

Victorian public hospital funding and productivity study

Presentation to Victorian Healthcare Association members

8 May 2009



The health care system

- The Victorian health care system is at the forefront of service delivery in many areas.
- Victorian hospitals compare well against the national average in terms of productivity.
- CoAG's direction is towards the Victorian model.
- But...
- The system is complicated and bureaucratic.
- Public hospitals operate under significant financial stress.

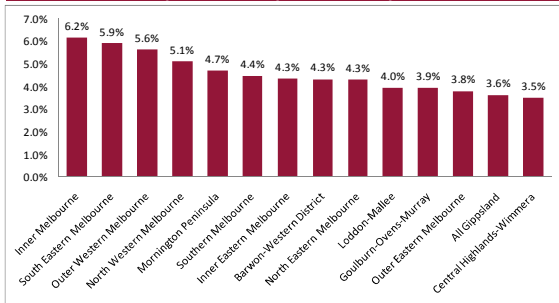


There are significant challenges ahead

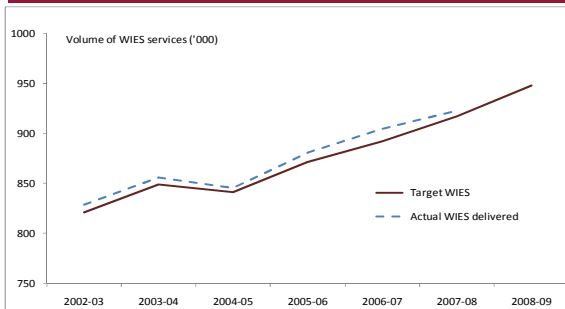
- Much needs to be done to prepare the health system for the challenges ahead:
 - an ageing population;
 - an increasing burden of chronic disease;
 - rising cost of and demand for new medical technologies; and
 - significant health workforce constraints (particularly in regional areas).
- The current economic downturn will eventually place significant pressure on the funding of all public services. But it may provide a short term opportunity via fiscal stimulus.



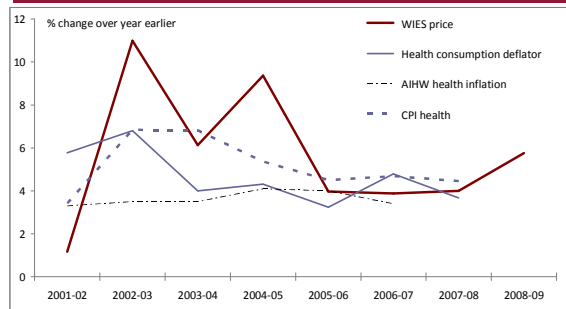
Regional demands – projected growth in admitted patient expenditure per annum



Performance – WIES quantities delivered over time



Financing – growth in WIES price over time



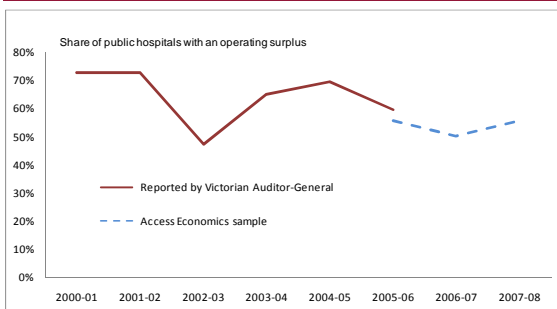
Finance and efficiency

- 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.

Financial stress

- The Victorian Auditor General found nearly half of Victoria's public hospitals ran an operating deficit in 2005-06.
- Within hospitals, cross-subsidisation between departments is widespread. This is potentially unsustainable and can occupy the time of administrators.
- Overall, the public hospital system in Victoria remains under significant financial stress.

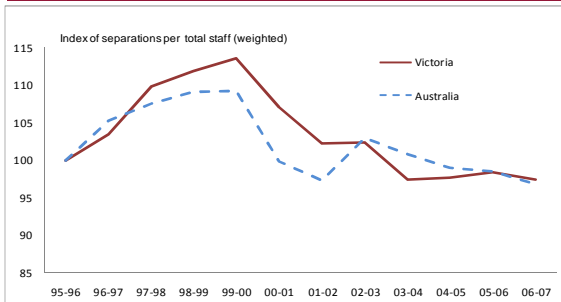
Half the State's hospitals in the red



Stronger productivity is one option

- Improving productivity is one solution ... but
- In general, productivity growth in the health care sector is difficult to achieve.
- Broad measures of productivity growth shown here suggests these targets are not being achieved.
 - and more importantly, this is supported by the actual financial performance of hospitals.
- A better framework for understanding and thinking about productivity would be useful.

Separations per EFT staff over time



Generating productivity

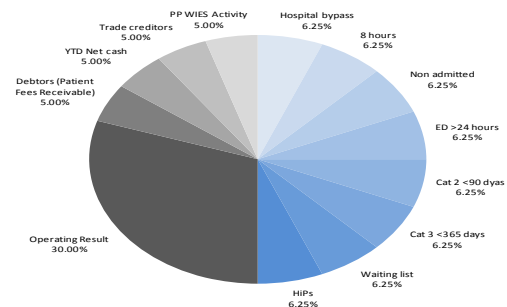
- Sources of potential productivity improvement include:
 - research
 - more capital
 - better use of capital
 - changing the mix of labour and capital
 - more efficient work practices
 - streamlining administration
- Stronger and better planned capital investment is part of the answer, while gains may also be made on the back of good benchmarking data.

Sources of capital funding

Description	Funding \$ m
Medical Equipment Replacement Program	145.0
Statewide Infrastructure Renewal Program	80.0
HealthSMART shared Information and Communication Technology (ICT) operations	26.9
Hospital Energy Supply Project	23.6
Prevention and Recovery Care (PARC) Services - Stage 1	9.6
Short Stay Units, Day Treatment Centres and Medi-hotels	4.0
Intensive Care Service Expansion	3.0
Neonatal Hearing Screening Equipment	1.2

Source: 2007-08 and 2008-09 DHS Policy and Funding Guidelines.

Contributions to the performance monitoring framework



Incentive structures

- Better incentives also need to be embedded in the system to reward performance.
- The performance monitoring framework (PMF) 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.

Member survey

- A survey of VHA members identified a range of issues which may be constraining efficiency, including:
 - the amount of and allocation methods for capital funding;
 - skill shortages, particularly in the nursing workforce;
 - a lack of information sharing by DHS;
 - many respondents saw the budget setting process as far from clear; and
 - similarly, provisions for the nurses EBA had created confusion with a lack of information on funding for this.

Member survey

- Further key themes from the member survey included:
 - the lack of good management information being provided to hospitals;
 - a stronger benchmarking role (leveraging off existing data collections) was seen as an important direction for DHS;
 - tied grants and an overall tight financial position were seen as limiting flexibility in shifting resources around; while
 - the overall funding system was also seen as limiting regional coordination, with many health services feeling they are in competition with one another.

Case studies

- The project included six case studies covering two each of large, medium and smaller scale health services.
 - The aim was to understand the financial position of these services and identify constraints to performance, upcoming challenges and potential solutions.
 - The financial performance of this group seemed roughly in line with the broader sector.
 - A word of thanks – case study participants were very generous with their time and many ideas were generated through these discussions.

Case studies

- **Key issues identified included:**
 - The continuing pace of demand growth which is presenting notable challenges.
 - Related to that demand pressure, access to GPs in the community is a significant issue, particularly on weekends, adding to pressures in emergency departments.
 - Ageing infrastructure is proving to be a major impediment to improving performance.
 - Staff shortages have been another key issue, particularly for the regional health services.
 - Benchmarking of hospital performance remains in its infancy (but also offers potential to drive improvements in efficiency).

Recommendation 1 – capital funding

- **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.**

Recommendation 2 – capital funding

- **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.**

Recommendation 3 - benchmarking

- **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.**

Recommendation 4 – admin burden

- **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.**

Recommendation 5 - transparency

- **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.**

Recommendation 6 – setting the WIES price

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



Recommendation 7 – setting the WIES price

- 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.



Recommendation 8 – bonus funding

- 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.



Recommendation 9 – skilled workforce

- 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.



Recommendations 10 – ICT strategy

- 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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