Health Policy xxx (2018) xxx–xxx

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Beyond Activity Based Funding. An experiment in Denmark

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ARTICLE INFO

Article history:
Received 11 October 2017
Received in revised form 13 April 2018
Accepted 16 April 2018

Keywords:
Activity based funding
Alternative models of hospital funding and governance
Discourse
Denmark

ABSTRACT

Over past decades Activity Based Funding has been an attractive tool for hospital funding and governance, but there has been growing frustration especially with its unintended effects. There are numerous examples of alternative models, but there is little in-depth knowledge about how these models came about. The aim of our study was to analyse how the discourse of Activity Based Funding was successfully challenged. This contributes insights into how international/national debates are translated into concrete alternative models through specific discursive mechanisms. The analysis used a discursive policy approach and was based on a case study from Denmark ('New Governance'). The data consisted of project and policy documents as well as qualitative interviews with regional and national experts. The analysis identified four discursive mechanisms: the problem definitions underlying 'New Governance' were clear and simple; the underlying assumptions both accepted and challenged the premises of Activity Based Funding; the alternative of 'New Governance' was defined in rather broad terms; and it was produced, disseminated and defended as part of interweaving processes regionally but also nationally. Our study showed that new models of hospital funding and governance need to be carefully engineered and that they draw on a mix of governance logics. Future research needs to study more examples from a broad range of institutional contexts and points in time.

1. Introduction

For three decades New Public Management and its transfer of market principles to the public sector has been seen as the solution to many problems in healthcare systems in industrialised countries including Denmark [1–5]. Waiting times and increasing expenditures were targeted with Activity Based Funding, with the underlying aim to increase both activity and efficiency of hospital services [6–8]. Hospitals were offered a fixed amount per bundle of services typically delivered to clinically similar patients [9,10]. This required an accounting system to quantify the individual bundles of services and Diagnosis Related Groups (DRGSs) have been most widely used to connect individual bundles of services to a specific diagnosis and to a specific price. Activity Based Funding emerged as an attractive tool for hospital funding and governance [9,11,12]: it was firmly embedded in a broader governance paradigm, it promised to square the circle between higher activity and high efficiency, and it offered the transparency that comes with putting a price on a service.

However, for some time, the limits of New Public Management have been widely debated, both more generally [13] and more specifically in healthcare services (for example, [3–5,14,15]). There is also a growing frustration with outcomes of New Public Management [16], including Activity Based Funding (see for example, [8,9,11,17–20]). Firstly, it is uncertain if this type of funding in fact improves activity and efficiency of hospital services. Secondly, Activity Based Funding may adversely affect the equity of healthcare systems as the funding provided by a specific DRG value is fixed. There is a potential incentive for hospitals to give preference to patients without special needs or complex illness trajectories. Thirdly, as hospitals are rewarded for activity, it is a common concern that Acitivity Based Funding may motivate hospitals to focus on maximising earnings rather than offering integrated care and the highest quality of treatment.

In response, there have been moves to adopt alternative models of governance [16,21], that focus on collaboration, regulated self-regulation and new tools to motivate professionals. This also applies to healthcare services (see for example, [3,22–25]); for example, Fierlbeck [26] suggests that health policy in the EU is embracing new forms of health governance that are strongly partic-

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https://doi.org/10.1016/j.healthpol.2018.04.007
0168-8510/

ipatory and collaborative in nature. In relation to alternative models of hospital based funding and governance a recent review by Milstein et al. [27] identifies 34 programmes in 14 OECD countries and concludes that programmes are very heterogeneous in their aims as well as clinical and financial indicators. A prominent example is Hospital Value-Based Purchasing [28,29] introduced by Medicare in the United States. The model redistributes 2–3 per cent of all activity based payments to hospitals based on a total performance score that includes measures for process, patient experience, safety and efficiency. Michael Porter is an influential proponent of value-based care [30,31] and seven regions in Sweden have experimented with his approach to connecting costs to outcomes; the latter typically relate to simple outcome measures like pain and physical function [32].

These alternative models of hospital funding and governance are in line with broader changes in health governance, but insufficiently accounted for in the health services literature. There are studies of the effects of alternative models (see for example, [27,33,34]), but there is little in-depth knowledge about how these models came about. How was the discourse of Activity Based Funding successfully challenged? Answering this question is highly relevant as it offers a look behind the scenes of substantive change in hospital funding and governance. It provides insights into how international/national debates are translated into concrete alternative models through specific discursive mechanisms. The literature on (comparative) health policy and its change predominantly draws on approaches that rely on varieties of functionalism (for example [3,35–38]). Health policy change can be a more or less direct response to the at face value problems facing health systems, like ageing populations and advances in medical technology. Health policy change can also be a reflection of the specific organisation of health systems, in terms of both the policy problems such an organisation creates and the conditions it offers for addressing policy problems. Analyses of discourse adopt a more critical stance [39] and instead ask, how views about what is functional in health policy come about and change. This seems to be particularly relevant for areas health policies that have long been dominated by a single, strong policy, like Activity Based Funding. The at face value and institutional problems of the policy were well known for a long time, but it required a careful reconstruction of the discourse of hospital funding and governance to unhinge the functionality of Activity Based Funding.

In Denmark, in 2014 Central Denmark Region decided to pilot its own alternative model of hospital funding and governance [7,8]. The name of the model was 'New Governance' and it was based on the Triple Aim approach, which focuses on patient-experienced quality, health outcomes and cost containment. Whereas Activity Based Funding is typically a centralised tool for performance management, the goals of 'New Governance' were decided locally and formulated by the individual hospital departments. As part of 'New Governance' the individual departments also received global budgets. The basis of measurement in 'New Governance' was performance rather than activity, and health professionals were responsible for balancing the goals according to the three components of the Triple Aim approach. Monitoring of performance was based on a soft approach and the management of the individual departments had to account for performance as part of regular meetings with the regional administration. 'New Governance' deliberately excluded any more formalised measures, including pay-for-performance and sanctions.

1.1. Aim and scope

Considering there is little knowledge, internationally and in Denmark, about how alternative models of hospital funding and governance came about, based on a case study of Central Denmark Region, the aim was to investigate how the decision to suspend Activity Based Funding and to experiment with an alternative system of hospital funding and governance became possible.

2. Methods and data

2.1. Theoretical approach

In our analysis we applied a discursive policy approach informed by Bacchi's [40–42] 'What's the problem represented to be' (WPR) approach. Bacchi's analytical framework is well suited to answer the research question posed above: it facilitates 'critical interrogation of public policies' [39 p. 21] such as how Activity Based Funding became a 'problem' for hospital funding and governance. The central point is to move beyond the understanding of problems as something 'objective' and given, and instead to investigate how problems are given shape in specific, political discourses. This offered important insights into how the status quo (Activity Based Funding) became problematic, and how this was translated into an alternative model of hospital funding and governance ('New Governance'). The WPR approach outlines six research questions to take a step back from the normal frames of reference [42]. Bacchi's approach also requires self-reflexivity and we have taken great care to tailor the approach to our specific research question. We chose to address three questions (1,2 and 4) and to add a fourth (question 3) for reasons of relevance. Our case was rather contained time wise and we were mainly interested in frames of understanding and agency. Therefore questions about the historical development of Activity Based Funding (original question 3), silences in understanding (original question 4) and the lived effects of presenting Activity Based Funding as the problem (orginal question 5) were less relevant. Instead we added a question about new models of hospital funding and governance to set focus on agency. As suggested by Bacchi [42] we have translated and adapted the questions to our object of investigation:

1. What problem definitions are underlying 'New Governance'?
2. What assumptions about hospital funding and governance are these problem definitions based on?
3. What new models for hospital funding and governance do the problem definitions open up for?
4. How and where are the problem definitions and new models produced, disseminated and defended?

Whereas the first two questions deconstruct the problem, the third question directs our attention to potential alternatives to the problem produced. The last question focuses on spaces and lines of argumentation at play in the production of a problem. Here we are not interested in causality as such, but instead in investigating various processes involved in the problem production. The four questions informed the collection, reading and analysis of our material.

2.2. Setting

The health care system in Denmark has a number of central actors. In relation to the governance of hospitals the regions are key. Denmark is divided into five regions, each responsible for governing the hospitals in their geographical areas. The regions cannot collect taxes and are therefore dependent on the funding they receive from the national government. Funding typically comes with strings attached, such as requirements of activity, quality and efficiency improvements. Beyond this, the regions are free to govern the hospitals in the way they see fit. Danish Regions is

Please cite this article in press as: Burau V, et al. Beyond Activity Based Funding. An experiment in Denmark. Health Policy (2018), https://doi.org/10.1016/j.healthpol.2018.04.007