

050: BENCHMARKING HOSPITAL CARE

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Objective:

The objective of the Hospital Benchmarking Programme was to develop and test measures of hospital productivity and to expand performance measurement beyond the hospital level.

Methods:

STAKES (National Research and Development Centre for Welfare and Health) launched a Hospital Benchmarking Programme in co-operation with the hospital districts in 1997. One of the aims was to develop a new measure that would describe the output of the hospitals better than the traditional measures, such as admissions or out-patient visits.

The programme took advantage of the existing information systems in hospitals. The output data were supplemented with data on resource usage. Total hospital operating costs and the costs of the services in each speciality were provided by hospitals. Productivity was defined as the relationship between the output and input needed to produce the output.

The programme set out to organise data collection and to identify the key measures needed in the benchmarking process. A set of performance benchmarks were designed to serve as indicators of productivity. The main aim was to extend the comparison of productive performance beyond hospital level. Due to the special characteristics of hospital production, benchmarking in hospitals requires multiple performance indicators.

The basic measure used to describe hospital output was the episode of treatment, the total care process of the patient in the specialised care. As final outputs, the episodes of treatment consisted of one or more discharges and often outpatient visits. Episode generating algorithms based on case-mix classification were used to combine all of the relevant contacts of a patient into a single care process. Productivity measures could be, for example 'episode productivity' (the sum of weighted episodes divided by the total costs), 'the average number of admissions per episode' and 'the average costs per episode'. The indicators that were used to measure productivity could be viewed from different viewpoints and levels e.g. hospital, speciality, patient group (DRG = diagnosis related groups) and from the regional viewpoint.

The information collected in the national database was made easily accessible to all participating hospitals via the Internet.

Results:

The results of this programme have encouraged hospitals to launch their own projects to improve performance. For example, benchmarking data have been used to set hospital budget target levels that take into account the savings potential or potential for productivity improvement. They have also been used to sort out the most significant patient groups economically and to assess the savings potential in resource usage by these groups. Benchmarking data have also been employed to reallocate resources and restructure care processes, such as the balance between hospital and outpatient care or between hospital and long-term care. Still, there remains a large potential for wider use of the benchmarking databases.

Conclusions:

Assessing the impact of the Benchmarking Programme requires evidence of its effects on hospital performance. The present system already covers a broad range of process and productivity indicators that can be used to manage patient care on the operative level of action. However there is wide agreement that productivity indicators cover only this aspect of performance measurement, and that balanced measurement would also include information on health outcomes.

The productivity of Finnish hospitals will be estimated by using appropriate methods and will be monitored continuously. However, a major educational effort will be necessary before optimal use can be made of the benchmarking services and large volumes of data available.