4 BENCHMARKING IN THE HEALTH SECTOR

INTRODUCTION

Defining benchmarking

In a recent study by the Australian Manufacturing Council (AMC 1994), benchmarking is defined as 'the ongoing, systematic process to search for and introduce international best practice into an organisation'. It is elsewhere defined as 'the continuous process of measuring products, services and practices against the toughest competitors or those companies recognised as industry leaders' (Camp 1989).

Paraphrasing the AMC, best practice can be defined as the cooperative way in which organisations undertake business activities in all key areas leading to sustainable world-class outcomes.

A standard dictionary entry for benchmark refers to a surveyor's mark on a rock, etc. to mark a point in a line of levels. The term also has a figurative meaning, and refers to the matching of a value against a criterion. The criterion is synonymous with 'best practice', and explains why the terms benchmarking and best practice are commonly seen together.

The benchmarking process

Benchmarking typically comprises five basic phases.

1. Preparation, in which the following are determined:
   - what to benchmark; and
   - who or what to benchmark against.

Box 4.1 A short history of benchmarking

Benchmarking is reputed to have started when the Xerox Corporation wanted to improve its order fulfilment process in 1982. The company approached a mail-order catalogue organisation considered to have superior order-filling processes. Xerox sent a group to visit the company's warehouse to study its processes, as it felt that it could learn and adapt the best of the company's practices. Xerox executives credited the technique with helping save the company from being crushed by Japanese competitors in the early 1980s.

Soon other companies conducted one-on-one analyses of the processes of other companies, and found that it led to significant successes. Interest in benchmarking as a quality management tool was further spurred by its inclusion in the criteria for the prestigious Malcolm Baldridge National Quality Award in the United States.

2. Comparison, which may include the following activities:
    - data collection;
    - data manipulation, construction of indicators, etc.; and
    - comparison of results with benchmarking partners.
3. Investigation, that is, identification of practices and processes that result in superior performance.
4. Implementation, in which best practices are adapted and/or adopted.
5. Evaluation, where new practices are monitored to ensure continuous improvement, and, if necessary, the whole cycle is repeated.

Levels of benchmarking

The AMC report describes five levels of benchmarking ranging from ad hoc observations of competitors' products at the low end, to detailed comparison of processes and outcomes against the world's best – inside or outside the industry – at the high end. A finding of the report was that industry leaders tend to engage in higher-level benchmarking.

APPLICATION TO THE HEALTH SECTOR

The previous section outlined the concepts of benchmarking, most of which were developed in the industrial sector. The principles, however, can be directly translated to the health sector.

Best practice in the health sector

World-class outcomes in the health sector are difficult to identify for a number of reasons:

- it is difficult to directly measure health outcomes;
- where measures are used, they may not be the same as those used by the potential benchmarking partners;
- outcomes may be measured along a number of dimensions, for example, change in health status and cost, and achieving an excellent outcome on one dimension may compromise the outcome on another level;
- outcomes do not necessarily relate to one component of care; rather they are the result of many phases of investigation, intervention and evaluation. Not all of these phases occur during a hospital stay, so that inferences about hospital performance and outcome may be misguided;
- there are few precedents in Australia for setting desired performance levels; and
- there are political, psychological and sociological factors associated with an organisation not achieving benchmark performance levels.

Although it may be difficult to develop indicators for health care outcomes, it is possible to measure the processes and outputs of health care that contribute to health care outcomes. Indeed, the performance indicators in this document focus on these processes and outputs, and it is reasonable to infer that favourable results for these performance indicators

would be correlated with favourable results on outcomes indicators.

Application of benchmarking to health sector management

As noted in Chapter 1, an objective of the benchmarking program is to provide governments and health services funders with a core set of performance information to assist in health sector management and policy development.

To this end, the NHMBWG has developed a succinct set of performance indicators to assess performance of the sector as a whole, incorporating the most critical measures of a complex health care delivery system.

In developing and publishing this set of indicators it is anticipated that interest in benchmarking will be stimulated and further incentives for continuous improvement will be generated.

Application of benchmarking at the hospital level

Although the set of indicators in this report may be directed towards measurement of the performance of the system as a whole, it is evident that benchmarking has greater utility at the organisational level, where decisions related to changing behaviour are to be made. Benchmarking requires information on the current performance of the organisation, exchange of information with best practice providers on practices and processes, and implementation of changes if appropriate. In most cases, changes will be made at the individual provider level, so information on that provider's performance and on the changes that need to be made has to be available to the manager of the individual organisation.

The data presented in this report are highly aggregated – mostly at the level of the State or Territory. Not only does this not reflect the performance of a single provider, but there is no information on the best practice providers (because they cannot be identified).

To a large extent, the indicators discussed in this report are meaningful only in the aggregate. For example, separations per 1,000 population reflect the performance of the whole hospital system: it may only be appropriate to report these rates for groups of providers that serve a particular catchment population, taking account of specialisation and complementary services in the private sector, among other things.

For other indicators, data are not readily available at the hospital level. For example, the cost per casemix-adjusted separation requires data on average case weights. This item is only readily available at an aggregated level, so that estimates of average cost per separation for each hospital would be based on incomplete information.

For benchmarking to be useful at the hospital level, current indicators will have to be enhanced, new ones developed, and data collections expanded, so that data collected at the hospital level can be used to construct indicators. Then, however, the results and information about the processes that led to them need to be shared with similar providers, and so on in the benchmarking cycle.

Facilitating inter-hospital communication of benchmarking information

The exchange of information is crucial to a successful benchmarking program. Providers have to communicate with best practice organisations, sharing information about the processes and practices that lead to superior performance.

Communication of this kind already occurs in some parts of the system. For example, hospital groups share a central administration, and regional or district health authorities collect data from hospitals that can be redistributed to other hospitals in the group.

Informal communication occurs among hospital managers and administrators through conferences, meetings of professional colleges, journals and published material (for example, Victorian 'Rainbow' series).

Benchmarking requires a cooperative, systematic approach to the exchange of information. It may be difficult for some hospitals to enter a cooperative arrangement with other hospitals for this purpose, and some assistance from central health authorities may be required to initiate such arrangements. It may also be beneficial to categorise hospitals along the dimensions of size, casemix complexity, areas of specialisation, etc., so that networks of similar hospitals can be established that will enhance the value of benchmarking activities.

To facilitate a systematic approach, standard reports may need to be developed. In these reports, hospitals would report their results on the performance indicators, as well as document key practices and processes.

In the United States, for example, a comprehensive report card is used by a number of health plans to monitor and document the quality of care. The Health Plan Employer Data and Information Set (HEDIS) includes more than 60 performance indicators covering quality, access to and satisfaction with care, membership and use of services, finance and management. HEDIS results are published so that, among other things, purchasers can make better choices.

There is merit in having a standardised, systematic approach to the collection and presentation of performance information, and formalised information sets such as HEDIS may be useful in guiding development in Australia.