

# **The Benchmarking Club**

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# Benchmarking Club - Who we are?

- **Benchmarking club** is formed by group of hospitals needing knowledge to improve their own practise (and decision making) implementing best practises from partner hospitals
- The **founding members** are:
  - Aalto university with 9 Finnish Central Hospitals
  - The Orbis Group, NL
  - MetroHealth, Cleveland USA
  - North Estonian Regional Medical Center, Estonia
  - Center Hospitalier Emile Mayrisch, Luxemburg

# Why we need Benchmarking Club?

- **Problem**

- Expense in Health care systems are growing faster than GNP
- Ageing society need more services with less money, present funding will be reduced, a new situation for many service providers

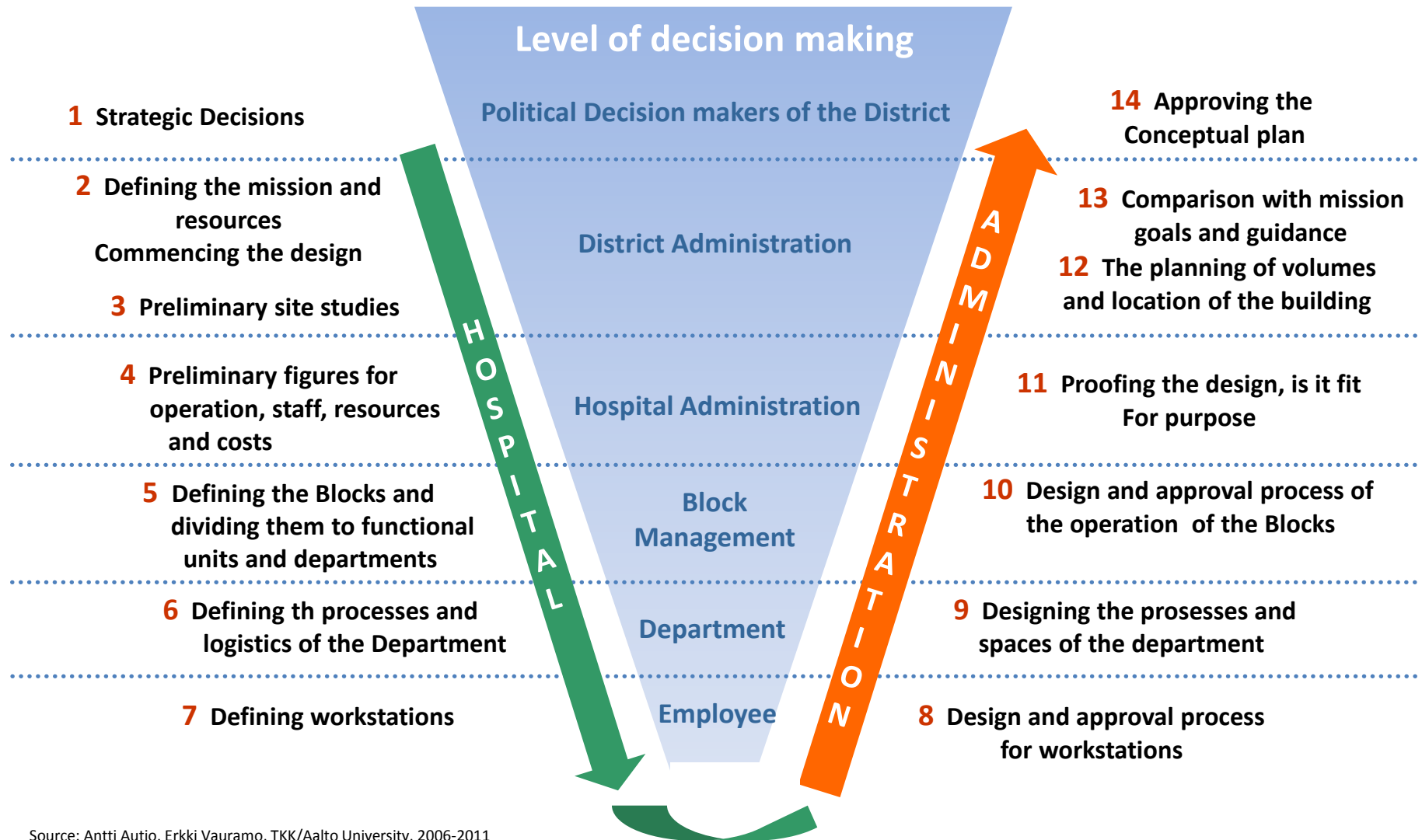
- **Need**

- Benchmarking based on patient data and disease treatment are available but
- Benchmarking on regional service systems, on expenses of hospitals and on cost of procedures at department level are missing but needed

- **Solution**

- Benchmarking Club can add facts and figures facilitating decision making on hospital level with reference knowledge based on best practices

# The need of benchmarking data exists at all levels of planning and decision making



# How we work?

## Benchmarking Comprehensive

- Regional silo organisations (special care, primary care and social care) are overlapping. Therefore an integrated picture of service system is needed

## Information from several sources

- At country level: OECD health statistics, WHO Euro data bases
- National registers and other public databases
- Confidential Hospital data collected special for Benchmarking purposes

## Reliable results

- To often comparisons are done by using only one characteristic as total figures as hospital has 300 beds not mentioning population served. Therefore three aspects are needed as: **Test/inhabitant = test/worker x worker/inhabitant**
- Only meaningful variations, over +/- 10% are interesting.

## Data processing

- Temporary at Aalto University, Department of Accounting

# Levels and parameters

## Levels

We compare systems at appropriated administrative levels with special focus on regional services and resources as whole. The levels are:

1. National
2. Regional
3. Hospital
4. Departmental

## Parameters

List of used parameters will be varying according to target

- Time, FTE, hour easily comparable
- Cost , easy to add
- Area m2
- Productivity, population
- Others

# Relevant and available parameters?

- **Getting comparable information**

- Regional target population is easy. If there are several hospitals in same region patient profile might be different?

- **Employment**

- FTE is a good parameter, but how it is calculated?

- **Cost**

- Accounting systems are different
- How overheads are calculated ?
- How to open the process cost behind from budget or DRG pricing?

- **Time**

- Hours used for a procedures can be estimated, a good figure
- Transit times are seldom available

- **Area**

- m<sup>2</sup> is clear, but how the floor area is defined?

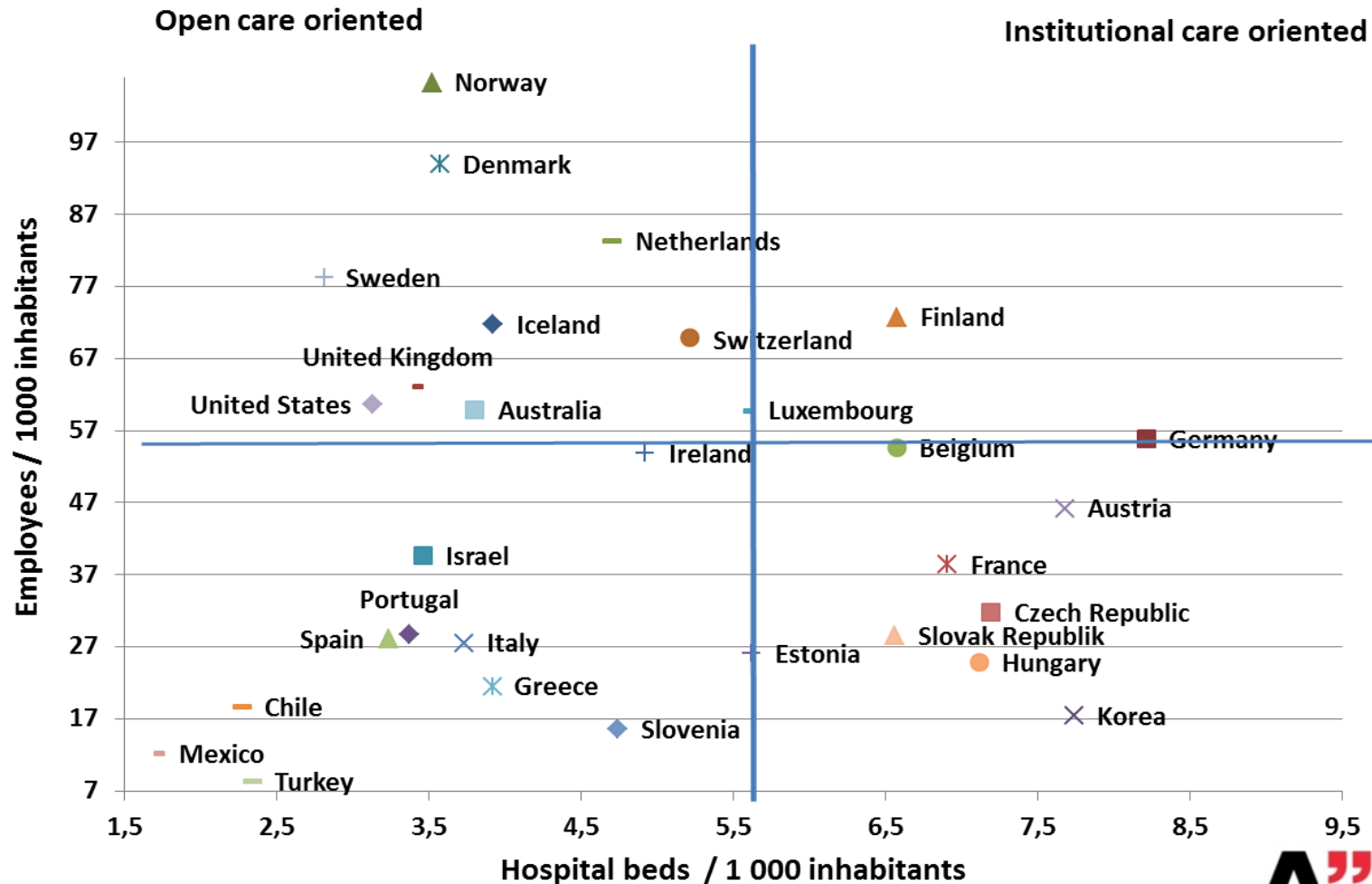
- **At Present**

- Definitions of parameter packages for various targets is ongoing

# National care systems

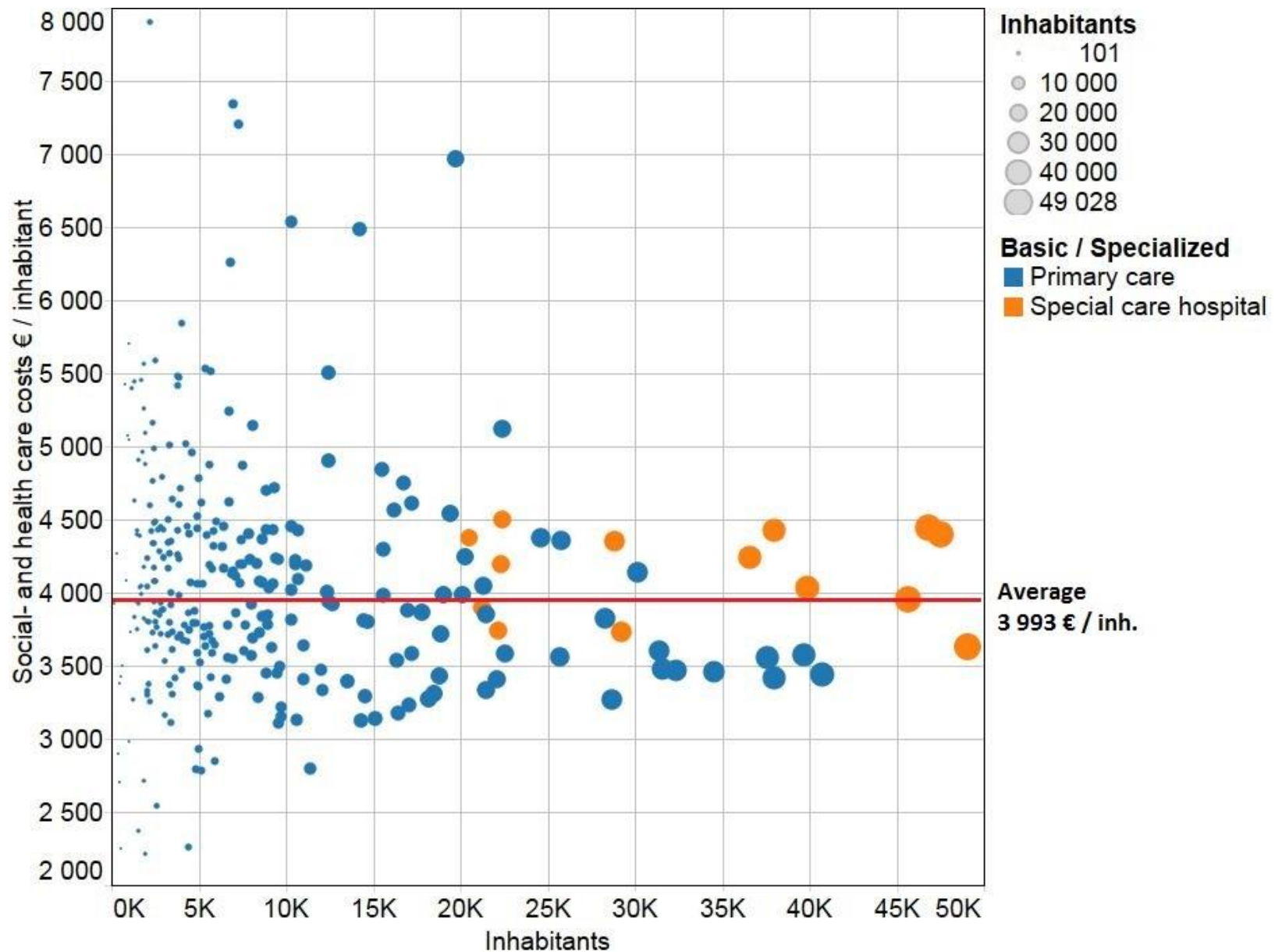
Source OECD 2013

## Total social and healthcare employment and hospital beds /1 000 inhabitants





# Total social and health care cost and population of municipalities under 50 000 inhabitant in 2012

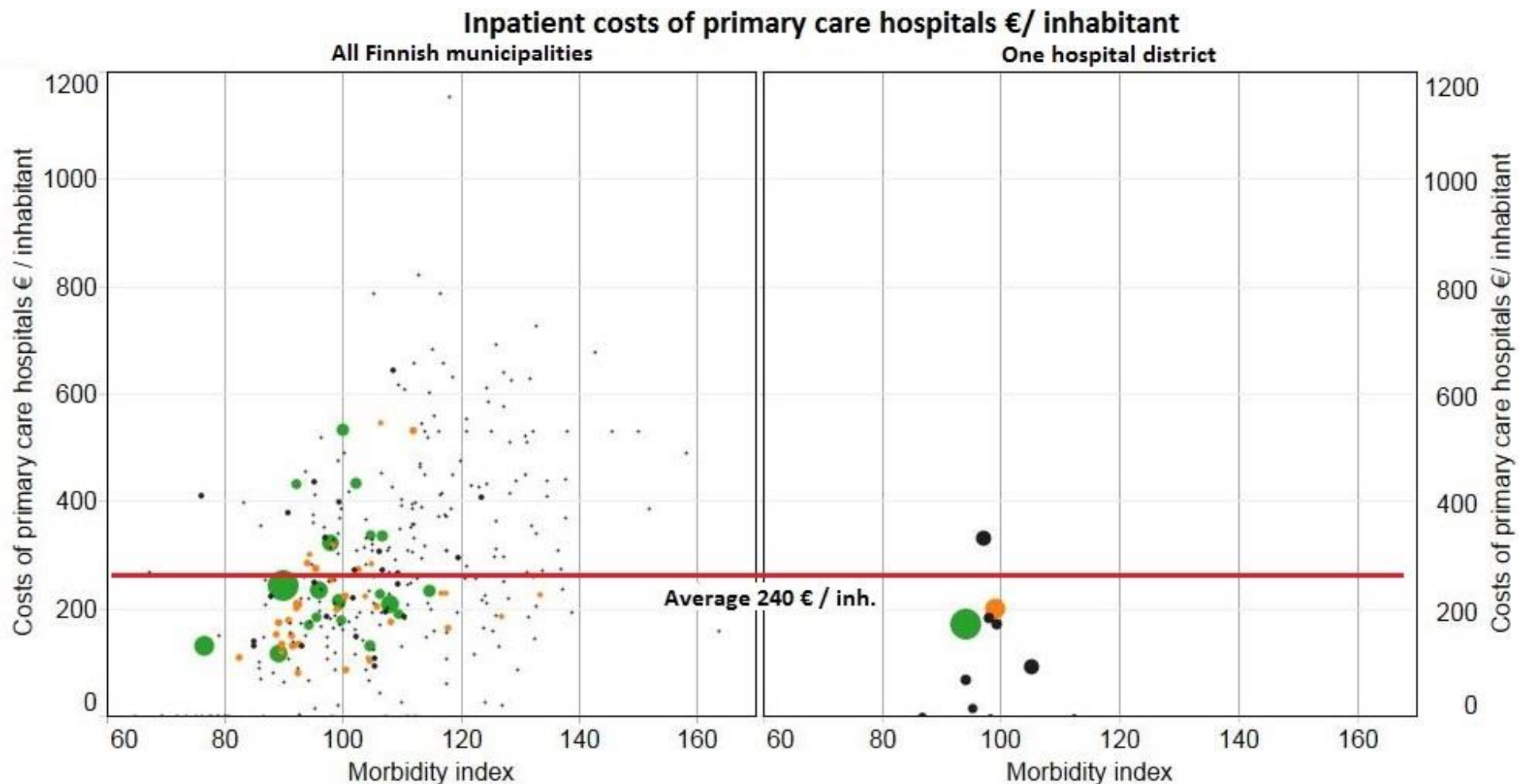


# Size of municipality and services cost per inhabitant

Finland 2012

Population of municipality/ Expenses / inhabitant €	Under 20 000 inh.	20 000 - 50 000 inh.	Over 50 000 inh.	Average
Special care	1 112	<b>1 132</b>	<b>1 080</b>	1 100
Primary care, inpatient	<b>288</b>	<b>208</b>	239	247
Primary care, open care	<b>590</b>	550	<b>529</b>	551
Elderly care institutions	<b>182</b>	<b>167</b>	169	172
Other social services	1 887	<b>1 852</b>	<b>1 970</b>	1 922
Private medicine	<b>638</b>	645	<b>895</b>	675
<b>Total</b>	<b>4 059</b>	<b>3 909</b>	<b>3 987</b>	<b>3 993</b>

# Costs of inpatient care in primary care hospitals and morbidity index



## Municipality size

- under 20 000 inh.
- 20 000 -50 000 inh.
- over 50 000 inh.

In morbidity index variation is from 80 to 140, factor = 1,75

In cost per capita variation is with equal morbidity from 100 to 600, factor = 6

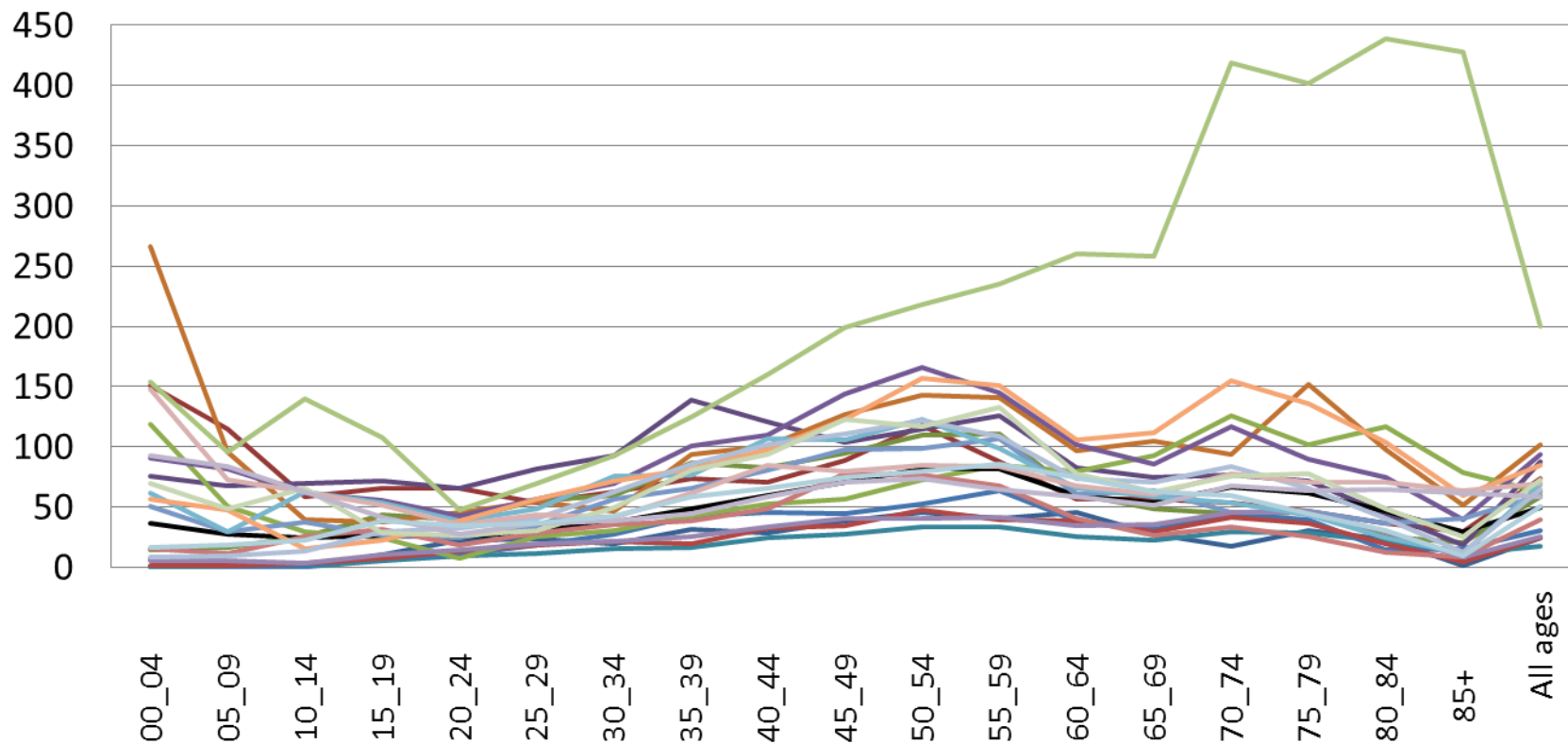
# Departments work differently

**Acute care, region  
200 000 inhabitants**

	<b>Country A</b>	<b>Country B</b>	<b>A/B%</b>
<b>Emergency</b>			
Floor area m <sup>2</sup>	700	900	78
Emergency visits	17 000	27 000	63
Workers	27	30	90
Visit /worker	630	900	70
<b>Radiology</b>			
Radiology procedures	64 500	147 000	44
Workers	59	50	118
Procedure/workers	1 093	2 940	37

# Rehabilitation, outpatient visits / 1 000 inhabitants

## All hospital districts, Finland year 2012



**Large regional variation. In age group 50-54 from 30 to 150 or factor 5**

**Only one district has focused in elderly, most regions reduce services for 65 +**

# Preliminary observations

- **Regions produce services with different profiles**
- **Health and social service profiles are overlapping specially in elderly care**
- **Morbidity index or age are not explaining great variation in service cost – expensive organization?**
- **Effective social and health services require a minimum population of 25 000**
- **There is a great need of producing information out of existing data based to support decision-making when resources will be more limited.**
- **Here international cooperation is a must**