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Translating value-based healthcare into practice

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Abstract. In this paper, we report from an experiment into healthcare governance called 'new governance in the patient's perspective' (NG) initiated by a Danish Region. The experiment was inspired by principles of value-based health care (VBHC), and initiated to transform governance from a productivity-regime, allegedly incentivizing clinical conduct in 'perverse' and counter-productive ways, towards a new regime focusing on value for the patient. Pursuing this ambition the Region exempted nine hospital departments from activity-based financing based on Diagnosis-Related Groups (DRG), and asked instead the departments to develop self-chosen indicators to measure and account for 'value for the patient'. Drawing on the notion of 'translation' (Latour, 1987) we analyse how NG was put into practice in the departments, and how their indicators were accounted for. Relating to literature on performance indicators, our case seemingly confirms a well-established distinction between indicators for internal improvement vs. external accountability. However, in pointing out the dialogues facilitated by the indicators between the Region and the departments, this distinction is challenged. Our analysis provides inspiration for healthcare governance to think of indicators as means, not for purely data-driven governance, but for dialogical practices in which concerns with accountability and local quality improvement conflate.

Productivity, value, and performance in healthcare

In this paper we report from a three-year governance-experiment initiated by Danish Region entitled 'New Governance in the Patient's Perspective' (NG). Inspired by value-based healthcare (VBHC) (Porter 2009) the Regions intention

was to transform healthcare governance from a strictly productivity-oriented regime to a value-based regime. The Region in charge of the experiment had for several years criticised the national system of Diagnosis-Related Groups (DRG) because it held hospitals accountable based on their levels of activity, disregarding whether their activities were right, in terms of health-value for the patient and cost-efficiency. DRG works by associating patient's diagnoses with pre-calculated costs of treatment, making productivity measurement and reimbursement based on the costs of each patient possible. Allegedly the DRG-system entails 'perverse' and counter-productive incentives. For example, since only one DRG-rate can be generated per patient visit, hospitals are incentivised to perform pre-examinations on the same patient on different days. Other examples are 'over-treating' or 'cherry-picking' patients in order to maximize DRG-value.

In the NG-experiment, the Region exempted nine departments from DRG-based reimbursement. Instead the departments were asked to develop self-chosen indicators through which to be held accountable, hoping that this would lead to the discovery of new indicators that would be both meaningful to clinicians and in alignment with VBHC-principles.

The loose framework for choosing indicators diverges from VBHC-principles, in which indicators are specifically to measure outcome (Porter 2009). We see this divergence as a specific and interesting 'translation' (Latour 1987) of VBHC, as it can be taken as an unfolding in practice of what VBHC might look like when developed and practiced from the clinicians' perspectives.

More generally, the critique of DRG's 'perverse' incentives and the consequent 'setting free' of clinicians to develop indicators, relates to broader discussions regarding the uses and effects of indicators in healthcare (see fx Kerpershoek et al. 2014) One particular issue, which is interesting to the present case, is whether indicators for professionals' use for internal improvement are also suited external accountability. Sceptics argue that performance information for internal improvement is too specific for external reporting, and in so far as this was to be externally reported and rewarded, incentives to game the numbers immediately arise (for an overview see Freeman 2002).

The following analysis shows how the nine departments responded to NG and how indicators were developed and accounted for to the Region. Based on our analysis, we discuss how NG on the one hand seems unsuccessful and naïve in its ambitions to make locally developed indicators the basis for governance and accountability, consequently supporting the distinction between internal and external indicators. On the other hand we argue that the indicators did facilitate a fruitful interaction between the Region and the departments, which might inspire future governance schemes to: (1) engage with the idiosyncrasies of local practices; to (2) rethink the role of performance indicators; and (3) to develop formats in which concerns with accountability and professional values conflate in mutually engaging relations.

Our analysis is based on interviews with the heads of the nine departments, observations of meetings between Regional staff and the departments as well as access to documentation and evaluation reports of the NG-project.

Translations of New Governance at the departments

Generally the departments welcomed the delegation of responsibility and authority to define quality indicators in accordance with their specific medical practices and values. Also they found the focus of the project on quality and value instead of productivity meaningful.

Most evident, however, was the refusal that NG and the exemption the departments from DRG-based reimbursement would constitute such a dramatic and paradigmatic change, as the Region suggested. They rejected the implicit assumption, which motivated the NG-experiment in the first place, that they should have been driven by the 'perverse' DRG-incentives. This was evident from examples of how the departments prior to NG had initiated changes causing a decrease in DRG-value but an increase in organisational efficiency and value for the patient. For example transitioning to ambulatory treatment, or guiding patients to choose rehabilitation before high-cost and (high-risk) surgery. The resulting decrease in DRG-value was coped with for example by scaling up production in ambulatories, by balancing out DRG-deficits and -surplus between hospital departments in dialogue with hospital management, or by revising patient journals for errors in diagnostic entries that generated a lower DRG-rate than the actual treatment justified. Thus for the departments the NG-project was not considered a novelty that radically changed the basis of their conduct, but rather an initiative that provided more leeway for the quality and efficiency agendas they were already pursuing.

Accordingly the indicators were not developed from scratch with a sole consideration of a future governance paradigm, but rather in a pragmatic manner by tailoring existing practices and agendas to fit the NG indicator-framework. Another circumstantial factor was the relatively short timeframe (3 weeks) for the departments to suggest indicators. Indicators were decided upon exclusively by the heads of the departments, and overall the majority of the 55 resulting indicators represented improvement initiatives that were either planned or already taking place locally at the departments irrespective of NG.

Here is a short example of an existing practice turned into an indicator in NG: A few months prior to NG, a department started an initiative allowing patients from the primary sector who experienced painful joints, access twice a week to a brief examination and clarification of whether the pains were caused by arthritis or not. The purpose was to improve collaboration with the primary sector and internal procedures for treating arthritis. Here NG became a timely and obvious opportunity to evaluate the initiative via indicators measuring the number of

patients clarified at first visit. Other examples of indicators are reducing the number cancellations, comparing work-times across clinical teams, monitoring the number of patients receiving immunoglobulin at home.

Accountability: Translating the indicators back to the Region

The examples above serve to illustrate how indicators were locally bound to the departments in terms of their purpose and meaning. This made indicator-data far from self-explanatory for the Region, and it left the Region perplexed of how the myriad of local and idiosyncratic indicators would be conducive to their new governance vision. Unfit for aggregation and comparability how would these local indicators serve as meaningful accounts to the upper levels of the hierarchy, from hospital management to the Regional council?

NG did not find any solutions to these challenges, but as a part monitoring the progress with the NG-experiment, the indicators were indeed reported and accounted for to the Region. This accounting practice was of a dialogical kind rather than a standardized, data-driven kind: Regional staff members visited the departments twice a year for a status meeting. During these meetings, the departments explained their indicators, how and why progress or regress was made. Based on these meetings Regional staff members collaborated with the departments in writing evaluation reports to the regional council. These reports included a listing of indicators and performance data as well as contextual, explanatory information for each indicator. The reports also included qualitative accounts about how the exemption from the DRG-system had mattered locally. Obviously in these meetings and evaluation reports a lot of account giving was performed, and Regional staff played an active part in constructing accounts. The indicators facilitated these accounting-practices, not by constituting a 'front stage' of performance information to be assessed by Regional staff, but by facilitating structured conversations about the department's efforts to improve quality.

Discussion: dialogical or data-driven governance?

As mentioned the literature on indicators points out internal improvement and external accountability as two distinct and mutually exclusive functions of indicators (Freeman 2002). One the one hand our case confirms this distinction, as NG was not able to build a system in which local indicators could be meaningfully accounted for to upper levels of the hierarchy in a standardised manner. Thus NG might seem unsuccessful, and perhaps also quite naïve, in its ambition to develop indicators for a new governance paradigm from the bottom-up.

However, as a part of the Regions continuous evaluation of how the NG-experiment played out locally, the indicators were successful in facilitating dialogues with the departments which provided the Region with a detailed insight to the manifold and hitherto only locally known efforts to improve efficiency and quality at the departments. Compared to such an insights in the departments' work, the Region's initial critique of how the DRG-system incentivised the departments in perverse ways, arguably represents a far more simplified and distorted view of the conduct and quality-efforts at play here.

Thus, although NG did not succeed in developing a new standardised system of indicators, the dialogue facilitated by the indicators in the process of the NG-experiment can in itself be regarded as a fruitful result, as it engaged the Region and the departments in each other's practices. This observation is not so much about the representative (in)capabilities of indicators, but about the kind of interaction they make possible between different stakeholders.

Therefore, we will argue that NG might indeed inspire how mutually engaging accountability-relations in a value-based healthcare paradigm can be developed. Crucially, this seems to require new imaginations of how accountability-relations can be developed and sustained: Imaginations that are not tightly harnessed to ideals of data-driven governance and self-explanatory data-flows that connects different stakeholders, but consider indicators instead as the things around which healthcare professionals and their authorities meet in a dialogue on performance and goals, and where quality is a shared matter of concern rather than a contested issue torn between interests of external accountability and local, professional values.

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