in obtaining data and checking the eligibility of the beneficiary.

Continuous Need for Service

From a procedural point of view, there is no national registry of the beneficiaries of (health, social, and educational) care services and other forms of support. This means that the procedures for registering beneficiaries and their required data are insufficient to develop the services in a manner that best suits their different needs. In addition, beneficiaries are not provided with case management procedures within the caregiving entities, which requires these beneficiaries to move between various caregivers and causes them and their families to incur additional efforts, as well as to experience delay in accessing the services they need. Each entity within the Care System provides services according to the functions entrusted to it, without considering care services as organized sequential services. Beneficiaries and their families and practitioners are all confronted with a number of obstacles in obtaining these services due to the absence of integration procedures between the care service providers, and more importantly, because of the absence of case management procedures. The absence of case referral procedures by care service providers constitutes an additional challenge to the sequence of services and makes the process of providing services to the beneficiaries ambiguous and non-transparent.

Another problem highlighted by practitioners relates to the absence of referral procedures and protocols between the caregivers, and these practitioners' ignorance of the services required by beneficiaries and provided by other caregivers. This problem restricts the available opportunities for guiding and directing beneficiaries in the Care System. Another relevant challenge indicated by practitioners is the lack of automation of files or the absence of electronic linkage between care service providers, which makes it difficult to transfer data and information about beneficiaries among these entities.

It was also found that protocols, systems and procedures that limit individual differences in providing services efficiently are missing. The results of the research showed that the success of a number of practitioners in handling complex cases is attributed to their scientific and practical backgrounds only, not to the existence of systems instructing them on how to deal with these cases. In such situations, beneficiaries and their families express their deepest gratitude to the practitioners who were able to create easy solutions to improve the beneficiary's condition. On the other hand, the long waiting lists of beneficiaries lead to a poor quality of the services provided, as reported by some practitioners. In these situations, practitioners find themselves obliged to deal with the beneficiaries briefly and quickly in an attempt to provide service to the largest number of beneficiaries.

A number of beneficiaries reported difficulties relating to the incomplete provision of care services by service providers. For example, a caregiver provides an in-kind service (such as a wheelchair) but does not provide maintenance services, nor teach the beneficiary how to use that chair. This problem has forced some beneficiaries to search for other entities that provide this complementary service, and in most cases incurred additional costs to meet their needs.

The reasons for hindering service delivery are not only limited to service providers; rather beneficiaries played a role in creating these obstacles, as their experiences indicate. It was noted that beneficiaries who were subjected to assault or bullying confronted greater difficulties in finding their independence and trusting their abilities to overcome the obstacles they faced under the same system. Consequently, they fell into a vicious circle of need and dependence on the services provided by the system. The credibility of some beneficiaries with the care centers has had a great impact on the quality and continuation of the service they received once social workers verified their actual need for such services. Finally, it was found that among the reasons for the disruption of regular service delivery for many beneficiaries was the intervention of their families and their refusal of treatment for that family member who is in need of service, due to social, cultural, or financial reasons affecting the family's willingness to allow their children to obtain said services on a regular and continuous basis.

> "We have a problem that some fathers, especially in rural areas and villages, tend to drop out their children from school once they reach grade 5. These fathers argue that they no longer want their sons to continue their education. If you ask one of them why, he would say that it's not because of his son's disability, but only because he wants his son to stay at home. In this case, the father is depriving his son of something that can develop his abilities and potentials. Many schools are always complaining that the father no longer allows his child to attend school, or declines to follow up on his child's attendance to school."

A social care practitioner

How suitable are care facilities?

It is observed that the Care System relies on facilities to provide care services and that these services are concentrated within the facilities. Although these facilities apply certain special standards, the actual reality indicated by several practitioners and beneficiaries shows that a number of facility buildings are not suitable in terms of specialization. Another shortcoming is that these facilities, especially shelters, receive different types of beneficiaries within their buildings, which leads them to accommodate mental patients with addicts, for example, in the same place. This surely impedes the full and timely delivery of the service.

In addition, these centers lack the necessary specializations to fully deliver the service that the beneficiary needs. For example, rehabilitation centers lack specialists in special education, speech therapy, functional therapy, and psychological therapy, which affects the quality of life of beneficiaries and their families.

If we move to the management of these facilities, practitioners have reported the need to manage operational risks in these buildings. Some beneficiaries, for example, reported that they have been negatively affected by the constant change of the operators of the electronic system within these facilities. In addition, the research team observed that a number of elevators were not working nor properly maintained although they were located at centers designated for the elderly and for people with physical/motor disabilities.

Due to the high demand for care-giving facilities, especially in small and medium urban areas in cities and governorates, several charities find themselves obliged to rent unqualified and old buildings.

Family visiting the Family Development Association in Buraidah

Providing care outside facilities:

The areas and spaces where beneficiaries spend their time determine their lifestyle. To integrate the beneficiaries of the Care System socially and economically, these facilities should be prepared and customized according to approved controls and requirements. For example, access controls for people with disabilities are a prerequisite for this group to be able to make use of public facilities.

Beneficiaries reported their dissatisfaction with public facilities stating that these places are not qualified enough to spend some time there. For example, some public places are still not equipped to receive people with disabilities, as reported by beneficiaries belonging to this group, especially those with mental disabilities.

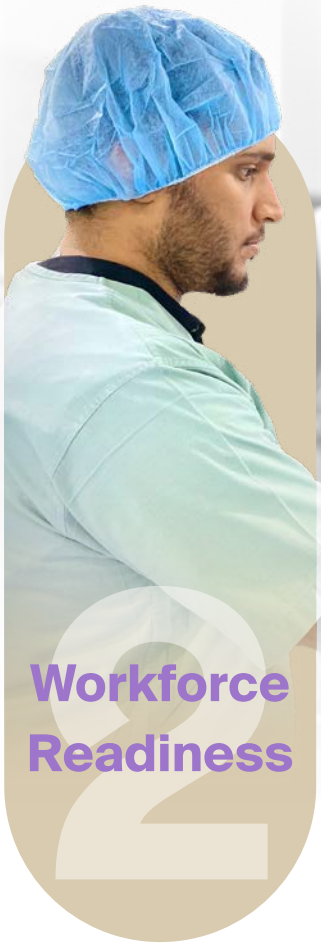
Another challenge reported by practitioners, especially in small and medium urban areas, is the long distance that they have to travel to access care services. This indicates the need for controls and requirements to qualify available facilities to provide services, or to develop alternative/temporary plans to provide services through seeking assistance from the private or non-profit sector, based on structured procedures to be approved. The Section entitled “Access to Care Services” will discuss more results and details about the experience of access to care service. The beneficiaries of facilities that allow inclusion – such as integration schools – shared their experiences, stating that these schools are still unable to accommodate the needs of the integrated groups. For example, the families of beneficiaries reported lack of some educational equipment required by students with disabilities in some schools.

With regard to rehabilitating beneficiaries to graduate from facilities and care homes, practitioners are required to have more qualification and awareness to be able to help beneficiaries to become effective members in society. They should not be only satisfied with providing limited services that could keep those beneficiaries constantly confined with a vicious circle of need and dependence on centers and associations, especially that many centers have now started to take the beneficiary out of the care home after a specific age (as is the case with orphans and people with special circumstances). The practitioners at these care homes reported that they are not sure whether the beneficiary is yet well-prepared to leave the care home, nor that rehabilitation programs are adequate enough to ensure his integration in the society. Among the obstacles that beneficiaries encounter is their poor knowledge of the available services provided by various entities. Following is an example of a beneficiary whose ignorance of the available services led to the loss of a family member:

> "I have experienced a situation with my aunt, may her soul rest in peace, who died with cancer. I did not know about the Association. If I had, she would have received her treatment with the association. I have lived through this experience in person for almost five years, and I don't want anyone else to go through the same experience."

A Beneficiary

Another relevant problem is that of relapse. Relapse happens when a beneficiary fully receives the service, then goes out into the external world to be surprised that his surroundings, namely his environment and society have not changed their view of him or refuse to accept him. In that case, it becomes difficult for this person to adapt to the society; so, he relapses into the circle of need for care services. an example of this case relates to people recovering from addiction. An addict goes through a treatment journey with specialists who help him get rid of drug dependence. He sticks to a particular routine and attends counseling courses until he fully recovers from addiction and returns to his normal life. However, the absence of a "midway house", which rehabilitates and helps addicts to recover and get involved in the external world and hold on to the progress they have made within the treatment facility. If such midway house was missing in some areas, relapse would be a potential result because the recovering addict would return to the same family and social environment that primarily pushed him to the brink of addiction. The need for a midway house is not limited to addicts only, but also extends to other groups, such as juveniles. Many beneficiaries relapse to the same activities after going back to their environment, and it becomes more difficult to integrate them and rectify their behaviors after such relapse.



2 Workforce Readiness

The field research comprised lengthy interviews with care practitioners from various specialties and sectors to investigate the status quo of care services from their perspective and the cases they encounter in their daily interactions with beneficiaries and other care service providers. The research focused on investigating the lifestyle of practitioners in the Care System, starting from their daily routine within their families and the impacts of their work on their psychological, social and economic status.[48]

Most practitioners mainly expressed the great moral return of providing care services, and their close attachment to beneficiaries and their families, which increases in proportion to the vulnerability of the group they serve. Practitioners also highlighted the increasing pressures they were subject to due to the small number of specialized staff, the increasing number of cases they are required to handle, and the emotional attachment to the cases that some of them develop to the extent that they keep delivering services to some beneficiaries even after the official working hours. The research team noticed that the practitioners' expression of their sense of job burnout and their suffering from insomnia, depression and sadness decreased with the progress of their career age and the years they spend in service. This phenomenon appears more clearly among social practitioners in non-profit sector organizations, such as associations, than among their peers in other sectors, due to the increasing number of cases they handle. Social practitioners sometimes have to handle hundreds, and even thousands, of cases. In addition, care practitioners in the non-profit sector implement different work mechanisms from others, as these organizations apply a case management process, which requires much effort in collecting and analyzing data and conducting field visits to beneficiaries.

48. To have access to all the questions asked to social practitioners, please review the Methodology Appendix at the end of this Document.

"We experience psychological pressures, I mean, we are really affected by some cases. Sometimes when I go back home, I start crying, holding my head. We feel sorry for the cases; we feel how heart-broken a case may be. We wish to give them more than we can, but we have nothing on hand to offer. Sometimes, you feel you want to take that victim out of the violent environment she is living in, but you can't."

A female care practitioner, at a government care facility

"We can't sleep enough. When we go back home, we still have children and responsibilities."

A female care practitioner, employed by an association

The majority of the care practitioners we interviewed complained that they did not have channels for psychological counseling at their workplaces. Some of them expressed their own need for psychological counseling, while others searched on their own for psychological treatment to heal the repercussions of their work on their health. On the other hand, field practitioners complained that they were exposed to field risks, such as violence or harassment during visits. they expressed their need for a protection team to accompany them on their field visits. A number of practitioners reported being abused and assaulted in their offices inside the facility, to such an extent that they put up glass barriers when receiving beneficiaries. However, employers do not provide any compensations or allowances for such job risks. Some practitioners reported the absence of a law to criminalize the abuse of social practitioners, as is the case with health practitioners.

Practitioners spoke at length about the current state of social practitioners, highlighting the poor outputs of social work specializations and their focus on the theoretical and academic aspect. Some practitioners claimed that university education did not provide them with sufficient qualification to handle real-life cases on the ground. However, the research team noticed a better performance of social workers in areas where universities offered social work majors in comparison to areas where these majors were not available. As far as training and rehabilitation are concerned, practitioners indicated the absence of specialized training programs in social service, except for the training programs which are offered by Al-Fozan Academy for Community Service and which can be attended either in person or remotely. Moreover, the Saudi Commission for Health Specialties provides approved training courses for social workers who register with the Commission as clinical social workers. A number of social workers resort to this option in order to benefit from training and development opportunities. Newly graduated practitioners referred to the difficulty they encountered in choosing specialized training places in their jobs to hone their skills and build their capacities.

With regard to available care jobs, especially social care jobs, this category of practitioners complained about the poor job titles and career paths that the job market currently offers. The employment options currently available are limited to positions of a care worker, social observer, social researcher, and social worker. Practitioners reported delayed promotions and poor allowances. Most importantly, they lamented their feeling of not being appreciated at their workplace. All practitioners shared the opinion that they are paid low salaries that are not commensurate with the size of the tasks assigned to them.

It should be noted that not all care practitioners are professional and qualified in their field of work. Practitioners complained about the random provision of care services currently, due to the lack of specialists and the absence of appropriate training and qualification programs. These shortcomings surely affect the service that the beneficiary receives. Many problems have arisen in relation to the practitioners' behavioral competences. Some practitioners exaggeratedly sympathize with beneficiaries or blame them for the situation they found themselves in; they even sometimes look down on these beneficiaries. Further, some beneficiary cases are not correctly or accurately diagnosed, as detailed in Section 1. Finally, some practitioners lack knowledge of the proper ways to study and manage beneficiary cases.

> "There are supervisors who harshly treat beneficiaries, and swear at them, using insulting words [redacted] …! or get out o[redacted] you …,"
>
> A beneficiary

Other practitioners shared some experiences related to the progress of their careers in handling different vulnerable groups. Some of them spent several years serving people with disabilities, then moved to serving orphans, and later to victims of violence and abuse. This means that some practitioners have implemented a job rotation throughout the entire Care System. This could lead to the practitioner's loss of the opportunity to be specialized in a particular service provision field. However, some practitioners find that such rotation is a good opportunity to learn about different needs and to develop their skills and experiences.

The results of this Section show that care practitioners are in dire need of job regulation, namely the creation of a code of ethics for the profession. They lament the absence of a law for practicing care professions, and emphasize their need to introduce appeal procedures to protect the rights of practitioners and beneficiaries alike. They also stress their need to develop rehabilitation and training programs for care professions. Despite shortcomings on the part of some practitioners, and the random behavior of others in providing service, they already fill a large gap in service provision for beneficiaries and their families, who express their gratitude for these efforts. In conclusion, the quality of the practitioner's performance is linked to the quality of service provision to beneficiaries, and the efficiency of service delivery.

3 Access to Care Services

The experiences of beneficiaries and their families in accessing care services vary due to several reasons discussed in this Section. It is noted that practitioners play a weak role in facilitating a beneficiary's access to services within the Care System through guidance and direction of the beneficiary and his family. The practitioner's lack of knowledge of service access channels within the Care System causes the beneficiary either to miss the opportunity to obtain the service, or to have very late access to it. Worthy of note is the absence of a community of social care practitioners where they can share experiences and develop professions, unlike the case with health, engineering and other personnel.

This Section discusses a number of characteristics of the Care System in its current form. This new system has made beneficiaries and their families recipients of services, not only eligible subjects to receive the service, as shown in Section 1.

Regulatory Obstacles

Beneficiaries and their families, as well as practitioners, highlighted a major obstacle that hindered them from accessing the service, namely the absence of care centers in several regions, especially in small and medium areas in cities and governorates. For example, specialized centers for mental disabilities are not available in some regions of the Kingdom. This would oblige the beneficiary and his family to move to another city. As a result, the associations providing care services experience increasing pressures to meet the demand at the national level. They are further required to operate through local centers in the regions to meet such needs. It would thus be challenging under these circumstances to maintain the same quality level of service provision on an equal footing in all regions.

"The biggest challenge is that we have beneficiaries from all regions of the Kingdom, but [redacted]ome areas are not served in terms of … diseases. We were [redacted]le to address part of this challen[redacted] by establishing the …Project, through which practitioners managed to reach unserved areas. We have also started to narrow down the gap in beneficiary needs in remote areas and the presence of associations. The other challenge is that we are not able to obt[redacted] for the new branches [redacted]

A practitioner

Practitioners indicated another major problem in providing equal services to all beneficiaries at the national level, namely failure to activate partnerships with entities that could contribute to service delivery. This failure to involve the private and non-profit sector in the initiatives as a primary partner in the provision of care services undermines effective access to the service. For example, a few non-profit sector organizations have specialized excellent centers for care service provision at the national and regional level. These centers, however, are unable to provide the service to all regions of the Kingdom, despite the urgent need for their services. Such cases may benefit from the creation of service provision alliances and partnerships throughout all regions of the country, as proposed by the practitioners and families of beneficiaries.

A number of beneficiaries and their families complained about the long periods of time they took to obtain the service and the long waiting lists, especially pertaining to health care services. Accordingly, some associations incur additional financial burdens, by purchasing services from the private sector and providing them to their beneficiaries to reduce the long waiting times that could lead to deterioration of the beneficiary's condition.

The families of some beneficiaries reported the "lack of regulatory flexibility" of the caregivers in dealing with them. For example, a foster family wishing to adopt a child with special circumstances experiences delay in the adoption procedures, which could lead to difficulty in obtaining health care services, since this family is required to prove the kinship between the beneficiary and his new family.

Missed Opportunities

The process of care service provision is mostly about addressing and responding to needs, without paying much attention to the preventive side. This may be due to the poor design of interventions and initiatives and the absence of case management procedures and integrated treatment plans. The research team found cases of people with motor disabilities where the lack of early intervention led to their inability to access rehabilitation services and reduced their chances of rehabilitation. As a result, they were placed in care centers and left their homes forever.

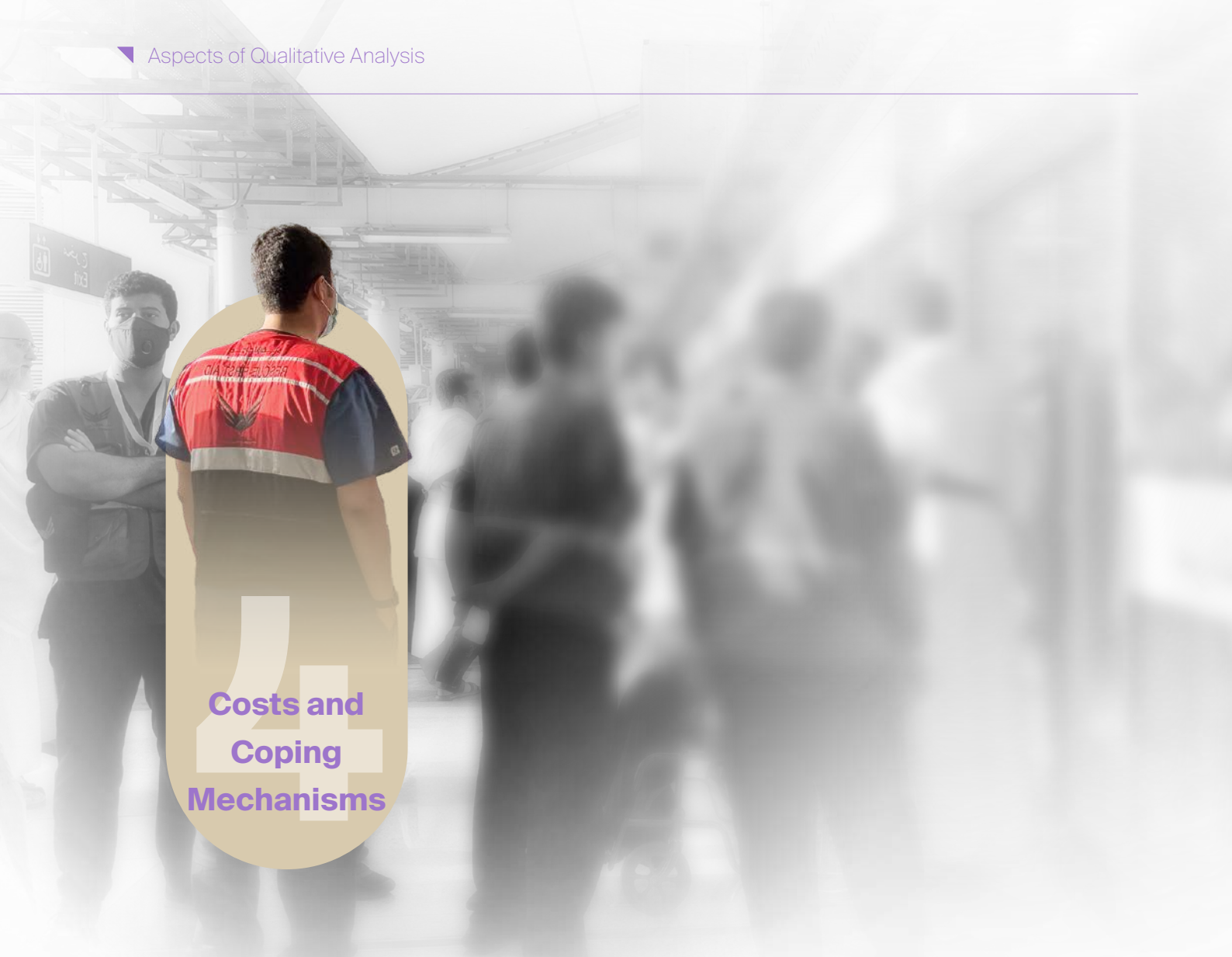
Some beneficiaries shared their delay experience in obtaining information about their own condition, and its negative impact on the deterioration of their condition. For example, there is a story of a beneficiary whose health condition has deteriorated due to delay in diagnosis. During a medical examination upon his retirement, this patient found out by coincidence that he had a liver disease. He recounts the story in his own words as follows:

> "I know it is all a matter of fate, but I'm only sad because I did not know about the illness all that time. I used to spend my time between home and work. I only knew about it when I received a piece of paper on my retirement day. When I went to collect my entitlements, they told me I had to do tests and other procedures. The hospital people didn't even let me know about it. I mean, only at the time of retirement, they gave me that piece of paper, saying I had a liver disease."

A beneficiary

A major aspect of these missed opportunities is the discontinuation or interruption of service provision, which often leads to exorbitant costs, to be discussed in the coming pages. For example, in the context of service access, starting the provision of rehabilitative care services, then suspending it after a particular period, leads to relapse. The families of beneficiaries with disabilities expressed their dissatisfaction with this issue. They explained that care services are concentrated during childhood, then are interrupted or suspended in adulthood, which often leads to a deterioration of the beneficiary's condition.

Service interruption is a recurrent pattern in all forms of care service, as these services are designed without conducting a case study and are suspended without prior notification. They do not take into account empowerment aspects required by the beneficiary to be able to fully integrate into society. The current experience of any beneficiary can be summarized as being centered on his receipt of temporary services to treat his current condition without a far-sighted study that would draw up a clear treatment plan through which he can become an independent and effective individual in his surroundings.



4 Costs and Coping Mechanisms

Practitioners and beneficiaries and their families share the burden of costs due to the inability of the Care System to meet their needs. These beneficiaries and practitioners are considered the weakest element in a system designed and led by administrative and financial decision makers, without significant involvement of the front row of service providers, beneficiaries and their families.

However, each of these groups share a different experience based on the nature of their roles and their environment. Practitioners enjoy a greater degree of independence and control, despite their weaknesses, if compared to beneficiaries, who are in need of service and who constantly rely on its provision. All these costs generally lead to a decrease in the beneficiary's financial income and standard of living, as well as a decline in healthy life expectancy, and a deterioration in the quality of life itself. Accordingly, this Section highlights the experiences of beneficiaries and their families, and practitioners, as well as the financial, psychological, social, and health costs that they all incur, in addition to the coping mechanisms they all resort to in order to mitigate risks and repercussions.

Beneficiary Adaptation

Beneficiaries and their families recounted several traumatic experiences of the heavy losses they incurred due to the Care System's failure. Poverty is among the main financial manifestations of this experience; it is a natural result of the higher cost of services to be borne by these beneficiaries and their families using their own savings. In many cases, these costs may not necessarily relate to receiving an emergency service, but rather to expenses of transportation or travel to the city where care would be provided, or expenses of searching for temporary accommodation, or obtaining rehabilitation or social services subsequent to receiving primary care service.

Several beneficiaries also complained that they spent huge amounts of money, fell into debt and destitution, and had to ask for charities due to the insufficiency of social subsidies to cover care costs and other related expenses. Many families also complained about the low amount of monthly subsidies (whether from comprehensive rehabilitation, social security, or other care subsidies). For example, a number of families who received cochlear implantation services for their children born with a hearing impairment stated that speech rehabilitation sessions cost them huge financial amounts on a monthly basis (up to 3,600 riyals for one-month sessions per child). It is also necessary to pay monthly amounts for the maintenance of consumable hearing aids. Other families with autistic children stated that the costs that private centers charged from them amounted to 40,000 riyals annually, which constitutes a financial burden even for middle-income families, let alone the costs of physical therapy sessions for people with injuries and motor disabilities. Lack of access to these services would certainly lead to the deterioration of their health condition.

> "I was trying to get an appointment with ..., but I was excluded out of nothing. I was given an appointment by e-mail. Yes, I had an appointment via [redacted] could not see it as I had no credit on my phone card. Then when I put credit on my phone, I called them. I told them I didn't see their email. I spoke to the operator. She told me that the appointment was gone, and they had nothing in their hands to help me. She told me to wait for about six or eight months. I told her I had an appointment but I had no credit on my phone as my family went to Makkah for Umrah. Then I put credit on my phone and called. She said it was out of her hand, and that the appointment was cancelled. She told me to call them after eight months. I answered that eight months is too long for me. But she gave me no other option and insisted that I can only call them after eight months."
>
> A beneficiary

The qualitative field research recorded the suffering of a number of non-Saudi dialysis patients who are not eligible for free treatment due to their foreign origins. These patients pay for their own dialysis sessions, with a total cost of 5,000 riyals per month. Accordingly, they find it obligatory to request help from benefactors to obtain enough money to cover the cost of treatment. In addition, a number of unethical practices were detected in some private sector hospitals. For example, they would refuse to hand over a sick child or the body of a deceased person until his family fully pays the costs, in violation of the circulars issued by the Ministry of Health, banning these practices.

Some beneficiaries disclosed that they hoard medicines that they obtain from pharmacies, and spend much money to get quantities of medications in excess of their current need, since they feel afraid that they may not be able to find such medicines in future. Some ADHD or autism patients reported that time and again they failed to find their prescribed medications at pharmacies. Some specialized health charities incur additional costs to maintain a stock of necessary medicines for the treatment of their beneficiaries in the event of any shortage.

Beneficiaries also try to cope with financial costs by redistributing family expenses, borrowing, or seeking assistance from charities. A non-Saudi beneficiary of a health association residing in a small town stated that he used to take the trouble to travel with his family to the city where he received the treatment. He added that he had to cut down on family meals and reduce spending on food in order to be able to pay for transportation and housing. Some families are also forced to move to live in a particular city where one of its members can obtain the care service needed. The research team interviewed a number of beneficiaries whose parents were divorced because their children were diagnosed to be ill and had to start their treatment journey, but one parent could not accept this new situation. As a result, the other parent had to bear the whole burden of care alone or with the help of a grandfather or grandmother. This undoubtedly affects the structure of the beneficiary's family.

As it seems, the costs incurred by beneficiaries are not only limited to money, but also sometimes extend to include physical or psychological suffering. A number of beneficiaries and their families revealed that they were assaulted, bullied, violently treated, exploited, discriminated against, and racially treated for various reasons, most notably because they are helpless and weak. Their vulnerable situation thus made them a target of abuse. This is usually accompanied by a deterioration in their psychological state and a sense of injustice and abandonment. Some beneficiaries fall victim to symptoms of depression and injustice and may sometimes develop suicidal thoughts. A practitioner handling cases of orphans with special circumstances stated the following:

> "Society's view is a major challenge that these children face. The nature of our society makes people always question your origins and family. They would ask you for example where you come from. These questions cause embarrassment to children, and some of them may experience racist feelings. Some children were exposed to depression due to this issue, and some of them developed suicidal intentions."

A practitioner dealing with orphans with special circumstances

For example, any delay of early rehabilitative intervention for children diagnosed with Down syndrome may lead to deterioration of their health condition. They would not be able to benefit from rehabilitative treatment services at the right stage of their life. This delay in receiving such services would lead to muscular atrophy and complete loss of the ability to move, and thus may lead to a decrease in healthy life expectancy. The same case applies to cancer and liver patients. Early intervention for these cases makes a huge difference in recovery rates.

Some families take notice of these issues at an early stage, but unfortunately they seek help from non-specialists, recruit unskilled workers, or start early intervention on their own, despite their lack of the necessary skills. A mother once stated that she bought books and browsed the Internet for the best methods to provide early intervention exercises for her infant diagnosed with Down syndrome until he was admitted to a specialized care center.

In some other cases within the non-health care system, the research team observed that some beneficiaries suffered a relapse and returned to addiction as the care services provided to them were interrupted before they fully recovered. The research team interviewed a number of beneficiaries of addiction health care services. They described their struggle with relapse and recidivism due to lack of post-hospital care services (e.g. midway house and community support groups). The team met with a number of beneficiaries who obtained these services and who managed to avoid returning to addiction. As for non-health care services, the team detected recurrence of a number of aforementioned situations, such as juvenile recidivism due to their lack of access to integrated social care that addresses the roots of their family problems, and ensures their enjoyment of social counselling services. These services would also ensure that these juveniles return to school and to their residence with their families or with any person who can appropriately serve as a parent for them.

In addition, families receiving health and rehabilitation treatment services for their children with disabilities may suffer from the costs of refusal to admit their children to schools or to the society due to lack of full social and educational care services. Some mothers indicated that they had to accompany their autistic daughters to school every day in order to carry out their personal care tasks due to the absence of specialized staff at school who can perform these tasks. Some family members may be obliged to leave the job market as they are required to take on necessary care roles for family members with disabilities or illness. Others are even forced to drop out of education or to leave the job market altogether. A previous study conducted by King Khalid Foundation reported that the burden of care is among the reasons that make young people decline to join employment, training or education.[49]

Some beneficiaries may even resort to violence and revenge on the family or society due to the interruption of care services or the failure of society to understand their needs, or because they have been subject to experiences of abuse and bullying, or feelings of resignation, frustration and psychological deterioration. An ADHD young man shares stories from his peer community of young men and women diagnosed with ADHD:

49. King Khalid Foundation (2022): "Access to the Future: Journey of Youth between the Seats of Employment, Education and Training."

"A young man says that his father treats him as a small boy. He would say, "Oh, this is crazy." He gives him 2,000 riyals and asks him to carry out so many things for him. I noticed that most of the problems that ADHD people suffer have nothing to do with the patient, but with the society around him, the domination of his father and mother, and the culture of society. For example, they would say "don't do that, otherwise people will call you so and so." Many a time I see that the father is too cruel. Most people with ADHD want to take revenge on their fathers."

A beneficiary

A beneficiary is constantly ignored and not involved in making decisions regarding the care services related to him. He is not consulted or allowed to express his opinion. This is because people do not take him seriously, nor give priority to his independence or believe in his ability to make decisions. This may lead to moral damage to the beneficiary and violation of the privacy and confidentiality of his information. In addition, some practitioners treat him only in terms of friendliness and spontaneity, rather than dealing with him as a client and a competent person. Sometimes, this would lead the beneficiary to miss the opportunity to become economically and socially empowered, even though the outputs of the integration and empowerment programs help the beneficiary to end his dependence on the Care System and to become an active member in his society.

Costs incurred by practitioners and coping tools

As far as beneficiaries incur financial, health, and psychosocial costs, health and social practitioners and caregivers bear similar costs as well. Many practitioners, especially social care service providers, complain about their low wages compared to their workload or to their peers in other professions. A number of practitioners reported their exposure to job burnout, as a result of long or tiring working hours, as well as work injuries. A newly appointed physiotherapist shares his experience:

"Many people in Saudi Arabia talk about how much a physiotherapist is affected by his profession. Two months ago, I myself was diagnosed with a strong herniated disc in the fourth and fifth vertebrae. I underwent x-rays here in the hospital. I truly suffer from my back pain. We specialists experience the same situations, each according to his specialization. For example, those handling cases of children usually sit while working, and subsequently suffer from back problems, unlike myself; my job requires me to keep standing, so I have problems with my neck and with the thoracic vertebrae."

A physiotherapist

Some practitioners also suffer from psychological problems as a result of their contact with critical cases and their exposure to the pain and concerns of beneficiaries. A social practitioner recounts his struggles in this regard:

> "I swear to God, when I put my head on the pillow to sleep, I start thinking of the cases I handled, and I can't sleep anymore."

A male practitioner

A female social practitioner also states that she has already started to look for a medication for insomnia:

> "This week, I began to contacted sleep disorder clinics."

A female practitioner

Some practitioners also complained about an unsuitable work environment, stressful work conditions, and lack of staff compared to the volume of work and need. They also referred to their exposure to infection and field risks, and their dissatisfaction with the financial benefits they are entitled to. For example, unlike health practitioners, they are not paid an infection allowance although they become equally exposed to the same infection risks upon providing care services. Other practitioners also complained that because of the absence of protection, they are sometimes subjected to violence, beatings, and abuse by the families of beneficiaries, which led them to experience serious psychological effects and made the society adopt an inferior view of their profession.

Practitioners try to adapt to their situation by invoking a number of convictions. For example, they resort to patience and think of the moral return they get when beneficiaries express their gratitude to them, and seek reward from Allah. A number of practitioners, however, reported that they have developed a feeling of insensitivity and loss of empathy due to their frequent exposure to abusive situations, burnout, and contact with miserable cases of beneficiaries. Other practitioners complained that they have to incur out-of-pocket expenses to compensate for the shortages of the Care System both for them and their beneficiaries. Practitioners often contribute their own money to improve a service provided to a beneficiary, when this service is not available free of charge, or even to cover their own training costs so as to renew their practice licenses or guarantee promotion.

Other practitioners reported having been obliged to repeat previous examinations or diagnoses, as the system does not require each practitioner to record the necessary case data for use by the next practitioner. Home health care practitioners complained that they mostly find no integrated medical reports on the patient's home needs nor required recommendations relating to his environment, nutrition, and rehabilitation services. Some physicians only discharge patients from hospital, without caring about providing the necessary information on the case to other caregivers who may undertake this responsibility later. Accordingly, a home health caregiver finds himself obliged to request a re-diagnosis and evaluation from another physician to prepare an adequate report for use after the beneficiary is discharged from hospital.

Recommendations

The research results indicate that the growing demand for care services limits the ability of the care economy to fully meet the needs of beneficiaries and their families, and care practitioners. As a result, there is an urgent need to rebuild the components of the care economy in KSA to enhance efficient, comprehensive and proactive service provision to beneficiaries, and to achieve economic growth through regulating this vital sector. For this reason, we provide an overall set of recommendations that together constitute two packages of options that the decision-maker can adopt to conduct a radical and comprehensive transformation in the care economy.

We present two separate options for restructuring the Care System in the Kingdom, as follows:

1st Option

Proposing the creation of a single regulator to lead the Care System

2nd Option

Proposing a coordination mechanism for service provision through a number of operators

We believe that the two options provide a new vision for providing care services, as they both place beneficiaries at the heart of the system. However, the first option will serve to transform the Kingdom into a leading global model in providing care services, and to achieve a greater economic return.

Adopting either option would constitute a shift in the care economy and would have a positive impact on the gross domestic product and tax revenues. It would also provide new direct and indirect job opportunities, ranging between 1.5 and 1.6 million direct jobs and 500,000 indirect jobs in the Saudi Care Economy by 2030 based on the predictions of the economic models previously discussed in Chapter 1.

Growth is expected to be driven by higher government social spending, coverage of health services for the population (particularly extended care centers, home health services and community care), growth in early childhood care and pre-primary education services, growth in care of the elderly and people with disabilities, and social entrepreneurial research and innovation activities, as well as increase in the contribution of the private and non-profit sector to social spending and non-oil GDP, increase in consumer spending by individuals and families on care products and services, and increase in employers' spending on comprehensive insurance coverage for social and health care services for their employees.

1st Option

Proposing the creation of a single regulator to lead the Care System

This option is based on the establishment of a new ministry under the name "Ministry of Care" to lead the regulation of the health and social care sector. This is because there is a need to re-establish the system, by regulating the affairs of practitioners and the profession as a whole, registering beneficiaries and keeping their records safely and reliably, and ensuring equal service delivery by establishing service-provision alliances at the national level. Following is an account of the proposed recommendations under this model:

1. Establishing a ministry under the name "Ministry of Care" by merging the Ministry of Health with the Deputyship of Social Security and Empowerment affiliated to the Ministry of Human Resources and Social Development. This new ministry will be entitled to coordinate with the Ministry of Education for providing integrated early childhood care services.
2. Transforming the Saudi Commission for Health Specialties into the Commission for Care Specialties after merging it with the Social Specialties Unit. This new commission will be in charge of identifying care professions and professional standards, and issuing practice licenses for health, social, rehabilitative, and other care professions.
3. Transforming the Saudi Central Board for Accreditation of Healthcare Institutions (CBAHI) into the Saudi Center for Accreditation of Care Facilities, to include all government, private and non-profit facilities providing social and rehabilitative services.
4. Expanding the competence of the Education and Training Evaluation Commission to include early childhood programs, and programs for special education, technical rehabilitation and training targeting persons with disabilities in program and institutional accreditation.
5. Issuing a law for the practice of care professions to regulate and protect health and social professions, maintain the rights of practitioners and ensure their protection upon performing their duties, and create a code of ethics for the practitioners of care professions.

2nd Option

Proposing a coordination mechanism for service provision through a number of operators

This option offers coordinating solutions to regulate the current situation of service provision between a number of operators. It is expected to improve beneficiary experience, support integration in service provision, provide new frameworks for regulating care professions and protecting their practitioners, pave the way for building a care economy that supports job growth and achieves a comprehensive economic growth. However, this option would entail higher costs, as it requires the creation of new entities to be in charge of social care, whereas the first option adopts a comprehensive view of care in all its specializations and relies on expanding the scope of existing entities to support regulation of the care sector in terms of services and workforce.

1. Transforming the Social Specialties Unit at the Ministry of Human Resources and Social Development into a Commission for Social Specializations and entrusting the new commission to identify social care professions, determine professional standards, and issue social care practice licenses.
2. Establishing a Saudi Center for Accreditation of Care Facilities to examine the readiness of facilities to provide social care services and to issue licenses for these facilities.
3. Expanding the competence of the Education and Training Evaluation Commission to include early childhood programs, and programs for special education, technical rehabilitation and training targeting persons with disabilities in program and institutional accreditation.
4. Issuing a law for the practice of social care professions to regulate and protect the professions, maintain the rights of practitioners and ensure their protection upon performing their duties, and create a code of ethics for the practitioners of social care professions.
5. Including a specialty for consideration of professional malpractice as a non-health care specialization with the public judiciary, and including insurance against professional malpractice for all forms of care professions.

1st Option

Proposing the creation of a single regulator to lead the Care System

6. Including a specialty for consideration of professional malpractice as a non-health care specialization with the public judiciary, and including insurance against professional malpractice for all forms of care professions.
7. Transforming the Healthcare Development Holding (HDH) Company into a Care Holding Company to ensure full provision of health, rehabilitation and social care services in current health clusters, and transforming these clusters into integrated care clusters, provided that they build service provision alliances with the private and non-profit sector in the event of any shortage in providing integration services.
8. Assigning the task of care service financing to the National Health Insurance Center to include social care services and the services provided by the non-profit sector.
9. Entrusting the National Health Insurance Council to review the mandatory coverage of health insurance to include rehabilitative social care services.
10. Developing the private sector participation program (an initiative of the Health Transformation Program) to support expansion of care service assignments to the non-profit sector according to controls and incentives to provide high-quality and efficient services.
11. Approving a government cadre for care professions, together with a scale of financial incentives that corresponds with the burdens and risks of engaging in these professions.

2nd Option

Proposing a coordination mechanism for service provision through a number of operators

6. Supporting the outsourcing of social welfare facilities supervised by the Ministry of Human Resources and Social Development to the private and non-profit sector.
7. Entrusting the National Health Insurance Council to review the mandatory coverage of health insurance to include rehabilitative social care services.
8. Approving a government cadre for care professions, together with a scale of financial incentives that corresponds with the burdens and risks of engaging in these professions.
9. Establishing a ministerial committee formed of the Ministry of Human Resources and Social Development, Ministry of Health, and Ministry of Education to set up a national care strategy up to 2030. This strategy would entail monitoring targets of care service provision, workforce, funding, integration between service providers from governmental, private and non-profit sectors, designation of geographical coverage, protection of eligible beneficiaries, and service provision to all age groups of the population.
10. Expanding the scale of the Social Support and Protection Platform at the Ministry of Human Resources and Social Development, to include a national register of care service beneficiaries to ensure accurate classification of each case and its health, social and economic conditions, and to enhance case management and referral processes between support providers; and making this register available to all caregivers, along with setting controls for data protection and reliability.

1st Option

Proposing the creation of a single regulator to lead the Care System

12. Launching a national care strategy up to 2030, provided that this strategy includes monitoring targets of care service provision, workforce, funding, integration between service providers from governmental, private and non-profit sectors, equal geographical coverage, protection of eligible beneficiaries, and service provision to all age groups of the population.
13. Establishing a national register of care service beneficiaries within the digital identity initiative of the Digital Government Authority, to ensure accurate classification of each case and its health, social and economic conditions, and to enhance case management and referral processes between support providers; and making this register available to all caregivers, along with setting controls for data protection and reliability.
14. Encouraging non-profit organizations providing care services and non-profit health organizations to expand their research and development activities to provide treatment for chronic diseases, and to activate their societal roles to raise awareness of the methods required to care for beneficiaries and merge them in society.
15. Approving a monthly government social aid for caregivers (Carer's Allowance).
16. Adopting a participatory approach in designing programs and interventions targeting beneficiaries of the Care System, by involving beneficiaries and their families in developing their own initiatives.

2nd Option

Proposing a coordination mechanism for service provision through a number of operators

11. Encouraging non-profit organizations providing care services and non-profit health organizations to expand their research and development activities to provide treatment for chronic diseases, and to activate their societal roles to raise awareness of the methods required to care for beneficiaries and merge them in society.
12. Approving a monthly government social aid for caregivers (Carer's Allowance).
13. Adopting a participatory approach in designing programs and interventions targeting beneficiaries of the Care System, by involving beneficiaries and their families in developing their own initiatives.

Appendix: Methodology of the Qualitative Field Research

The research relied on the methodology of qualitative field research. The King Khalid Foundation's team conducted interviews with the respondent in 18 cities, governorates, and villages in the KSA. The field study specifically included the following cities and governorates: Riyadh, Madinah, Jeddah, Taif, Sakaka, Rafha, Hail, Buraydah, Unaizah, Ar Rass, Al-Bataliah (Al-Ahsa), Safwa, Al-Qatif, Al-Khobar, Al-Rayyan (Wadi Jazan), and Al-Reith, Abha, and Khamis Mushait. A number of 374 respondents from the category of the beneficiaries of care services, their family, and the practitioners in the field of providing care services were interviewed. The respondents were called through communicating with the NGOs in these areas, in addition to the inclusion of the care facilities affiliated to the Ministry of Human Resources and Social Development in the city of Riyadh as part of the research sample.

The research is conducted to try to identify the extent to which the Care System can respond to the needs of the beneficiaries, their family, and the practitioners:

The research question:

What are the challenges facing the beneficiary, his family, and the practitioner within the Care System?

The respondents were interviewed by the research team in individual interviews. The questions were asked to them based on their category. The research team prepared 3 forms for asking specific questions to each of the three categories of respondents; enquiring about their social and psychological aspects, their experience of receiving and accessing care services, their economic situation and ways to improve according to their perspective. The complete forms and questions can be found in (Form A) below. Some group interviews were conducted for the category of care practitioners if they are from the same caregiver. Other group interviews were held with beneficiaries. The number of participants in the group interviewed ranged from 2 to 8 people. The question was directed to each participant separately to collect data individually from each respondent.

With regard to the beneficiary and the categories that were interviewed, they are as follows: Mental patients, addicts, juveniles, down syndrome, attention deficit hyperactivity disorder, orphans, orphans with special conditions, Alzheimer's, patients receiving medical care services, female victims of violence, people with disabilities, autistics, elderly, and multiple sclerosis patients.

All interviews with the respondents have been transcribed and kept confidential and private. Any clear indication of the beneficiary's data and identity were removed. The research team pledged to save the data of the participants in the research, and the participants signed the consent form to participate in the research. The King Khalid Foundation undertook to keep the data received securely, without disclosing the identities of the participants. A non-disclosure consent form can be found below (Form B).

Research in Numbers

18 Cities

374 Persons

77 Recorded Hours

619,091 transcribed words

Classification according to the category of the respondent

117 Beneficiary

The beneficiary is every individual receiving a health, social or rehabilitation service

215 Social Practitioner

The practitioner is the person who works in a care institution, such as a social and psychological specialist, specialists in the field of rehabilitation, in addition to some workers in administrative positions who, contrary to their job title, provide care services due to the great need for service provision and the scarcity of qualified people to provide it in care facilities.

42 Beneficiary's family

374 The total number of interviews

The qualitative analysis process relied on pivotal qualitative analysis, whereby all texts of interviews from different regions of the KSA were reviewed, and the text was encoded with codes expressing the behavior, opinion, or participation of the participant throughout the individual interviews. Some group interviews were held with practitioners working in the same entity and beneficiaries of the same organization. The respondents were contacted through the associations providing care in the various regions of the KSA, in addition to communicating directly with government social and health care associations. The codes varied for each text between 1 to 5 codes in the analysis process, in reference to the diversity of the semantics of the experiences that the respondents go through. The codes and observations of the field research team were collected to formulate an "aspect/theme" and, in some areas, a "sub-aspect/sub-theme" and the corresponding codes, totaling 142 descriptive codes. The following is a review of the codes and their definition:

#	Code	Code Definition
1	**Refusal to receive the service**	The beneficiary refuses to receive the service provided by a practitioner or concerned party, while he is eligible to it.
2	**Incomplete experience as a result of defective operations: organizational problem**	The beneficiary's experience is incomplete due to organizational problems by the concerned authorities, such as poor management of the organization, poor coordination with other entities, and the absence of legislation.
3	**Incomplete experience as a result of lack of merit**	The beneficiary's service or experience is incomplete as the caregiver is not qualified and lacks the competencies necessary to serve the beneficiary.
4	**The care process is interrupted**	Complete interception of the care service provided by the caregiver.
5	**Additional costs**	Incurring additional costs for the beneficiary, his family, or the caregiver.
6	**The need to increase knowledge**	The beneficiary, his family, caregiver, or community members need to increase knowledge to make the care journey better.
7	**The practitioner's experience: Poor mental condition**	A feeling of psychological exhaustion and dissatisfaction, which may take different forms; either depression, loss of life meaning, despair, etc.
8	**The practitioner's experience: Functional burnout**	The practitioner works hard to the point of burning out either due to long hours, absence of holidays, etc.
9	**The practitioner's experience: Low salary**	The practitioner explains that the pay he receives is low.
10	**Absence/scarcity of care centers**	The absence or scarcity of centers needed by the beneficiary in his city.
11	**Incomplete experience as a result of defective operations: Lack of staff**	The shortage of the number of employees caused a deficiency, disruption, negligence, and incompleteness of the service provided to the beneficiary.
12	**The practitioner's experience: Lack of protection**	The practitioner is exposed to risks while performing his duties inside or outside the facility without the presence of protection measures.

#	Code	Code Definition
13	**The practitioner's experience: Not qualified**	The practitioner is not academically qualified or does not have sufficient experience to perform the work professionally
14	**The practitioner's experience: Lack of passion**	The practitioner is unpassionate and lacks interest in or sense of the importance of the tasks entrusted to him to serve the beneficiaries.
15	**Refuse treatment**	The beneficiary who suffers from a disease refuses to receive the treatment proper for his case.
16	**Relapse**	The deterioration in the beneficiary's condition after his recovery.
17	**Continuation of the care process**	The care process aims to reach the beneficiary to a certain independence and this code means that the process is still continuing.
18	**Transition from beneficiary to practitioner**	This code expresses defines the beneficiary's condition after finishing the receipt of care and after being empowered, which inspires him to transition from care receiver to caregiver; usually after he gets better.
19	**An unbreakable cycle of need**	The constant need for the same type of service, and dependence thereon in the absence of empowerment.
20	**Underage marriage**	Underage marriage case
21	**The practitioner's experience: Insomnia**	The practitioner experiences insomnia or lack of sleep, usually due to work conditions.
22	**The need for regulations and legislation**	The need for systems and legislation that guarantee rights, clarify tasks and competencies, and improve the process of providing services.
23	**Difficulty coordinating/ aligning with other entities**	Difficulty coordinating between caregivers, or the difficulty of the beneficiary, his family, and the practitioner's coordination with the caregivers.
24	**Random provision of services**	Randomness in providing services; which impedes the arrival of appropriate and professional service.
25	**Difficulty in forming partnerships**	Difficulty in attracting the attention of different parties to form partnerships on providing incomplete services or improving existing services within the Care System.
26	**Bureaucratization disrupting the procedures**	A long line of procedures and requirements to obtain approvals, data or requirements, which disrupts procedures and obstructs services.
27	**Child neglect**	Lack of interest in children in terms of the physical, psychological and educational aspects.
28	**Lack of opportunities to develop and train the social practitioner**	Difficulty in finding development opportunities such as specialized and high-quality training places.

#	Code	Code Definition
29	**Non-specialization of courses**	Difficulty finding specialized and high-quality training courses.
30	**The salary does not commensurate with the nature the job**	The remuneration received by the practitioner does not commensurate with the effort expended in performing his jobs.
31	**beneficiary's feeling of high entitlement**	A high feeling of the beneficiary of his entitlement to obtain a better and unconditional service, even if he does not meet the criteria that make him entitle to it.
32	**The practitioner's experience: Exposure to infections**	The practitioner is exposed to infection from diseases and epidemics, which gives rise to his claim for protection and allowances.
33	**The practitioner's experience: Exposure to field hazards**	The practitioner is exposed to assault or other risks on site visits
34	**The practitioner's experience: Need for support in the field**	The practitioner's need for supports, such as security protection in field visits
35	**Delays in providing services**	Delays in providing services to the beneficiary
36	**Need for automation/ digitization**	The need for digital transformation to provide services professionally, accurately and quickly.
37	**Random provision of care**	The practitioner provides the service without a clear professional procedure and standard.
38	**The place of care is not proper**	The facilities are not ready to provide the necessary care.
39	**The practitioner's experience: Need for psychological support**	That the practitioner suffers from psychological difficulties that make him needs support.
40	**The importance of sports for people with special needs**	Explain the importance of sports for people with disabilities.
41	**Unmet needs**	Feeling deprived due to non-fulfillment of a need.
42	**Culture of a people**	The culture of a people or region impedes the provision or receipt of service.
43	**Scarcity of jobs**	The jobs available are few.
44	**Organizational problems / in the organization: Long working hours**	The worker is forced to stay after the official working hours due to problems in organizing the work and the increased burdens or the number of cases he is responsible for.
45	**The service is outside the scope of the institution**	The need desired to be met is outside the scope of the available institution.
46	**Gender differences**	Differences between males and females, whether inside the family, in care homes, or otherwise.
47	**Family obligations**	Family ties that prevent the comprehensiveness of providing or receiving care.
48	**Negative view of the beneficiary**	Negative view of the beneficiary, either on the part of society or by the practitioner.

#	Code	Code Definition
49	**Gratitude**	Feelings of appreciation and gratitude felt by the practitioner on part of his work, or from the beneficiary or his family for the benevolence he received and witnessed.
50	**Confusion due to scattering care systems**	The beneficiary is lost between multiple care entities and is unable to obtain services
51	**Incomplete experience as a result of defective operations: Absence of technical solutions**	A bad experience for the beneficiary, in receiving the service due to the paper works inside the entity
52	**The need for financial support**	The practitioner or the beneficiary's need for additional financial support.
53	**Requesting opportunities**	The need for opportunities and the respondent's request for the same due to their scarcity in the field.
54	**Incomplete experience as a result of a defect in the operations: Unavailability of proper facilities**	The premises in which care is provided are not well-prepared for the beneficiary; either because it is risky or not accessible for the people with disabilities, the elderly, juveniles, etc.
55	**The need for support**	The respondent's sense of being let down and generally unsupported.
56	**Donor scarcity**	Scarcity of funders from various institutions and entities to support associations and initiatives that meet the needs of the practitioners.
57	**The need to provide suitable workplaces**	The practitioner's need for a workplace to help him provide his service, or the beneficiary's need for workplaces that suit his circumstances.
58	**The beneficiary experience: Psychiatric disorders**	The beneficiary faces psychological difficulties that may be translated into various disorders.
59	**Reducing the number of centers**	Closing some programs and reducing the number of employees.
60	**The need to raise awareness**	The need to educate the beneficiary, the community, the practitioner, or the beneficiary's family.
61	**The beneficiary experience: Exposure to violence**	The beneficiary is exposed to violence, such as verbal or physical violence.
62	**The beneficiary experience: Being bullied**	The beneficiary has been bullied, either due to his disability, his illness, etc.
63	**The beneficiary experience: Being assaulted**	The beneficiary is assaulted.
64	**Introversion**	The desire of the respondent to isolate himself from his surroundings, or the practitioner's tendency to transfer a state of introversion to the beneficiary.
65	**A sense of unfairness**	The beneficiary or the practitioner feels being wronged.
66	**Refrain from asking for help**	The beneficiary is usually reluctant to seek and receive help due to societal constraints.
67	**Absence of social service specialization in the region**	In this region, there are no social service professionals that are qualified, with the appropriate certificates and with the necessary experience to provide services, due to the absence of specialization in universities.

#	Code	Code Definition
68	**Region-specific challenges**	Certain areas suffer from challenges that distinguish them from others, such as tribalism, addiction, or lack of specific centers to provide care.
69	**Addiction**	The respondent has suffered or is suffering from addiction or that the practitioner has had an addiction.
70	**The need for a midway house**	After completion of the care and rehabilitation program, the need for a midway home before returning the beneficiary to the community; to gradually prepare him to become an effective human being and to reduce the chances of his relapse.
71	**Lack of balance between life and work**	Difficulty balancing personal and professional life due to the large number of jobs or the nature of the cases that the practitioner works on.
72	**There is no appreciation for the social work major**	The practitioner's frustration with not being appreciated by the employer, the beneficiary, or society.
73	**Need for housing**	The beneficiary's need for housing and the entity's failure to satisfy this need.
74	**Problems with government subsidies**	Delay, interruption, or inappropriateness of the amount with the case.
75	**Suicides**	The practitioner's handling of suicide cases.
76	**The beneficiary being rejected by his family**	Parents' denial or lack of understanding of the beneficiary's situation and needs.
77	**The need for allowances**	The practitioner's need for allowances commensurate with the nature of the tasks and work.
78	**Data challenge**	The absence or scarcity of data or its dispersion between different centers and destinations.
79	**Failure to benefit from the association's services**	The association provides services, but they are ineffective or non-feasible, or do not meet the beneficiary's needs.
80	**Transportation problem**	Problems in finding transportation, their availability, and the need for a driver or a car.
81	**Violence**	The respondent has been exposed to violence or the practitioner's dealing with victim of violence.
82	**Suicide**	The beneficiary or the practitioner has suicidal thoughts or the practitioner's expression of a case of suicide he dealt with.
83	**Multiple association services**	Non-specialization of the association, which leads to randomness in providing services.
84	**The beneficiary' non-credibility**	Weakness or absence of the beneficiary's credibility regarding the details of his condition, or that he receives benefits from more than one entity.
85	**Lack of family stability**	The beneficiary or the practitioner does not enjoy family stability.
86	**Lack of psychological support for the practitioner**	The entity does not provide psychological support channels for the practitioner.

#	Code	Code Definition
87	**An incomplete experience: As a result of the intervention of the beneficiary's family**	The negative impact of the beneficiaries' family on the beneficiary's experience in receiving the appropriate service.
88	**Salary interruption**	The practitioner is usually unpaid for a long period of time
89	**Salary disparity**	Salary disparity among the practitioners.
90	**Burden of care**	The practitioner or the beneficiary have responsibilities towards a family member; such as caring for an elderly or people with disabilities, which requires additional time and effort for care and attention, and meeting the necessary needs, such as medication appointments, hospitals, etc.
91	**The need for community solutions**	The need for community-based solutions that serve the beneficiary, such as support groups.
92	**Racism**	Exposure to racism due to color or nationality, or expressing beliefs that are inherently discriminatory on the basis of race or color.
93	**Intervention in advanced stages**	Intervention with the case is delayed, which led to cumulative consequences.
94	**Bad treatment of the beneficiary by the society**	The beneficiary is not accepted by the society.
95	**The high cost of specialists in the region**	The appropriate and specialized service provided for the beneficiary is costly.
96	**The practitioner's experience: Work stress**	The practitioner suffers from work stress, either due to too much work or not giving enough time to complete it, etc.
97	**The importance of partnerships**	The need for partnerships between different entities to reach the service in a timely and appropriate manner.
98	**Global practices**	Comparing or reviewing care practices in other countries around the world.
99	**Empowerment of the beneficiary**	Targeting the beneficiary's independence and self-reliance through providing him with a job for example.
101	**Diagnose the case**	Delay or error in diagnosing the case.
102	**Desire to activate partnerships**	The need for entities to enter into partnership in order to better serve the beneficiary.
103	**Competency training**	Training qualified and competent people to develop them professionally.
104	**The need for educational workshops**	The need for educational and training workshops to complete the care process.
105	**Activating social service centers**	Different social centers are activated in different sectors and regions.

#	Code	Code Definition
106	**Age bias**	Negative treatment due to a person's age, whether he is young or old.
107	**The need for media support**	The need for the authorities to highlight their issues in the media.
108	**The beneficiary experience: Poor mental state**	The beneficiary is in a bad mental state.
109	**Inferior view of practice**	The practitioner's work is disrespectfully looked at.
110	**House arrest**	Forcing person to stay without his consent.
111	**The beneficiary experience: Exposure to exploitation**	The beneficiary's vulnerability and need to serve is exploited for profit.
112	**Treatment disruption**	The cessation of treatment by the caregiver or the withdrawal of the medications from the market.
113	**Request for rehabilitation centers for people with special needs**	Request to increase the specialized centers for the rehabilitation of people with disabilities.
114	**Expecting promotions**	The practitioner expects promotions, especially after completing certain years of service, for which he becomes entitled to promotion or bonuses.
115	**Problems with the beneficiary's family**	The relationship between the entity and the beneficiary's family is not good.
116	**The need for qualification**	The beneficiary's need for qualification
117	**Difficulty in obtaining the Commission's classification**	Some social workers find it difficult to fulfill the requirements of the Saudi Commission for Health Specialties to obtain a license to practice the profession
118	**Ambiguous procedures**	The beneficiary's care journey is vague and unclear.
119	**The work environment is not suitable**	The work environment, including staff, management and location, is appropriate to the nature of the jobs.
120	**Multitasking of the specialist**	The care practitioner performs tasks outside his competence within the organization, such as undertaking administrative jobs due to poor division of duties or due to increased work pressure and lack of manpower.
121	**Problems in the educational sector**	The schools' level is low or there is a defect in the integration of the care beneficiaries within the educational system.

#	Code	Code Definition
122	**The importance of the practitioner's role**	The importance of the role of the competent practitioner in the beneficiary's journey.
123	**Lack of confidence in officials**	The beneficiary's lack of confidence in officials responsible for the Care System, such as government entities or associations.
124	**Dependence on personal relationships**	The practitioner's reliance on personal relationships to facilitate procedures or the practitioner's success reliance on his relationship with the beneficiary outside the scope of care.
125	**The moral return of social work**	The practitioner's feeling of positive feelings about providing the care.
126	**Problem with accepting new systems**	After changing the regulations, there is a difficulty on the part of workers in the sector to accept and work upon them.
127	**Awareness of the importance of psychological support**	The need to spread awareness on psychological support for the beneficiary, his family, and the practitioner.
128	**The importance of support groups**	The beneficiary or his family' need to join support groups for integration and cooperation between individuals and the formation of relationships.
129	**Difficulty accessing and communicating with the beneficiary**	The practitioner finds it difficult to reach or communicate with the beneficiary, which leads to obstruction of the services provided.
130	**Knowledge transfer**	The importance of knowledge transfer among the community of practitioners and the communication of the most qualified and experienced practitioners with the newly graduated practitioners.
131	**Guidance and advice**	Providing guidance.
132	**Availability of medicines**	Provision of necessary medicines, and whether or not they are available.
133	**Well-equipped rooms and facilities**	Availability or non-availability of rooms and facilities equipped to provide the service.
134	**The importance of professional empathy**	The importance of having empathy within the boundaries of professionalism with the beneficiary on the part of the practitioner.
135	**Lack of professional empathy**	Lack of empathy beyond professionalism with the beneficiary on the part of the practitioner.
136	**Undermining and lack of appreciation in social work**	Some of the social practitioners feel that the social work sector is undervalued compared to other sectors of work.
137	**Applying the regulations on the ground**	The applicability of regulations relating to the provision of care services.

#	Code	Code Definition
138	**Integration and sharing between social professions**	Cooperation between different social professions in the Care System to provide an integrated service to the beneficiary.
139	**Respectful and trustworthy relationship between the caregiver and the recipient of social care**	Existence of respect and trust between caregivers and care recipients.
140	**Incomplete experience: Service providers' fraud**	Fraudulent and opportunistic treatment of the beneficiary or his family, by the practitioner personally or by the organization in general.
141	**Domestic violence**	The beneficiary's exposure to violence by his family, whether it is verbal or physical violence or neglect.
142	**Refusal to provide service**	The practitioner or organization's refusal to provide the service to the beneficiary.
143	**Diminution of the beneficiary's independence**	Not enabling the beneficiary to get out of the circle of need.

The pivotal analysis concluded that the research team deduced these four axes, summarizing the results:

1 The Care System's absorption of the beneficiary

2 Workforce readiness

3 Access to care services

4 Costs and coping mechanisms

Based on this analysis, the research team formulated the answer to the research question as follows:

"The costs of the beneficiary's variable experience to access and receive care services, and the poor infrastructure of care, limits the ability of the Care System to enable the practitioner to meet the needs of the beneficiary and his family comprehensively and efficiently."

Axes map
and the corresponding basic codes

The Care System's absorption of the beneficiary

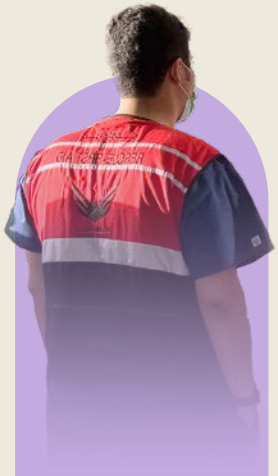
- Provision of care outside facilities
- The beneficiary identification site (collection)
- Adequate social infrastructure facilities
- Continuous need

Workforce readiness

- An unbreakable cycle of need
- Dependence on personal relationships
- The salary is not commensurate with the nature of the jobs.
- Expecting promotions

Access to care services

- Systemic obstacles
- Missed opportunities
- Deprivation
- Letting down



Costs and coping mechanisms

- Adaptation of the practitioner
- Financial costs
- Psychological costs
- Health costs
- Social costs
- Adaptation of the beneficiary

Form A

Topic Guide for Interviewing

The questions differ according to the persons participating in the interview and their different roles in the Care System. In this research, they were divided into three sections, as follows:

Introduction:

- Thanking the participants for attending.
- Introducing the research team and participants.
- Recalling the research topic, its importance, and the purpose of the discussion session.
- Specifying the question form number, either 1, 2 or 3.
- Emphasizing the privacy of information and confidentiality of data (using pseudonyms).
- Obtaining the participants' consent to audio record the interview, by signing the consent form, and informing them that they can withdraw the consent or stop the recording.

Opening Question:

- How are you today?
- How your daily schedule usually goes?

First: The questions directed to the beneficiaries of Care Services

(the elderly, people with disabilities, survivors of violence, orphans, juveniles)

Socially

- Do you think that your voice is heard by the community (Is there a party/ someone that hears your opinion, desires, or needs?)
- How would you describe society's view of you?
- What do you do in your spare time?
- Is there a public or specific place that you like to spend your time in?
- Are there adequate public places for you to spend time in?
- How would you describe your psychological state?
- Do you feel you need a leave?
- Are you getting enough sleep and rest?

Family

- How much time does your family spend caring for you?
- What do you think of the way they care about you?
- Do parents have a role in providing educational and work opportunities for you?
- Are there family obligations that distract you from work, education, or hobbies?
- Are there family obligations that distract your family from you?
- Do you feel there is difference between the distribution of family obligations on girls and boys? Do you think the difference is justified?

Friends

- Do you have a circle of acquaintances and friends?
- How do associations with friends affect the lifestyle? Does it have an impact on opportunities?
- Do you meet with your friends? Where do you usually meet? Do they go to work or school?
- Do you know any of your friends facing psychological difficulties?

Care System

- Do you receive government cash subsidy, devices, or support?
- Do you incur additional costs to cover your needs?
- How do government entities treat you?
- Introductory question: Do you deal with social workers in the association or a government agency?
- What is your assessment of the work of social workers in the association?
- What is your assessment of social workers in government entities?

Education, training and work for the able-bodied category

- Have you completed your education?
- Do you receive a monthly salary / do you have a stable source of income?
- Do you have job opportunities?
- Do you have a job or working as freelancer now? Have you been employed?
- Do you feel you need a vacation? What is your favorite type of vacation?
- What are your hobbies? Is there anyone interested in your hobbies? What is the job that you aspire to? How much is the salary?
- If you get a job opportunity less than your aspiration, will you accept it? Do you feel that job opportunities are biased towards one over the other (gender, nationality, etc.)?
- The unsegregated work environments have become widespread recently, what do you think of them, and is it suitable for you to work in such environments?

Second: Questions addressed to the families of the beneficiaries from care services

Socially

- Do you think that your voice is heard by the community (Is there a party/ someone who hears your opinion, your desires, or needs)?
- How would you describe the society's view of you?
- What do you do in your spare time? What are your hobbies?
- Are you getting enough sleep and rest?
- Are there public places where you can spend time with the beneficiary?
- If you are single, would you consider getting marriage? Are your finances sufficient?
- How would you describe your psychological state?
- Do you feel you need a vacation? What is your favorite type of vacation?

Friends

- Do your lifestyle and responsibilities affect your relationships and social life?

Care System

- Introductory question: Do you deal with social workers in the association or a government agency?
- Do you receive government cash subsidy, devices, or support?
- Do you incur additional costs to cover needs?
- How do government entities treat you?
- What is your assessment of social workers in the association?
- What is your assessment of social workers in government entities?
- Do you receive support or assistance from the authorities concerned with providing social or health care to the beneficiary?
- What are the types of assistance - if any - (medical equipment, tools, psychological support, vocational guidance, etc.)?
- What is your assessment of the services provided by the social or health care providers to the beneficiary?
- Do you receive support or assistance from the authorities concerned with providing you with social or health care?
- What are the types of assistance - if any - (financial, psychological support, vocational guidance, etc.)?
- What is your assessment of the services provided by the authorities concerned with providing you with social or health care?
- Is there coordination/ harmonization with other concerned authorities (doctor, hospital, association, ministries, etc.)?

Education, training and work for the able-bodied category

- Have you completed your studies?
- Do you receive a monthly salary/ do you have a stable source of income?
- What are your aspirations for the future? Are you facing current challenges?
- What is the most important source of support and empowerment you have/ need?

Third: Practitioners

Such as social researchers in non-profit organizations, workers in care centers, and professional specialists

Socially

- How would you describe your psychological state?
- Do you feel you need a vacation?
- Are you getting enough sleep and rest?
- How is your relationship with the family of the beneficiary?
- Do you receive support from your employer (e.g. psychological counseling)?
- Is the salary suitable for the nature of your jobs?
- What are your hobbies? do you practice them?
- What challenges do you face that hinder your work (licensing delays, receiving treatments, etc.)?
- What are the challenges you face with the group you work with?
- Do you think that the working hours are flexible or convenient? How many hours do you work per day?
- What are your aspirations for the future? Are you facing current challenges? What is the most important source of support you have/ need?

Family

- Are there professional obligations that distract you from your family or your hobbies (work-life balance)?

Care System

- Does your work provide opportunities for development and training?
- What areas do you think require change or improvement in the social service sector?
- Is there coordination/ harmonization with other entities concerned with the case you are supervising (doctor, hospital, association, ministries, etc.)?

Form B

The consent to participate in the research and the rights of the respondent

Study Title: Social Care
Principal Researcher's Name:
Information about the selected sample and the estimated time period for completing the interview or questionnaire:

You have been selected to participate in this research as you are a social caregiver or recipient.

Expected risks and privacy

The questions that we will ask in the research are general questions. If you feel embarrassed or unwilling to answer any question, you can inform the researcher of that and he will stop immediately. The participant's name will never be associated with any information. The interview will be recorded audio, and the recordings and data will be saved in a secure digital platform, and only members of the research team will be able to access them.

Expected benefits

Participation in the research will not necessarily secure a personal benefit, however, it will add knowledge value and contribute to improving policies relating to the title of the study.

Research team members

List the team members

The consent or signature of the research participant

- Consent can be obtained orally and without signature.
- I have been given a detailed explanation of the study, its aims, procedures, benefits, potential risks and complete freedom to participate.
- I understand all the information provided and received an answer to all my questions.
- I agree to participate in this study voluntarily and without any kind of coercion or pressure.
- I understand that I can stop participating at any time.
- I know that my participation will be audio recorded as part of this study.

Name
Signature
Date

Policy Design and Advocacy
King Khalid Foundation 2023

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