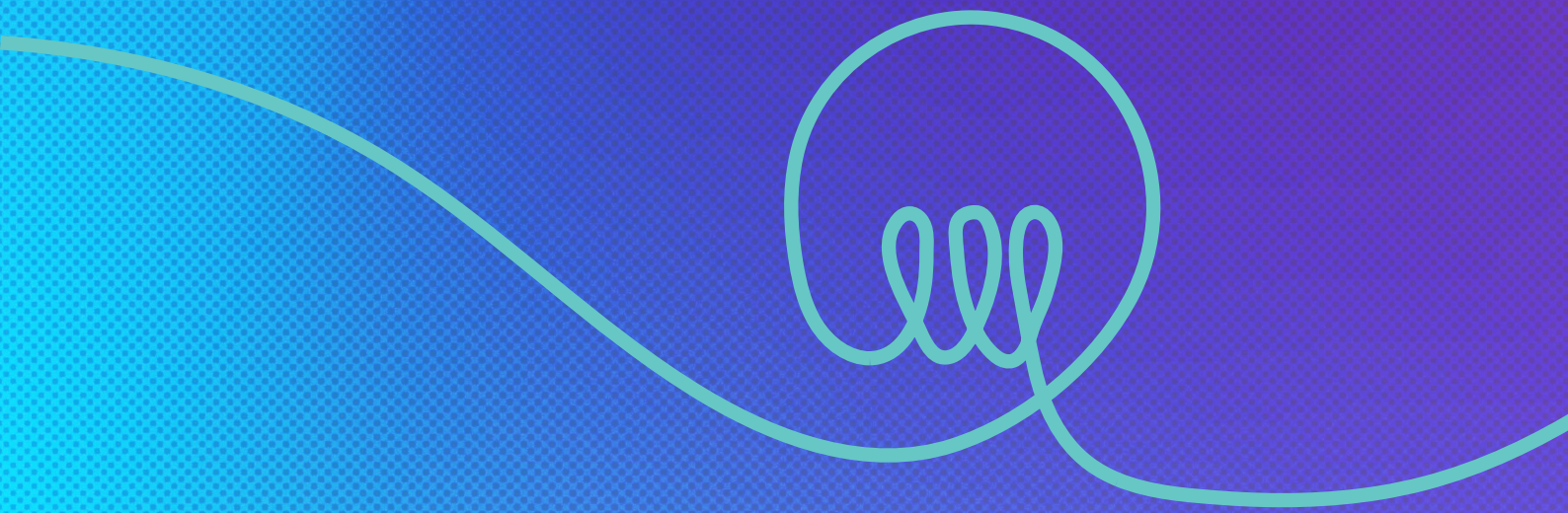
الصحة الحكيمة
value in health

Spending Well: Principles For Measuring Efficiency In The Health System Of Saudi Arabia

Policy Brief | June 2024



Contents

Authors

Mr Abdullah Alrehaili and Dr John McGhee, Value in Health

Acknowledgments

Mr Abdullah Alrehaili and Dr. John McGhee developed this policy brief under the guidance of Dr. Reem Bunyan (Value in Health).

We thank the following individuals for contributing to the development of this document: Mr Ehab Alatassi, Dr Hussam Alfaleh, Dr Azhar Ali, Eng Mohammed AlHuzami, Dr Brent James, Dr Ross Wilson, Mr Khaled Sharaheli, Dr Ayman Awad and Ms Haneen Alhussainan.

List of boxes

Executive summary

- Efficiency is a significant health system topic for Saudi Arabia, as in other health systems. International experience suggests that all health systems should be able to generate substantial efficiency gains. Although the concept of efficiency appears simple, there are a variety of meanings and uses of the term, in contexts both within and beyond healthcare, which generate a risk of confusion arising between stakeholders.

- The Saudi health sector transformation aims to improve health, improve healthcare and improve value. It is critical to note that "value" and "efficiency" are related but distinct concepts. A definition of efficiency for the Saudi health system, building on the definition of value previously developed by Value in Health, is proposed in this policy brief as follows:

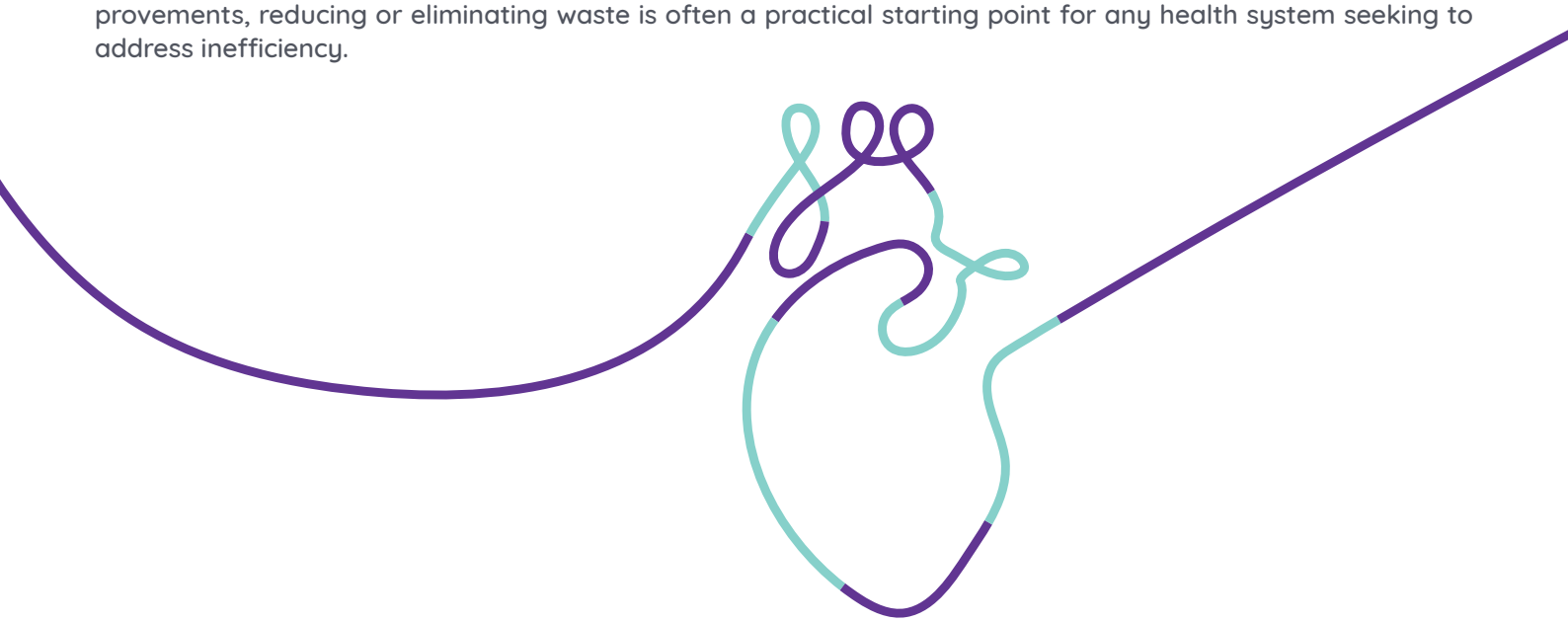
> **Health system efficiency for Saudi Arabia is the ratio of benefits delivered for individuals, communities and the population to the level of all human, capital and natural resources used to create those benefits, compared to the best-recorded performance of any health system globally.**

- **Five principles are identified as being of particular relevance to guide policymakers in selecting specific metrics to support the measurement of efficiency in the Saudi health system:**

  - Feasibility: use of currently available relevant and valid data; not delaying until data is perfect
  - Parsimony: use of as few metrics as are needed for the decisions to be taken
  - Consistency: same metrics used for all units for analysis, measured in the same way
  - Systematic adjustment: agreed rules for reflecting local factors outside the control of the unit of analysis
  - Evolution over time: increasing the completeness of measurement over time

- There are distinct and divergent perspectives on efficiency typically held by funders, payers and providers in any health system. It is imperative that, even when these perspectives cannot be fully aligned, each stakeholder is aware of the relevant concerns of others when planning activities relating to efficiency improvement.

- Even when inefficiencies can be quantified, there are substantial complexities to realizing and sustaining efficiency improvements in practice. Targeted improvements need to be translated into plans for specific changes to practice. Such plans then need to be translated into action, and the consequences of these actions must be evaluated for their impact on efficiency and sustainability. Given the complexity of delivering efficiency improvements, reducing or eliminating waste is often a practical starting point for any health system seeking to address inefficiency.



Policy brief

1. Introduction

1.1 Efficiency is a topic of great and increasing interest to healthcare policymakers. Many studies have reported material opportunities for health systems to improve efficiency and reduce waste. In a widely-cited 2017 report[1] the OECD stated, "around one-fifth of health expenditure makes no or minimal contribution to good health outcomes"; estimates in other studies broadly support this range. Unexplained variations in efficiency between regions, providers and individual services are a persistent feature of many health systems. One result of the sizable expansion in funding for healthcare necessitated by the 2019-20 coronavirus outbreak is that policymakers commonly face significantly reduced fiscal space to fund investment in health systems. Improving efficiency is one approach to releasing funding to strengthen the health system and redirect spending to other public services. For these reasons, ensuring what is spent on healthcare is spent well is now imperative.

1.2 This imperative applies equally to the health system in Saudi Arabia. The current transformation of the health sector in Saudi Arabia aims to improve health, improve healthcare and improve value. Among multiple aims stated in the country's Health Sector Transformation Strategy are the requirements to contain costs and control public healthcare expenditure without compromising the drive to improve outcomes[2]. Policymakers are now making critical decisions about how efficiency will be measured, what targets should be set, and what initiatives should be implemented to improve efficiency.

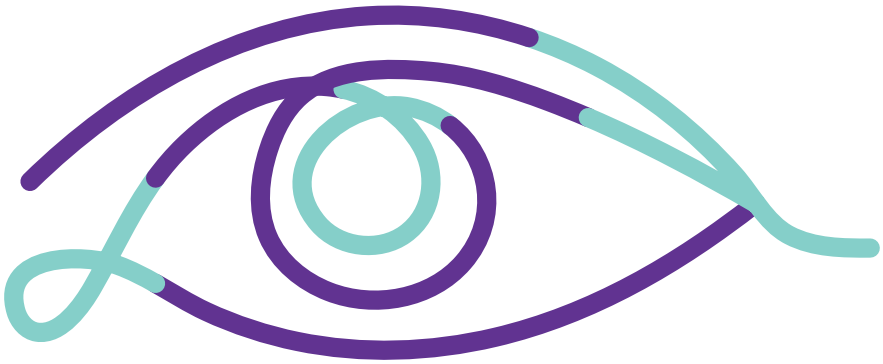
1.3 Relevant global evidence and best practices are being considered as policymakers determine how efficiency should be managed in the Saudi health sector. However, it should be acknowledged that, despite the extensive literature on health system efficiency and countries' experiences in pursuing efficiency-related initiatives over many years, health systems continue to find it highly challenging to make meaningful and sustained efficiency improvements. There are multiple challenges. Efficiency appears to be a simple concept, but it regularly proves difficult to define clearly. More foundationally, different interpretations of the term can stem from stakeholders having different - and potentially incompatible - understandings of what constitutes an inefficiency and what counts as an efficiency gain. Furthermore, efficiency targets based on national- or regional-level data can be problematic to translate into specific changes that healthcare providers can operationalize. Finally, efficiency must be seen as only one of several important factors contributing to the overall value delivered by a health system. Considering efficiency in isolation from or at the expense of other goals (for instance, outcomes, quality, access and equity) risks delivering poorer overall health system value.

1.4 Value in Health's role as the national knowledge center for value-based health and care in Saudi Arabia includes advising on policy relating to health system value, sharing relevant evidence and best practices, highlighting key issues and providing a focal point for stakeholder alignment and direction-setting. This policy brief is presented as a contribution to the current national discussion on health system efficiency and responds to the following questions raised in our ongoing discussions with policymakers:

- How should efficiency be defined for the Saudi health system?
- How does efficiency contribute to the overarching goal of establishing a high-value health system in Saudi Arabia?
- What principles should be applied to select the most appropriate measures of efficiency to meet the various needs of system stakeholders?

The intended audience for this paper is senior policymakers in the Saudi health sector, particularly those involved in managing the funding and financing of the public health system. It may also be of interest to leaders in provider organizations.

1.5 The recommendations in this policy brief are based on a rapid, high-level evidence review of recent literature on health system efficiency and feedback from briefings with senior Saudi healthcare stakeholders and international subject matter experts. The intended contribution of this paper is to propose a working definition of efficiency, aligned with the national definition of value, that can be used to promote a shared understanding of the concept across all stakeholders. More importantly, clarifying and aligning concepts and principles should be seen as only a first, albeit necessary, step towards practical actions to deliver better health system value, with efficiency improvement as an important contributing element.



2. Measuring efficiency in health systems

2.1 Definitions

2.1.1 In preparing this policy brief, it was important not to present an overly protracted conceptual discussion of efficiency. Policymakers' interest in health system efficiency should primarily be practical, relating to the decisions and actions needed to deliver more efficient care. However, a short conceptual discussion is unavoidable, given the multiple meanings and uses of the term efficiency and the high likelihood of confusion.

2.1.2 In its most general formulation, efficiency reflects how much of a desired objective is achieved for a given level of resource. Beyond healthcare, there are specific conceptualizations of the term "efficiency" in different fields such as economics, engineering and business[3].

2.1.3 In the literature, efficiency is typically considered a contributory factor towards, or sub-component of, value. Porter argues, "since value is defined as outcomes relative to costs, it encompasses efficiency"[4]. The European definition of value embeds efficiency as one of several essential sub-components of value, alongside "access and equity, quality and performance, [...] and productivity"[5].

2.1.4 One straightforward definition of health system efficiency is "a ratio of resources consumed (health system inputs) to some measure of the valued health system outputs they create"[6]. Here, "being fully efficient" means that no further valued outputs can feasibly be generated with the stated level of inputs (and, by extension, "inefficiency" is recorded where less than the maximum feasible level of valued outputs is generated by the given level of inputs). Therefore, it becomes apparent that the specific meaning attributed by a stakeholder to the term efficiency will depend upon which health system inputs and valued outputs are considered and how the maximum feasible level of valued output against which comparisons are made is determined.

2.1.5 So, to identify what health system efficiency means in Saudi Arabia, it is first necessary to understand the relevant health system inputs and valued outputs and the appropriate comparator. The Definition of Value for Saudi Arabia produced by Value in Health in 20217, reflecting the national context and goals of the health system transformation, defines system inputs and valued outputs broadly:

- "Resources [inputs] include all human, capital and natural resources,
- "Outcomes [valued outputs] relate to benefits delivered for individuals, communities and the population."

Neither the Health Sector Transformation Strategy nor the Definition of Value explicitly specifies comparators to be used that demonstrate full efficiency (and that can hence be used to quantify inefficiencies in the Saudi health system). In studies, efficiency is often expressed relative to the maximum level of outcomes that can be produced under prevailing technological processes (the most efficient system). This paper proposes "the best recorded performance of any health system globally" as the relevant comparator.

2.1.6 The Saudi definition of value also makes mention of the well-rehearsed distinction between "technical efficiency" and "allocative efficiency" in health systems (Box 1). This policy brief uses the term efficiency to refer to both technical and allocative efficiency unless otherwise stated.

Box 1 Technical and allocative efficiency

- Technical efficiency occurs when the maximum level of output is produced at a particular level of input (e.g., no more hip arthroplasties can be performed for a set level of funding) – as such it primarily relates to how outputs are produced
- Allocative efficiency occurs when no change in the mix of outputs produced could better deliver on the system's objectives (e.g., overall patient outcomes cannot be improved by changing the mix be tween hip arthroplasties, physiotherapy and medications) – this relates to what outputs are produced

2.1.7 Bringing this together, the following definition emerges:

Health system efficiency for Saudi Arabia is the ratio of benefits delivered for individuals, communities and the population to the level of all human, capital and natural resources used to create those benefits, compared to the best-recorded performance of any health system globally.

2.1.8 While this definition has the virtues of clarity and brevity, each element would require further detailing before efficiency could be quantified in practice. This exercise would no doubt highlight that many of these elements contributing to health system efficiency are not currently measured. Indeed, the literature shows that existing studies are pragmatic in defining health system efficiency more narrowly and limiting the analysis to input and output measures for which data are available. One recent systematic review8 indicated that studies used a range of inputs and outputs that can only partially represent the full range of elements required by the definition above (Box 2).

Box 2 Input and outputs commonly used in health system efficiency studies8

- Inputs: building blocks of health systems (e.g., financial value of resources spent, human resources, in frastructure); social determinants of health; health risk factors.
- Outputs: single or composite health outcomes (e.g., infant mortality rate, life expectancy); intermediate health outcomes (inpatient or outpatient workload; incidence of disease; financial risk protection; utili zation of services)

2.1.9 There are implications for how the definition of health system efficiency for Saudi Arabia should be used in practice. Firstly, for any individual efficiency analysis, the definition should be used as an aspiration and a starting point. Measures should be selected that address as much of this holistic measure of efficiency as possible, with any gaps clearly stated. Secondly, policymakers should seek, over time, to address data gaps that will enable more comprehensive efficiency measurement in the future. Finally, while the discussion to this point has focused on overall health system efficiency, the proposed definition can be reframed for application for any selected unit of analysis below the system-wide level (e.g., region, provider, pathway or individual unit of patient care). Policymakers could access a broader range of valuable insights to inform decision-making if comparisons can be made at these multiple levels. A suggested formulation is provided below.

Healthcare efficiency in Saudi Arabia, for any particular unit of analysis, is the ratio of benefits delivered for individuals, communities and the population by that unit of analysis, to the level of all human, capital and natural resources used to create those benefits, compared to the best-recorded performance of any sufficiently similar unit of analysis.

2.2 Principles

2.1.1 As discussed above, it is unlikely that policymakers in any health system will have access to the full range of measures to enable a comprehensive assessment of health system efficiency. However, there is significant scope for policymakers to choose between many available and possible measures to contribute to their assessments of efficiency. This section will propose a set of principles that can be applied to select the most appropriate efficiency measures (Box 3).

Box 3 Principles for selecting measures of efficiency

- Feasibility: use of currently available relevant and valid data; not delaying until data is perfect
- Parsimony: use of as few metrics as are needed for the decisions to be taken
- Consistency: same metrics used for all units for analysis, measured in the same way
- Systematic adjustment: agreed rules for reflecting local factors outside the control of the unit of anal ysis
- Evolution over time: increasing the completeness of measurement over time

2.2.2 Two principles relate to using any type of data for decision-making in health systems. The first, feasibility, encourages the use of all available data now, even if partial, in preference to defining a fully comprehensive framework of measures that may not be useable for many years while data and systems mature. Much can be achieved to improve efficiency and reduce waste without the need for fully granular, real-time data on all aspects of performance. Efforts to strengthen the data infrastructure of the Saudi health system should not get in the way of practical initiatives to improve efficiency based on available data and transparent assumptions based on judgment. Realistically, it should be noted that efficiency studies often focus on cross-hospital comparisons where data is more readily available. Many health systems remain far from being able to make meaningful comparisons of efficiency at pathway or individual unit of care levels.

2.2.3 The second principle, parsimony, also applies to data for decision-making beyond efficiency. While transparent reporting of different dimensions of health system performance is critically important to bringing about a high-value health system, the number of measures mandated in all health systems, including Saudi Arabia's, has increased rapidly in recent years. There have been calls to reduce the volume of measurement that does not directly contribute to making decisions that improve healthcare9. Regarding efficiency, as in other performance topics, "intemperate measurement is as unwise and irresponsible as is intemperate health care"[10].

2.2.4 The third and fourth principles are specific to the comparison of efficiency measures between units of analysis. Consistency – using the same metrics, measured in the same way over time for all comparators – is critical. There are significant risks of drawing wrong conclusions from analysis where data lacks appropriate levels of standardization both in metric design and collection methodology. Meaningful comparisons also necessitate an agreed mechanism to adjust for relevant dissimilarities between comparators. Some form of systematic adjustment of measures will be needed to reflect local factors and constraints beyond the control of the unit of analysis.

2.2.5 Finally, policymakers should initiate efficiency analysis with a clear understanding of the limitations of existing measures and a commitment to evolving measures over time. Policymakers in health systems such as Saudi Arabia that are committed to improving value have a strong desire to measure efficiency in terms of outcomes that matter for patients and the full range of financial and non-financial resources consumed to generate these outcomes. However, outcomes measures and broader measures of resource consumption take time to establish and get right. If it is only possible to measure intermediate outputs and financial resources now, these should constitute current efficiency measures. As new and more comprehensive measures emerge, these can be incorporated into efficiency reporting in due course.

3. Understanding typical stakeholder perspectives on efficiency

3.1 Funders

3.1.1 The preceding discussion of definitions and principles can assist in understanding the various perspectives on efficiency commonly held by different stakeholders in health systems. While the goals of "improving efficiency" or "eliminating inefficiency" are broadly shared by all stakeholders, these goals mean different things depending on your role in the health system. While it may not be feasible to fully reconcile the different requirements of funders, payers and providers concerning efficiency, it is important to describe how these stakeholders might understand efficiency differently. In the following discussion, the most common areas of interest for each stakeholder group in the topic of efficiency are described in terms of what inputs and outputs are relevant, their most relevant units of analysis, and what comparators are prioritized. This discussion should highlight any areas of contention that could form the basis for future alignment.

3.1.2 In broad terms, the funding entity's role in a publicly-funded health system includes identifying the total level of funding to be allocated to the health system to meet national objectives related to health and ensuring the health system operates within its allocated budget. If this is the case, funders will likely be most interested in efficiencies that reduce or control the financial resources spent on the health system (often described as spending efficiencies). While funders may be interested in regional variations in efficiency, their unit of analysis is often the national system as a whole, comparing its performance over time (i.e., against previous years' budgets) and across countries (i.e., relative efficiency compared to other health systems). While sophisticated funders will understand that improving the financial management of the health system should not come at the expense of health outcomes (in terms of quality, access, equity, experience), the focus is commonly on maintaining output in terms of quantity of activity or on high-level national measures of outcome (e.g. life expectancy, mortality).

3.1.3 This perspective can be illustrated with reference to how the Ministry of Finance in Saudi Arabia places efficiency firmly in the context of its goals of overall fiscal discipline and sustainable economic growth11. The Ministry of Finance is supported in its role by the Expenditure and Projects Efficiency Authority (EXPRO). This body enables "government agencies to adopt best practices that contribute to achieving efficiency in spending." While this in no way implies that the sole focus of funders is on spending efficiencies, such efficiencies are clearly of great importance.

3.1.4 This has implications for how funders estimate the potential for efficiency improvement, how efficiency targets are communicated to payers and what they would count as an efficiency gain. Funders may be interested in top-down assessments of health system spending efficiency, comparing financial resources committed and the level of output achieved between different years or regions within the health system or between their health system and others. Targets for efficiency improvement may or may not be explicitly set by funders for payers, but expectations about future spending efficiency improvement will be communicated by the total allocation of funding to the payer as a delta against historical spending. Finally, funders are likely to want efficiency initiatives to impact positively on total spending, not merely avoid future costs or improve outputs or outcomes at a greater cost.

3.2 Payers

3.2.1 Put simply, payers play a bridging role between funders and providers. Payers are accountable to funders to manage total spending within prescribed budgets while also delivering on the agreed goals for the health system. They carry out this role by, among other activities, contracting with providers, managing their performance and paying for their services. There may be tension caused by their accountability to funders for prudent spend management and their desire to encourage providers to improve outcomes. Therefore, payers may themselves wish to emphasize both improvements in outcomes and cost control; their accountability to funders may, in times of limited fiscal space, lead them by necessity to focus on spending efficiencies.

3.2.2 The primary unit of analysis for payers is the provider (in some health systems, the individual hospital or primary care center; in others, groups of providers or accountable care organizations). The payers' role in managing providers demands a degree of pragmatism about what can be measured and incorporated into provider contracts. While there may be a desire to contract providers against improved outcomes, the lack of available measures may preclude this. Payers may find themselves contracting for improved data from providers first, and there will be a tendency to prioritize currently available, countable data in the short term. Of critical importance to payers in relation to efficiency is the release of the benefit of efficiency improvements back to the payer. While the payer may encourage a provider to increase efficiency, improving services or reducing costs, the payer will see no benefit from this improvement unless it can be released as a financial benefit to the payer through the contract.

3.2.3 The approach taken by payers to setting and managing efficiency targets for providers will vary depending on the composition of the health system and the nature of the contractual relationship. Payers may provide targets for efficiency improvement informed by comparative analysis, and this could take place at any level of granularity: provider, clinician or unit of care. These efficiency targets may also be hypothecated would count as an efficiency gain. Funders may be interested in top-down assessments of health system spending efficiency, comparing financial resources committed and the level of output achieved between different years or regions within the health system or between their health system and others. Targets for efficiency improvement may or may not be explicitly set by funders for payers, but expectations about future spending efficiency improvement will be communicated by the total allocation of funding to the payer as a delta against historical spending. Finally, funders are likely to want efficiency initiatives to impact positively on total spending, not merely avoid future costs or improve outputs or outcomes at a greater cost.

3.2 Payers

3.2.1 Put simply, payers play a bridging role between funders and providers. Payers are accountable to funders to manage total spending within prescribed budgets while also delivering on the agreed goals for the health system. They carry out this role by, among other activities, contracting with providers, managing their performance and paying for their services. There may be tension caused by their accountability to funders for prudent spend management and their desire to encourage providers to improve outcomes. Therefore, payers may themselves wish to emphasize both improvements in outcomes and cost control; their accountability to funders may, in times of limited fiscal space, lead them by necessity to focus on spending efficiencies.

3.2.2 The primary unit of analysis for payers is the provider (in some health systems, the individual hospital or primary care center; in others, groups of providers or accountable care organizations). The payers' role in managing providers demands a degree of pragmatism about what can be measured and incorporated into provider contracts. While there may be a desire to contract providers against improved outcomes, the lack of available measures may preclude this. Payers may find themselves contracting for improved data from providers first, and there will be a tendency to prioritize currently available, countable data in the short term. Of critical importance to payers in relation to efficiency is the release of the benefit of efficiency improvements back to the payer. While the payer may encourage a provider to increase efficiency, improving services or reducing costs, the payer will see no benefit from this improvement unless it can be released as a financial benefit to the payer through the contract.

3.2.3 The approach taken by payers to setting and managing efficiency targets for providers will vary depending on the composition of the health system and the nature of the contractual relationship. Payers may provide targets for efficiency improvement informed by comparative analysis, and this could take place at any level of granularity: provider, clinician or unit of care. These efficiency targets may also be hypothecated against stated efficiency improvement levers, such as reducing administrative overhead or increasing the use of day surgery.

3.3 Providers

3.3.1 Irrespective of the level in the system at which efficiency targets are set, it is typically providers that are required to operationalize, deliver and realize the benefits of efficiency initiatives. Well-performing providers are likely to be committed to continuous improvement of their services. They can be expected to seek to improve efficiency without external incentives, as this would smooth the internal operation of the provider and free up resources to be reinvested internally. Beyond this, a provider might be expected to drive further efficiencies only to the extent to which their contracts incentivize them to do so. As a result, efficiency initiatives may focus on areas specified in provider contracts, and providers would rationally seek to retain as much of the benefit of each efficiency improvement as possible.

3.3.2 It should be noted that providers in publicly-funded health systems rarely have complete control over either the level of activity or the main cost drivers. If payers specify activity levels, quality targets, access and coverage levels, then there may be little that providers can do to reduce demand and activity. Similarly, if resourcing ratios are set nationally, if staff pay, facility, asset and consumable costs are specified by national bodies, individual public providers may have very little decision space to improve efficiency without compromising access or quality.

3.3.3 It is a straightforward task to conjecture efficiency improvements at the provider or payer level that might fail to meet funders' expectations. A provider that reduces an administrative team from six to three people but continues to receive the same level of funding or decreases theatre time for an operation by a small amount but cannot translate this gain into increased throughput has generated efficiency improvements that would not be valued by payers or funders. A payer that reallocates funding from one region to another, improving access and outcomes, has delivered an efficiency but not one that delivers the type of spending efficiency that funders require.

3.3.4 While it may be difficult to reconcile the different perspectives of funders, payers and providers on what constitutes an efficiency improvement, it is helpful to discuss and understand these different viewpoints. Being clear at the outset on what expectations need to be met will be valuable. In the remainder of this policy brief, it will be argued that all stakeholders can be aligned in the short term around the potential for improving efficiency by reducing waste in the delivery of health services.

4. Improving value in the Saudi health system: reducing waste and transforming clinical services

4.1.1 Today, the Saudi health system continues its comprehensive sectoral transformation. The goal to improve the measurement of value (costs and outcomes) at all levels of the system is well-understood, and there are multiple ongoing initiatives to progress this, such as efforts to align and streamline the current multiplicity of system-level performance indicators[12] and to quantify case-mix to facilitate assessment of the relative performance of hospitals[13]. While it is critically important to quantify and compare efficiency between and across health systems, an equally pressing question is how to generate efficiency improvements in practice. Health systems commonly find inefficiencies to be stubbornly persistent. There is extensive experience from other health systems, as well as from within the Saudi health system, of different approaches to tackling efficiency. One fruitful approach was presented by the Institute for Healthcare Improvement in its paper ***"Increasing Efficiency and Enhancing Value in Health Care"*** [14]. A distinction is drawn in this paper between "immediate efficiency drivers", where improvements can be achieved in the short-term even if the baseline level of efficiency cannot be fully quantified and validated, and "medium-term and national drivers" which require a greater understanding of the data or are beyond the immediate control of individual providers. Examples are given in Box 4. Rather than using benchmarking to assess potential levels of efficiency improvement, payers may be better advised to assess what is driving waste in their health system and establish measures that track initiatives to address the underlying drivers of waste.

Box 4 Examples of efficiency drivers

Immediate efficiency drivers

- Adverse events and complications
- Readmissions
- Procedures of low value and unnecessary/futile procedures (e.g., ineffectual elective procedures)
- Staffing: turnover and days lost; premium pay; skill mix
- Service throughput
- Wastes in administrative staffing
- Generics prescribing, cost-conscious prescribing
- Inventory management
- Medicines compliance

Medium-term and national drivers

- Health promotion and prevention
- Health literacy, the "social health contract" and cost-conscious use of health services
- Addressing non-health social determinants of health
- Use of incentives and competitive levers
- National service and quality specification, staffing ratios
- Reducing costs of regulation (inspection, admin)
- Nationally-set wage rates
- National procurement of medicines, consumables, services and assets

4.1.2 Focusing on eliminating and reducing waste in the short term will enable efficiency improvements to be delivered while efficiency metrics and longer-term efficiency opportunities mature. Frontline staff in providers can be empowered to pursue waste reduction without the need for onerous oversight and target setting.

4.1.3 Efficiency contributes to and is subsumed by the concept of health system value. From a system-wide perspective, efficiency is best pursued as part of an overall program of system transformation to generate better value, not as a standalone initiative. The Saudi health system already has the benefit of a system-wide clinical transformation program, and improved efficiency would be best approached as part of this existing program; it would seem counterproductive to focus purely on healthcare efficiency in a standalone initiative. Frontline staff will be less engaged if it interprets efficiency initiatives as cost-cutting measures that put at risk the quality of patient care. A recent review of global evidence on approaches to system-wide efficiency initiatives supports the view that focusing solely on efficiency may not be successful. The review identified several instances of the failure of "central approaches to improving financial performance such as "cost containment" initiatives, with limited consideration of impacts on care quality and potential longer-term impacts to service delivery"15. It also identified various prerequisites for success, including appropriate tools and training to support improvement, a focus on longer-term sustainability beyond the annual financial cycle, a localized approach to delivery under clear national targets and rules, and the engagement and enthusiasm of local leaders.

4.1.4 A final point is that discussions of health system efficiency risk focusing exclusively on supply-side improvement. A primary driver of efficiency in health systems is the informed and prudent use of health system resources by citizens. Funders are advised that substantial spending efficiencies may also be accessible through demand-side initiatives.

5. Moving forward

5.1 Efficiency is a key topic for policymakers in the health systems of Saudi Arabia, as it is elsewhere. No health system can yet measure efficiency comprehensively, and there are substantial methodological difficulties to resolve in comparing the efficiency of different health systems. Stakeholders are advised to treat the concept with appropriate caution and to expect confusion, as those with different roles will interpret efficiency depending on their perspective and priorities. This challenge should not stop us from seeking efficiency improvements, and the first practical areas for providers to address should be the elimination or reduction of waste and the identification of low-value care. Efficiency is not value, and value is not efficiency, but efficiency can be achieved in the Saudi health system through the existing national programs to deliver system-wide clinical transformation to bring about a high-value health system.

5.2 In a short policy brief on efficiency, it is difficult to be conclusive and impossible to be exhaustive on a topic of such complexity and extensive existing research and commentary. By framing efficiency as a sub-element of value and emphasizing the need to work pragmatically now while strengthening measurement over time, Value in Health seeks to prompt stakeholders to clarify and share their expectations and plans regarding health system efficiency. Our intent is to continue to encourage and support stakeholders in the Saudi health system to quantify and deliver greater efficiency. We are engaging national policymakers to generate further research questions for the Center on this topic. This paper and the definition proposed herein will be revisited in our work program for 2025.

References

1. OECD. Tackling Wasteful Spending on Health, OECD Publishing, Paris. 2017.
2. Ministry of Health, Kingdom of Saudi Arabia. Health Sector Transformation Strategy, V3. 2016. https://www.moh.gov.sa/en/Ministry/vro/Documents/Healthcare-Transformation-Strategy.pdfAccessed 3 September 2023
3. Roberts MJ, Hsiao W, Berman P, Reich MR. Getting Health Reform Right. Oxford University Press, Oxford. 2008.
4. Porter, Michael E. "What is value in health care." N Engl J Med 363.26 (2010): 2477-2481.
5. Expert Panel on effective ways of investing in Health (EXPH) Defining value in "value-based healthcare". 2019
6. Cylus, Jonathan, et al. Health system efficiency: how to make measurement matter for policy and management. World Health Organization. Regional Office for Europe, 2016.
7. Value in Health. Definition of value in health in Saudi Arabia: Policy Perspective. Value in Health, Riyadh. 2020.
8. Mbau, R, et al. Analysing the Efficiency of Health Systems: A Systematic Review of the Literature. Applied Health Economics and Health Policy. 2022.
9. Meyer, GS, et al. More quality measures versus measuring what matters: a call for balance and parsimony. BMJ Qual Saf 2012.
10. Berwick, D. Era 3 for Medicine and Health Care. JAMA. 2016.
11. Ministry of Finance. Budget Statement Fiscal Year 2023.
12. Al-Ghamdi, Mohammed, et al. "Development of national framework for health status and health system performance indicators in Saudi Arabia." Journal of Infection and Public Health 16.2 (2023): 295-302.
13. Alshehri, A.; Balkhi, B.; Gleeson, G.; Atassi, E. Efficiency and Resource Allocation in Government Hospitals in Saudi Arabi: A Casemix Index Approach. Healthcare 2023, 11, 2513.
14. Martin LA, Neumann CW, Mountford J, Bisognano M, Nolan TW. Increasing Efficiency and Enhancing Value in Health Care: Ways to Achieve Savings in Operating Costs per Year. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2009.
15. Walters, James Kenneth, et al. "Supporting efficiency improvement in public health systems: a rapid evidence synthesis." BMC Health Services Research 22.1 (2022): 1-11.

الصحة الحكيمة
value in health