

Sufficiency to Efficiency A Paradigm Shift in Health Financing



Introduction

Successful advocacy and increased global awareness has led to a significant increase in development assistance for global health in the past 20 years. One of the driving factors of this increase has been the objective of sufficiency — allocating adequate levels of aid to address defined goals. Development assistance has undoubtedly and significantly improved the health of millions globally; however, there is still great need and greater attention to health outcomes can augment resource success. Moving forward the focus can no longer be on advocating for larger global health spending. Instead, donors, countries, and health program managers alike have to strive for achieving better efficiency of spend. As noted by the Center for Global Development’s Working Group on Value for Money in Global Health “more health for the money is not about reducing costs or cutting budgets, but rather about maximizing the health impact of every available peso, pound, or pula to reduce human suffering and save lives”.¹

This paper provides a framework for successfully transitioning to a more efficient use of available development health resources and maximizing the value of global health investments.

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— Center for Global Development’s Working Group on Value for Money in Global Health

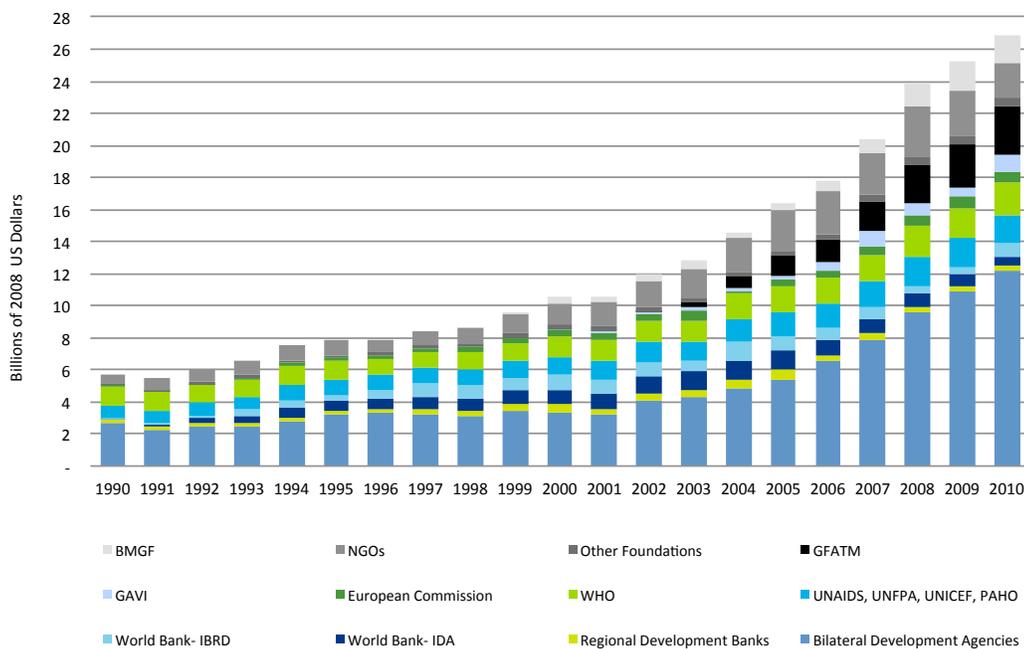
¹ Glassman, A., et al. “More Health for the Money: A Practical Agenda for the Global Fund and Its Partners.” Center for Global Development. <http://www.cgdev.org/sites/default/files/more-health-for-the-money-consultation.pdf>. (2013).

Reflection on the Sufficiency-Driven Development Assistance Landscape

Changes in Development Assistance Levels from 1990 to Present

Between 1990 and 2001, Official Development Assistance (ODA) grew 5.9% annually reaching \$10.8 billion US by 2001. By 2010, ODA nearly tripled reaching an astounding \$28.2 billion US. The influx of funding from the US President's Emergency Plan for AIDS Relief (PEPFAR) starting in 2004 catapulted US funding for HIV/AIDS. From 2004 to 2010 PEPFAR funding increased by 178% from \$2.3 billion to approximately \$6.4 billion US.² Changes in the contribution of all donors to ODA, including the US, are illustrated in Figure 1. However, recent global economic crisis has resulted in the leveling off of foreign aid assistance around \$28.1 billion US since 2012.³

Figure 1. Distribution of Official Development Assistance, 1990-2010



Source: IHME DAH Database 2010, Deloitte analysis

² "U.S. Federal Funding for HIV/AIDS: The President's FY 2014 Budget Request." The Henry J. Kaiser Family Foundation. <http://www.pepfar.gov/documents/organization/189671.pdf>. (May 23 2013).

³ "Financing Global Health 2012: The End of the Golden Age?" Institute for Health Metrics and Evaluation. Seattle, WA: IHME. <http://www.health-metricsandevaluation.org/publications/policy-report/financing-global-health-2012-end-golden-age>. (2012).

Increased Spending, Yet Still Great Need

The substantial net increase in global health funding over the last two decades has led to significant progress towards the World Health Organization's (WHO) Millennium Development Goals (MDGs). During the last twelve years since the implementation of the MDGs, improvements have been achieved in nutrition, reducing morbidity, and mortality due to HIV infection, tuberculosis and malaria, and increasing access to improved drinking water. However, there are large variations in health outcomes both between and within countries and there is still great need in the areas of maternal mortality and child health.⁴

Between 1990 and 2010 the maternal mortality ratio declined by an average annual percentage of 3.1%.⁵ Furthermore, the WHO declared that one quarter of the countries with the highest maternal mortality ratio in 1990 made "little to no progress" in reducing maternal mortality during the past 20 years.⁶ Globally the average maternal mortality ratio remains at 240 per 100,000 births, a ratio 15 times greater than the developed world.⁷

Currently, only 37 of the 143 low- and middle-income countries are on track to meet the Millennium Development Goal 4 target by 2015.⁸ Additionally, there is large variation in advancement of child health across countries and geographic regions. Africa has experienced the lowest decline in the rate of under-five mortality in the last twenty years. As a result the region's percentage share of the under-five deaths has increased from 33% in 1990 to 49% in 2012.⁹

Challenges to Health Outcome Performance

There are a number of significant obstacles that inhibit donor funding from maximizing tangible results. There is inconsistency in the donor funding process that often relies on incomplete and/or ill-informed partner budget proposals due to a lack of robust historical data to forecast future needs. Donor funding is fragmented leading to increased reporting burden on countries, increased administrative costs, and potential duplication of investments. There are weak incentives for recipients to create and measure impact. This can be partially attributed to the fact that there is a lack of utility-focused program and performance evaluation standards and methodologies limiting the ability to measure true program impact. Finally, there is a lack of transparency on funding usage, a lack of mechanisms for resource tracking, and limited verification of self-reported data. This lack of transparency makes it difficult to accurately account for the lifecycle of financial resources and understand how funds are being allocated by recipients in the field. The absence of these data prevents the identification of program and management inefficiencies, further diluting the impact of funding dollars.¹⁰

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⁴ "World Health Statistics 2012" World Health Organization. http://www.who.int/gho/publications/world_health_statistics/EN_WHS2012_Full.pdf. 2012.

⁵ Trends in maternal mortality: 1990 to 2010. WHO, UNICEF, UNFPA, and The World Bank estimates. World Health Organization. http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf. 2012.

⁶ "World Health Statistics 2012" World Health Organization. http://www.who.int/gho/publications/world_health_statistics/EN_WHS2012_Full.pdf. 2012.

⁷ World Health Organization. Maternal Mortality Fact Sheet. <http://www.who.int/mediacentre/factsheets/fs348/en/> (2012).

⁸ World Health Organization. World Health Statistics 2012. http://www.who.int/gho/publications/world_health_statistics/EN_WHS2012_Full.pdf. 2012.

⁹ Farag, M., et al. "Health expenditures, health outcomes and the role of good governance." *Int J Health Care Finance Econ.* 13(1): 33-52.

¹⁰ Glassman, A., et al. "More Health for the Money: A Practical Agenda for the Global Fund and Its Partners." Center for Global Development. (2013).

Another issue influencing the effectiveness of development aid is the “fungibility” of donor funding. Aid is fungible when a “government offsets donor spending for a particular purpose by reducing its own expenditures on the same purpose therefore aid substitutes rather than supplements local spending.”¹¹ Previous research demonstrates a clear substitution of donor funding for government health spending. The result is that donor funding is associated with reduced government spending on health. In particular, in low income countries, a \$1 US increase in donor funding per capita resulted in a 27 cent decrease in government health spending. This ratio was even more dramatic for middle income countries in which a \$1 US increase in donor funding per capita resulted in a 63 cent decrease in government health spending.¹² This conclusion suggests that even though donors have been increasing their attention on global health problems through increased resources, country governments have not done the same and have been shifting their funding towards non-health needs affecting their ability to improve outcomes.

A Re-evaluation of ODA Spending

In the face of continued fiscal constraints and recognizing that improvements in health systems performance and health outcomes has been inconsistent, there has been a movement to re-evaluate how health is funded with the ultimate purpose of increasing the effectiveness of health spending.

Increased attention towards development aid effectiveness has resulted in four international High Level Forums on the topic: Rome, Italy in 2002, Paris, France in 2005, Accra, Ghana in 2008, and Busan, Korea in 2011.

The 2005 Paris meeting led to the development of the Paris Declaration on Aid Effectiveness, a watershed document that details a comprehensive action plan to improve the quality and effectiveness of aid. Representing a broad consensus of over 100 developed and developing countries, this document provided measurable and evidence-based indicators to track progress and enforce the accountability of both donors and recipients. The Paris Declaration was a bold move towards improving the effectiveness of development spending. Yet according to the OECD’s report, *AID Effectiveness 2005-2010: Progress in Implementing the Paris Declaration*: “globally, donors, and developing countries [fell] short of the goals that they set themselves for 2010.” In fact, of the 13 targets established by the donors and developing countries who endorsed the Paris Declaration, only one target successfully met the 2010 deadline.¹³ USAID has also recognized the need to improve value for money as well as the effectiveness and sustainability of its achievements. In 2010, USAID began an ambitious reform agenda called USAID Forward, which has refocused the Agency on a results-oriented development approach with the aim of increasing accountability and transparency.¹⁴

These initiatives increasingly emphasize country ownership, systems improvements, greater accountability and long-term sustainability. While the goals are laudable, progress has been inconsistent. This paper hopes to provide a framework that can help both countries and donors translate their objectives into tangible action.

¹¹ Farag M., et al. “Does Funding From Donors Displace Government Spending For Health In Developing Countries?” *Health Aff* (4): 1045-55. (2009).

¹² Farag M., et al. “Does Funding From Donors Displace Government Spending For Health In Developing Countries?” *Health Aff* (4): 1045-55. (2009).

¹³ *Aid Effectiveness 2005-10: Progress in Implementing The Paris Declaration*. OECD Publishing. <http://www.oecd.org/dac/effectiveness/48742718.pdf>. (2011).

¹⁴ USAID Forward Progress Report 2013. U.S. Agency for International Development. <http://www.usaid.gov/usaidforward>. (2013)

Transitioning from Sufficiency to Efficiency: A Paradigm Shift



While health system performance has been a recent focus of the development and health community, there has not been an accompanying emergence of practical, real world-tested approaches to achieve and quantify program performance and link them back to health outcomes. The Sufficiency to Efficiency (S2E) framework provides a focused and comprehensive approach to thinking about how we finance health systems and deliver healthcare in the most efficient manner to maximize the outcome of investments. The objective of the S2E framework is to support country health systems in maximizing value for money. It aims to assist countries to do more with the money they have available by reducing margins, improving decision-making on resource allocations, and improving the distribution of resources within the health system.

The S2E framework supports a fundamental shift in thinking, offering an approach for countries and donors to make resource decisions based on expected outcomes and set up transparent processes to monitor resource spending, assess progress, and make mid-course corrections.

Understanding Efficiency

Critical to realizing this paradigm shift is understanding what efficiency and optimal performance of a healthcare system looks like and how we measure outcomes.

At its most basic level, efficiency measures output produced per unit of input or, alternatively, the cost of producing one unit of a product or service.^{15,16} An efficient process uses the least amount of time, effort, and cost and produces the maximum amount of desired output, whether it be a good or service, thereby maximizing the use of every dollar invested. When looking at efficiency within a healthcare system, the definition of efficiency is broadened to include not just program outputs, but longer-term health outcomes and impacts.

Efficiency should be manifest across the national health system, not just within individual, vertical health programs. We define the *healthcare system* as the collection of all stakeholders, systems, and processes that contribute to delivering health care within a country. Health systems are not limited to the public sector or a private hospital system, but are rather the combination of all inputs and actors (government, donors, community organizations, private practices, etc.) that are intended to impact health outcomes. An efficient healthcare system is one that achieves intended health outcomes and impacts with wise use of resources, aligns investments with its core vision and mission, and eliminates redundancy and waste.

The S2E framework supports country health systems in maximizing value for money by reducing margins, improving decision-making on resource allocations, and improving the distribution of resources within the health system.

¹⁵ McGlynn, EA. Identifying, Categorizing, and Evaluating Health Care Efficiency Measures. Final Report. AHRQ Publication No. 08-0030. Rockville, MD: Agency for Healthcare Research and Quality. April 2008.

¹⁶ Academy Health. Efficiency in Health Care: What Does it Mean? How is it Measured? How Can it be Used for Value-Based Purchasing? Highlights from a National Conference. May 2006.

The Sufficiency to Efficiency (S2E) Framework

The performance gap within healthcare systems lies in the lack of systematic and routine measurement and tracking of program inputs and their impact on health outcomes. Such information is critical to making informed resource allocation and other funding and programmatic decisions.

The S2E framework defines a process that can enable countries to continuously track financial flows within the healthcare system, trace resources to program outcomes, and rationalize, improve, align, and invest resources to maximize impact. This process emphasizes capacity building and country ownership to build sustainable systems through continuous process improvement.

The S2E framework segments health system performance into tangible health financing and performance measurement categories: resource allocation, resource management and consumption, measurement of return on investment, and alignment of resources to goals. While the individual components of the S2E framework are not new, the emphasis of the framework is on the comprehensive application of all components. This structure challenges us to rigorously study and document the flow of dollars through the health system, link health spending to health outcomes, and make informed budgeting decisions that align with strategic priorities and yield a high return on investments.

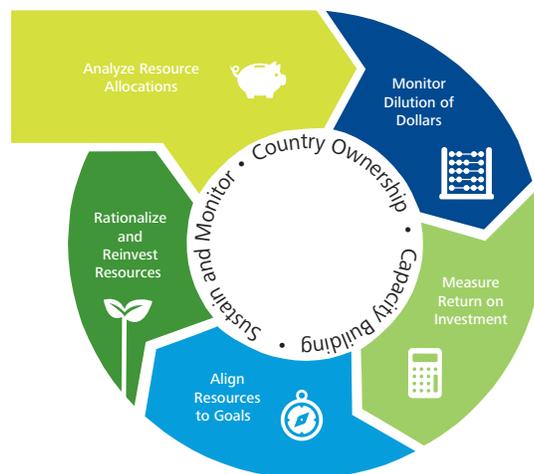


Figure 3. The Sufficiency to Efficiency framework

Analyze Resource Allocations

The first step in moving towards an efficient health financing system is understanding how much money is available for health programming and how those resources are being spent. This analysis examines availability of resources from internal (within the health system) and external (e.g., bilateral aid) sources, how these resources are currently being budgeted, and historical resource allocations. Data to facilitate this analysis can come from many sources such as the National Health Accounts (NHA). A critical element in this step is examining the rationale and process of allocating and obligating resources, as well as

identifying external variables that affect this process. In many health systems, resources are often allocated based on historical budgets, top-down norms that have been established by international agencies, political interests, or perceived strategic opportunities. Regardless of the resource allocation methodology used, many political and environmental factors can impact the budgeting process. Earmarked resources or an anomalous epidemic of diarrheal disease will have direct implications on how resources are budgeted. Understanding these factors and the scope of their reach will inform the inclusion of contingencies in the budget. Similarly, it is important to explore different budget scenarios based on a market analysis. Understanding the implications of different scenarios helps in analyzing the budget and available resource allocation options.





Monitor Dilution of Dollars

Once resources have been allocated, they pass through multiple layers of administrative processes before reaching the point of service delivery and ultimate beneficiary. Funds are diluted at various points in the system due to transaction costs, salaries for staff that process the funding at different levels, general inefficiencies in the system, delays in program implementation, high-cost, but low-impact programs, duplication of efforts, and misappropriation of funds among other factors. Dilution of dollars refers to this trend of diminishing resources as they flow through the financial system. Some sources estimate that through the dilution of dollars only a small proportion of donor funding will actually reach beneficiaries.¹⁷

Understanding where funds are “lost” in the flow of resources will help identify and address larger systemic problems and improve overall health system performance. Examining resource consumption patterns can help policy makers, program managers, and other stakeholders determine if budget execution is aligned to budget outlays, where the variance may lie, and the efficiency and performance implications that variance has.

The Health Resource Tracking Heat Map can be used to inform this step in the S2E framework. The Heat Map is a visualization tool that creates a graphical representation of the flow of resources through various layers — from the source to the point of service. This tool visually illustrates how much of the originally allocated resources reach the target destination and identifies the points of diversion (loss of funds) as well as potential reasons for these diversions.

Examining dilution of dollars through the Heat Map methodology requires the following three steps: (1) environmental analysis, (2) leakage identification and measurement, and (3) monitoring and reporting.

1. **Environmental Analysis** — The first step to developing a Heat Map is to chart the current funding flows and resource consumption patterns. This necessitates an environmental analysis where financial and budget data is reviewed at all levels of the health system: national, provincial, district, and facility levels. The mechanisms through which funds are being disbursed (donor, government, NGOs, private sector, facilities) and for what purposes (administration, training, treatment, prevention, commodity purchases) are closely scrutinized. An analysis of the actual health programs and interventions implemented and the cost of these activities will provide a very functional understanding of how resources are spent. It is also important to examine policy, cultural, political, and other contextual factors that impact disbursement of funds. For example, there may be specific regions within a country where resources rarely reach the point of service due to geographic isolation, weak infrastructure, conflict, or other social, economic, or geo-political reasons.

An efficient healthcare system is one that achieves intended health outcomes and impacts with wise use of resources, aligns investments with its core vision and mission, and eliminates redundancy and waste.

¹⁷ Ramachandran, V. et al. “Haiti: Where Has All the Money Gone?” Center for Global Development. <http://www.cgdev.org/content/publications/detail/1426185>. May 2012



2. Leakage identification and measurement — Once the disbursement hierarchy is defined through the environmental analysis, it is easier to trace funds through the system and evaluate resource diversions and the points at which they are occurring. Variances between funds received and funds disbursed at each link in the disbursement chain indicate the degree of leakage at different points. There is of course an expected amount of reduction in total funds as they go through the system to cover the cost of salaries and other administrative costs. The environmental analysis will establish the reasonable thresholds for this natural leakage within the specific context of each country. Any additional leakages will be graphically represented on the Heat Map using different colors to represent different causes of the leakage. The Heat Map will start to show where the greatest losses in transmission occur as the money flows through the system.

An integral component of this step is defining the underlying causes of the identified leakage. Subsequent analysis will examine the likelihood of these challenges recurring in the future and the relative impact on the flow of funds. Impact scores can be calculated to quantify the loss in the transmission of funds and the cost to the recipient program (which can be measured in terms of reduction in number of health service recipients, etc.). This scoring helps to define thresholds for the magnitude and severity of leakages in the system. As these thresholds will be defined by each country, they provide actionable parameters to prioritize challenges and design mitigation strategies to minimize, if not eliminate, identified challenges.¹⁸

3. Monitoring and Reporting — In addition to implementing processes to minimize identified leakages and mitigate impact on flow of resources, on-going monitoring is needed to keep track of the appropriate management of leakage points in the system. Such monitoring helps to identify any changes in the severity or magnitude of leakage points in response to mitigation activities. In addition, there should be periodic reporting and updates to the Heat Map to pinpoint any new and emerging disturbances.



Measure Return on Investment

After establishing how health resources are allocated and quantifying how much of the allocated resources reach the points of health delivery, the next question to ask is “how does the health system as a whole benefit from the spending of these funds?” In other words, “what is the return on investment (ROI)?”

While it is common place to actively track and measure ROI in the commercial sector, the public sector has not readily adopted this practice, particularly within health system strengthening. While many speak about improving value for money, it is rarely substantiated with tangible approaches to measure and optimize ROI. The S2E framework underscores the value of measuring and optimizing ROI as a necessary facet of advancing health system efficiency.

ROI is often confused with ‘cost effectiveness’, which is a common measurement in the health and development space. Cost effectiveness helps to answer the question: how much does it cost to be effective? On the other hand, ROI measures what a health system or economy gets in return for investing in specific health activities. It allows for a comparison to other investments by converting results into common units. For example, which investment yields more returns — expanding medical facilities or building a cadre of community health workers. The return or common unit can be defined in terms of savings in health expenditure, reduction in cost of care, improvement of health care infrastructure, or development of human capital, all of which can be powerful arguments for the Ministries of Finance and Health when allocating funds. This type of comparison can greatly facilitate the health budget planning process.

¹⁸ Deloitte. Health Resource Tracking Heat Map Concept Paper. Unpublished: 2013.



Define Investment Context:

As a first step in measuring ROI, it is important to define clear objectives for specific programs, investments, outcomes, or impacts to allow for measurement and conversion into common units. Objectives can be determined quantitatively or qualitatively. Though qualitative objectives are harder to measure, it is important to develop a comprehensive understanding of all dimensions of a health program and its intended outcomes.

All stakeholder groups should be identified and engaged in this process to identify all costs and benefits (value) associated with a specific program or initiative per the perspective of each stakeholder. This is an important differentiation to make as one program benefit may be perceived as a potential cost for another stakeholder.

When considering costs and benefits, it is critical to specify the stakeholder which is incurring the costs and accruing the benefits. There are many stakeholders in the health system. There are also many direct and indirect benefits from health programs. ROI calculation ought to be specific to programmatic stakeholders that are making the initial investment or resource allocation decisions. It is important to include the cost to households as well as the programmatic costs to associated institutions (e.g., governments, donors). Explicitly bringing households into the discussion will confirm that benefits can be calculated from different perspectives: donors, government or society as a whole. The results, and therefore policy implication, will vary significantly based on which perspective is taken. Within the context of the national health system, ROI measures should be focused on ministries of health and finance and direct benefits to the national health system.

Develop ROI Evaluation Model:

The standard ROI equation is:

$$ROI = \text{Net Benefits} / \text{Net Costs} \times 100\%$$

The net benefits of a program should include all intended or actual program outcomes or impacts. Benefits should be stated as specific and tangible program outcomes or impact. To facilitate common understanding across all stakeholders, the identified benefits should be weighted for relative importance against program objectives and performance expectations. The critical, and often challenging, step in calculating ROI is assigning a value to identified benefits in order to determine the ratio of benefits to costs.¹⁹ This challenge is compounded by the fact that many health sector benefits may not be realized for a number of years after the investment is made. All assumptions (including timeframe of expected returns), criteria, and rationale used to monetize benefits — especially qualitative program outcomes — should be clearly articulated and documented in ROI calculations. Given the time lag between investments and accrual of benefits it is important to decide whether to use social discount rates as opposed to market discount rates.

Once the program costs and benefits have been specified, weighted, and monetized, it is time to examine the effects of the outcomes and impact on the portfolio of healthcare investments.



Align Resources to Goals

Data from the resource allocation analyses, the dilution of dollars, and the ROI analyses should collectively be used to inform processes for improving the performance of the health finance system and improve overall value of health investments. The financial valuation of programs ought to be complemented by a broader analysis of non-financial

¹⁹ In the global health context, value is usually defined in non-monetary terms using measures such as disability-adjusted life years (DALYs) and quality of life adjusted life years (QALYs).

factors to improve overall efficiency of the health system. A health system is efficient only as far as it is able to achieve its goals and objectives with the resources it has available. Once ROI estimates have been established, the next question to ask is whether these returns on investment align with national health priorities. In other words, do the returns from investments align with and facilitate achievement of national health goals?

This requires an assessment of the larger policy context and competing national-level objectives. For example, investments in building health centers in rural areas may improve the overall infrastructure of the nation and improve health outcomes for adult males. However, the same level of investment in training a cadre of community health workers who can deliver in-home counseling and care may contribute further to improving maternal and child health outcomes.

The Multi-Attribute Decision Analysis (MADA) is a methodology to identify and compare trade-offs between different choices through a process of systematically assigning and weighting values to different financial and non-financial considerations.²⁰ MADA encompasses the following five steps:

1. Review and confirm national-level financial and strategic health objectives
2. Identify relationships between health investments and these objectives
3. Define ways to measure anticipated health project performance against objectives
4. Assign value to each objective, and
5. Interpret results and use information generated to assess the various strategies to achieve the health objectives.



Rationalize and Reinvest Resources

The resource allocation process should be revisited to better align investments to health activities that support national health objectives, have high return on investment, and have limited dilution of dollars as funds flow to the point of service delivery and beneficiaries. A transition to an efficiency-driven model necessitates enhancing existing financing systems to include performance-driven allocation strategies, such as Performance-Based Budgeting

(PBB). Performance-focused allocation processes are grounded in the relationship between program inputs and ultimate program results and will take into account program performance as well as return on investment. This results-oriented budgeting approach asks questions such as:

- Did this project cost what we expected?
- Did this project achieve what we expected?
- If not, why? Where are the gaps in cost and/or achievement?

Variances in budgeted cost and actual expenditure are not only used to adjust budget line items for subsequent budget cycles, but also to identify financial, programmatic, or policy changes necessary to achieve improved health results.

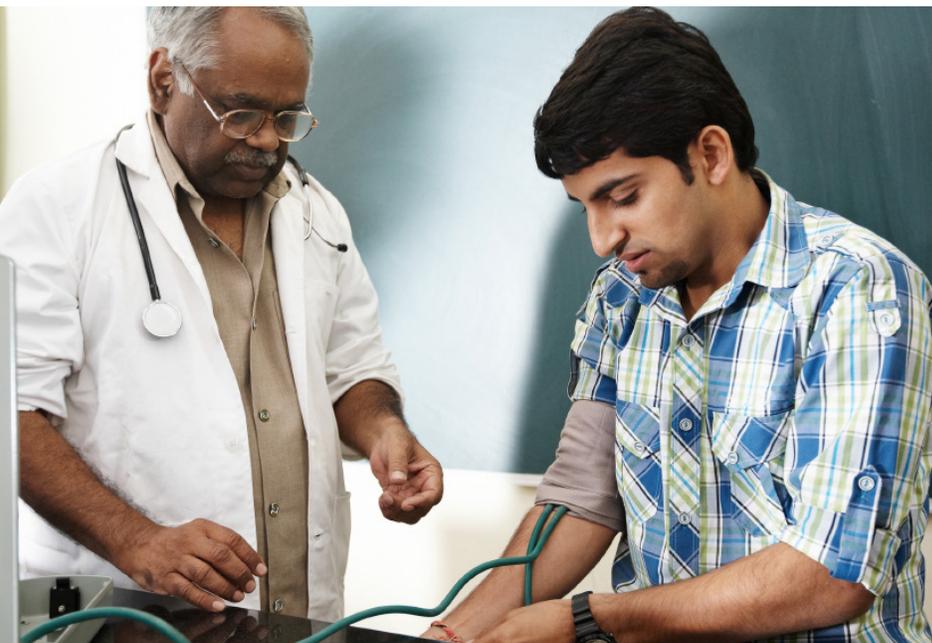
Once a decision is made to upgrade the financing system to a performance-based system, it is important to develop a policy statement that legitimizes and guides resource allocations based on defined performance criteria. Once this is completed, a work plan should be developed that includes staffing, timing, deliverables, milestones, budget outlay requirements, and program outcomes. A solid change management approach is also critical, as altering resource allocation processes will affect many programs and individuals across the health system. Orientation and training, as well as a strong tailored communication plans will enable successful implementation.

²⁰MADA is a Deloitte methodology that was developed based on decision-science to understand complex problems that are characterized by any mixture of monetary and non-monetary objectives.

The Way Forward

Recognizing that transitioning to a new financing system is not feasible for most settings, the S2E framework provides a series of steps to augment existing processes within different segments of the healthcare financing system. Taken together, the components of the S2E framework provide deep insight into the relationships between the healthcare financing system, resource allocation processes, program outcomes and impacts, and return on investments. This information will help to rationalize and improve resource allocation decisions to focus on high impact programs that provide a high value for money, improve the budget-execution, and tracking processes to minimize organizational redundancy and eliminate waste and align programs and investments around core mission areas.

To effectively implement the S2E framework, national health systems need to assume full ownership of the process and focus on building capacity of their personnel in health finance, budget planning, monitoring, and management, and program evaluation. Country ownership and capacity building can enable the customization of processes to accommodate local contingencies and help ensure sustainability of system improvements and gains achieved. National stakeholders should also put in place a monitoring strategy to document and assess the progress of the transition to an efficiency-focused health system. Any changes made to the health financing, budget planning, and allocation processes and resulting health system performance changes need to be diligently monitored and evaluated to determine whether and where gains in efficiency have been achieved. Feedback mechanisms should be in place to allow for regular communication of progress made and additional input into performance improvements of health system performance. This focus on continuous process improvement stresses the need for a country-led process and the development of new capabilities to enable gradual transformation to a more efficient system.



As the global health community increasingly demands to see value for money, national health systems, donors, as well as sub-national health programs must be prepared to validate the impact of every health dollar spent and demonstrate improved system and performance efficiencies. The more that health systems adopt and implement the *sufficiency to efficiency* mindset, the further that we, as a global health community, can impact a foundational paradigm shift in health financing and program performance in which achieving optimized resource utilization and maximizing program impacts are core objectives of health programming.

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