

Victorian public hospital funding and productivity

Report by Access Economics Pty Limited for

Victorian Healthcare Association

EXECUTIVE SUMMARY

The Victorian health care system is at the forefront of service delivery in many areas. However, **the current system is overly complicated and does not incorporate an evidence based review and benchmarking process** to provide detailed information to health services of where improvements might be made.

There is little evidence of notable productivity growth having been achieved over recent years (although admittedly productivity growth is very difficult to measure), and there are ongoing financial sustainability challenges for many health services.

Of late, the volume of services delivered by Victorian public hospitals has been roughly in line with targets. Total separations for 2007-08 at 1,397,000 were 0.8% below the target while within this, WIES separations were 0.7% above target. This indicates that health services are dealing with more complex care as WIES is an index of complexity. This may be part of the reason why labour productivity appears to be diminishing.

However, service delivery against targets can differ markedly by individual hospitals and by cost centres. While the overall volume of services being delivered is near target levels, the financial performance of Victoria's hospitals remains of concern.

Victorian hospitals do compare well against the national average in terms of efficiency. However, lately it is taking more staff time to achieve separations at public hospitals, both in Victoria and for Australia as a whole. This means negative labour productivity growth. However, this negative outcome may be offset by a rising quality of service over time (and the quality of public hospital services is difficult to measure). This may be due to increasing complexity of patients who are being treated in acute environments with increased prevalence of co-morbidity within our ageing communities. In addition, an increasing emphasis on ambulatory solutions to care will result in greater complexity and acuity when patients do end up in a bed based environment. With public expectations of the health system at high levels, increased activity in developing quality controls is evident. This results in increasing compliance costs for all hospitals.

Looking forward, it is evident that much needs to be done to prepare the health system for the challenges ahead. These include an ageing population, an increasing burden of chronic disease, rising cost of and demand for new medical technologies and significant health workforce constraints (particularly in regional areas). This combination of events will see increasing pressure on health budgets at a time when the ratio of workers to dependants for the community as a whole is also expected to rise – or in other words, the burden of paying for the system is falling on relatively fewer shoulders.

The current economic downturn presents an opportunity for the public hospital sector. Significant fiscal stimulus is being injected into the economy as a core part of the Federal and State government action to offset the impact of the global financial crisis.

A fast tracking of investment activity across the health sector – building new hospitals and health service facilities – funded by public borrowing may be a worthy element of the government response to the economic downturn. This is particularly so given that arguably there has been under-investment in public hospital infrastructure over the past two decades, there is likely to be strong demand for health care services going forward, and the next two years may provide a cyclical low point for construction costs.



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The financing system for public hospitals in Victoria encourages hospitals to produce efficiency gains over time. In practice however, many hospitals are not meeting the efficiency targets set of them. This is happening on a widespread scale, which suggests:

- efficiency targets are set at a level which is too restrictive; and/or
- hospitals are constrained in other ways from achieving further gains.

The Victorian Auditor-General found nearly half of Victoria's public hospitals ran an operating deficit in 2005-06. Access Economics' analysis suggests the situation has not improved in 2006-07 and 2007-08. **Overall, the public hospital system in Victoria remains under significant financial stress.**

The case studies shown later in this report include several hospitals who are still struggling to achieve break-even performance. While casemix funding is widely applauded as providing a mechanism to achieve technical efficiency in the distribution of resources, this outcome indicates a broader social need to review this funding mechanism in order to achieve better allocative efficiency and social equity.

In addition, this report has found that cross-subsidisation between departments is widespread, and creates problems for individual hospitals, particularly if it is ongoing for a number of years. This practice indicates an unsustainable set of circumstances in a particular department – perhaps running more services than it should or in an inefficient manner, or the root cause could simply be that the unit price attached to service delivery is inadequate. **Cross-subsidisation can mask such problems rather than trying to address solutions. The practice can also occupy the time of administrators, diverting them for their role in improving health service delivery.**

Although arbitrary productivity targets are being set within the funding framework, the broad measure of productivity growth shown here (and more importantly, the actual financial performance of hospitals), suggests these targets are not being achieved.

In general, productivity growth in the health care sector is difficult to achieve. It could be derived from a variety of sources, including:

- more capital** (a higher volume of equipment – 'more machines' – which can deliver outcomes more efficiently than alternate processes);
- better use of capital** (having better equipment or making better use of existing equipment to again achieve outcomes more efficiently);
- changing the mix of labour and capital** used to deliver services (particularly where lower cost labour or capital can be used to deliver components of services without any loss of quality);
- more efficient work practices** (such as rostering practices which minimise unused labour); and/or
- streamlining administration** (such as introducing centralised systems which can deliver economies of scale, provided there is no loss of functionality or quality).

Historically, many of the productivity gains in the health care sector have no doubt largely been achieved by adopting better technology over time (investment in more capital and better capital). Often such gains from additional investment do not mean a lower cost (indeed the investment often means a higher ongoing cost), but the investment does deliver an improvement in either the volume of services conducted or the quality of service.

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While capital investment as a driver of productivity gains is part of the answer, further productivity gains may also be achieved on the back of good benchmarking data. Only with the latter will hospitals have a good understanding of which of their activities perform well and which don't (and more importantly, be able to identify sources of difference between their own operations and best practice).

A concern with the current performance monitoring framework (PMF) is that it has little tie-in with broader Department of Human Services (DHS) policy, providing only output targets. The PMF is seen as a means of identifying underperformance, but provides few answers for hospitals as to how to get out of such a situation, or avoid getting into it in the first place, and limited assistance to allow the under performers to improve.

Under the performance framework, increased monitoring should help focus attention on the areas of underperformance. However it can also represent an increased burden on an already stretched health service. Additional reporting may help identify areas of stress or in need of improvement, but it also may merely consume the administrative resources that would otherwise be used to find problems and improve process.

The use of these indicators against a fixed bonus funding pool also has the potential to discourage sharing of information and methods – improvements made by other hospitals could result in less bonus funding for your hospital.

Capital funding

Capital is a key element of the future capacity of the Victorian health care system to deliver on productivity growth. Linking capital funding to areas of identified potential productivity improvement could well unlock significant gains for the overall efficiency and effectiveness of the health care system. Indeed, productivity dividends will become increasingly difficult to meet without the benefit of strategic capital investment. For example, many of the case study sites are operating from fully depreciated infrastructure. This results in a significant redirection of funds to infrastructure maintenance that might otherwise be applied to the provision of services.

The current allocations for capital funding are ad hoc and short term focused. It is also not clear how funded projects link in with social cost benefit priorities.

Many hospitals have infrastructure and asset management objectives integrated into their corporate and strategic plans. However, the current system is missing a critical link between these asset management objectives and the funding framework. Capital grants are decided on a year by year basis, based largely on immediate need, rather than any longer term asset planning. Population data (detailing growth and ageing trends) and town planning and urban growth strategies are readily available to guide the development of new health infrastructure.

Recommendation 1: The Victorian government develop a plan which sets out specific health system capital expenditure priorities for the next ten years and general priorities for the decade beyond. These priorities should be in line with population based projections of need and be the driving force behind future capital grants.

A ten year capital expenditure plan would provide health facilities with greater certainty about their future operations. The government should still retain a degree of short term flexibility in



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its capital grants, but allocate the bulk of those grants on the basis of identified longer term goals.

The existing system to allocate capital funding to Victorian hospitals is also overly complicated, creating a large administrative burden on health services. At present there are multiple sources of capital funding which require different funding applications.

Recommendation 2: DHS consolidate the capital grants framework into a single stream of funding for investment in infrastructure and equipment that is guided by the ten year capital plan.

Benchmarking

Benchmarking is an area where there is scope for considerable improvement. At present there is very little opportunity for health services to benchmark against their peers beyond the benchmarks set via the casemix funding process. The case studies undertaken to inform this report illustrate the difficulty of achieving meaningful comparisons of data using currently available public data from within the Victorian health system.

DHS have access to a wide range of information, and will have more once the HealthSmart system is fully implemented. However, little comparative data is provided back to health services leaving many in the dark about which areas of their operations are performing efficiently and which are less so. This is a significant shortcoming of the current system.

Reporting of financial outcomes may also be improved by reporting on individual business units, allowing better tracking of any moderation in productivity or acceleration in costs. Linked patient record data could also provide a significant improvement to service delivery.

Providing good data is only half of the benchmarking story – using the data to deliver more efficient operations is the other half.

For health services, embracing the move towards a greater emphasis on benchmarking through data analysis, comparison of inputs, operational procedures and outcomes is the best approach to managing change. Simply put, getting closer to the frontier of efficient performance today will be the best defence against future challenges.

Benchmarking needs to be accelerated and taken to the next level of development. More detailed analysis of hospital performance is required in order to adequately explain variations between best and worst performance. This involves isolating information by cost base and then analysing outputs to identify the reason for the outlier relative to the benchmark.

A dedicated function within the health system may be needed to research broad based opportunities to improve productivity over time across the entire public hospital system. In some cases this will involve broad base policy reform and potentially structural change in the delivery of health care. In other cases this will mean genuine micro economic analysis of operational practices against benchmarks identifying outliers with a view to improving productivity and identifying innovation.



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Recommendation 3: DHS develop standard reporting tools to allow detailed benchmarking and cost comparison across health services. Such information should be provided to health services in a regular and timely fashion and be supported by a business improvement unit embedded within DHS, or through an external provider funded by Government to undertake the task.

Administrative burden

For operational funding, beyond the core funding streams there are also a **network of grants** – all requiring administration - which often need to be applied for. At the individual hospital level these grants are a required part of their funding pool, but ensuring receipt of them can often be a difficult and/or time consuming process. Earmarking small streams of funding for specific items also limits the ability of hospitals to innovate and specialise.

Recommendation 4: DHS review its system of operational grants with a view to both consolidating small grants into bigger funding pools where possible and to analysing the efficacy of the current grant methodology to the service outcome being funded.

Note that this argument (against small specific funding streams) is the same issue as Commonwealth specific purpose payments to the States. The Commonwealth and COAG have now agreed to basically do away with these small grants in favour of singular infrastructure type block funding.

Transparency of funding

Many health services expressed frustration with a lack of information on changes to WIES allocations and EBA funding. Some information is also not being provided in a timely manner and therefore inhibiting planning. The process of how DHS arrives at an amount of compensation for EBA changes is not always transparent.

Recommendation 5: DHS detail the operational funding budgets for health services by the commencement of June each year and include a transparent tracking of movement in the sum of funds available to each agency.

Setting the WIES and other unit prices

The WIES and other unit prices are set as part of the Budget process, with WIES prices then published as applicable for major providers, with different (marginally higher) prices applicable for various smaller and rural providers. It is unclear how often these relativities are reviewed. Cost pressures can be notably stronger in rural areas, so without an annual review cost burdens for WIES services could unreasonably escalate in rural areas.



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Recommendation 6: The relativity between the WIES price for rural hospitals and smaller metropolitan agencies, and that for major providers be reviewed by DHS annually.

Overall the funding provided is seeing many health services struggling to achieve a break-even performance. The case study agencies demonstrated a range of results according to funding source. Funding for emergency services and for residential aged care (including mental health) is generally identified as inadequate. At some agencies, funding for acute services also presented a point of fiscal pressure. These findings indicate a need to review the methodology and mix of services included within each funding approach. Alternate activity based approaches are available, including the approach taken in South Australia where intensive care is funded through a blend of 70% fixed costs, and 30% variable costs.

Recommendation 7: The range of services funded through WIES and other fixed unit price approaches be reviewed to determine the suitability of the approach to the service being provided.

Bonus funding

The incentives in the bonus funding framework and in the hospital funding system more generally discourage co-operation and information sharing between health services, and even between health services and DHS. Each hospital is essentially pitted against other hospitals in the region, and across the State, as they fight it out for resources and funding for the community they service and for their own staff.

The result can be that assisting other health services to improve productivity or lower their cost base actually helps to take a slice of bonus funding away from your health service.

In large part the incentives for productivity growth are set at a broad level, with hospitals then given the task of figuring out how to achieve those gains. Some hospitals would be better placed than others to deliver gains, but that does not seem to be reflected in the productivity targets implicit within the funding framework.

Limiting funding and increasing required targets creates an adversarial environment between hospitals and DHS, whereby hospitals may have an incentive to be less than forthcoming with DHS (to 'hide' their efficient practices). This adversarial framework can also extend between hospitals as they compete for bonus payments in the bonus funding framework. The result can be that assisting other hospitals to improve productivity or lower their cost base actually helps to take a slice of bonus funding away from themselves.

Recommendation 8: DHS move the bonus funding framework to one which is consistent with greater co-operation. The framework may be modified to allow for a capped maximum bonus payment for each health service which is independent of the capped maximum bonus payment for other health services.

Skilled workforce

Maintaining a skilled workforce has been a big issue for many health services. There are initiatives underway at the Commonwealth government level to address health workforce



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shortages with a notable increase in training of medical professionals and nurses underway at present.

There are also other means of addressing skill shortages including greater retention of skilled staff to the sector and a more flexible allocation of tasks among the health workforce where possible. For example, that may mean nurses and allied health practitioners perform some of the roles of GPs where they have the skills to do so.

Recommendation 9: DHS sponsor workforce research that achieves job redesign and more flexible work practices to ensure the retention of an appropriate skill mix where alternate retention strategies have proven to be unsuccessful.

ICT strategy

The new HealthSmart system has the potential to make a difference in streamlining administration and being the vehicle which allows for much better performance data to be disseminated. However its implementation has been slow and counter productive to date for many services. Implementation costs are being borne at the service level, which has helped to generate resentment.

A further shortcoming of the current approach is that the capacity to implement the system is less than the need. That is, capacity does not exist to implement the system State-wide in a timely fashion and some services who have not been early adaptors of the product offering will be significantly disadvantaged financially through this choice of later implementation. This results in an inequitable approach to implementation and encumbers the potential productivity to be achieved through the strategy. The case studies indicated that product choice was the major barrier to agency willingness to participate as it was felt that the resource investment required far outstripped the potential gain.

Recommendation 10: DHS commit to both review the product suite and to fully fund the implementation costs for HealthSmart and proceed as quickly as practicable to rapid implementation.

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