Governing by numbers – A descriptive analysis of performance management schemes for hospitals in Denmark, Germany and England

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Introduction

Performance management has been characterized as an important part of the New Public Management (NPM) development, which has become a key reference point in much of the academic debate about public administration over the past three decades (Hood 1991, Læg Reid and Christensen 2012). Several recent studies have discussed performance management in a comparative light at the general level (Bouckaert and Halligan 2008, Moynihan 2008 etc). However, there is limited comparative knowledge about the way such general ideas are translated into specific designs in specific sectors and national institutional settings, and even less information about the effect of such schemes in practice. Part of the reason for the limited number of comparative studies is a lack of a robust theoretical framework for characterizing performance management arrangements. The aim of this paper is to develop and present such a framework for health care based on general literature about performance management.

However, the proof of any analytical framework is in applying it for empirical analysis. We will provide a preliminary and partial illustration of the framework through a comparison of key features of the performance management schemes for hospitals in three Northern European countries. Guiding our analysis will be the following question:

- What are the similarities and differences in the design of performance management systems for hospitals in England, Denmark and Germany?

Health care is a particularly interesting case study for examining performance management. First, a number of the key issues of the new public governance - such as the need for coordination, joined up governance and holistic intervention approaches - are particularly important within health care. Secondly, health care is characterized by clear articulation of a number of public value concerns for equity, fairness, robustness, efficiency etc. We can thus investigate our theoretical interest in performance management to support public values and changing governance needs. Thirdly, it is a sector with a strong medical scientific tradition for measuring clinical performance and a more recent strong push to combine this with administrative performance data to create comprehensive measurement systems. It can thus be considered a “most-likely” case for designing state-of-the-art measurement systems. Yet, at the same time, the complexity and pressures on health care systems make it an informative case for understanding the potential pitfalls and barriers to utilizing such data for integrated performance management schemes.

Within health care we have selected three country cases (Denmark, Germany and England) to provide variation on important underlying institutional characteristics within a setting of publicly managed health systems in Europe. We focus on hospital care, as this represents the bulk of health expenditures, but will include examples of performance indicators directed at collaboration between hospitals and other parts of the health system. We explore five hypotheses around performance management in Denmark, England and
Germany (see table xx) Table xx: Detailed hypotheses concerning performance management in three European health systems

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>Details</th>
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<tr>
<td>H1</td>
<td>PM designs in countries with early and extensive implementation of NPM are likely to be more comprehensive (scope, depth), with disclosure strategies to support contracting and choice, and with more emphasis on economic incentives.</td>
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<tr>
<td>H2</td>
<td>PM designs within health care are likely to be more fragmented and partial in countries that are generally conforming to the “performance administration” national style of PM.</td>
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<tr>
<td>H3a</td>
<td>The English style NHS will lead to PM designs that are focused on contracting, control and sanctioning.</td>
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<tr>
<td>H3b</td>
<td>The Danish style NHS will design PM systems emphasising control, learning and collaboration.</td>
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<td>H3c</td>
<td>The German SHI system will have less universal and integrated PM systems than the two other countries.</td>
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<td>H4</td>
<td>Countries with a high degree of medical professional autonomy and strong medical power vis-à-vis the state will design systems that maintain professional control and focus on benchmarking and learning within the profession (limited public disclosure, limited sanctions, limited economic incentives).</td>
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<tr>
<td>H5</td>
<td>PM systems within the three health systems largely remain embedded in an NPM logic, and that they show limited consideration for public values and accountability perspectives related to NPG (PM deficit).</td>
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Building an analytical framework for studying performance management in health care

Following Van Dooren, Bouckaert and Halligan (2010, p. 33) we can define performance as the realization of public values such as efficiency, effectiveness, equity and quality. *Performance measurement* is the process of acquiring performance information. Measurability of activities and their effects is a key concern. *Performance management* is the incorporation and use of performance information in decision-making and adjustment of organizational practices in order to ensure that practices support public values, goals and objectives.

The organisational psychologist Aubrey Daniels coined the term performance management as a broad description of the managerial and technical processes involved in ensuring the goals and objectives of organisations (and individuals, or indeed whole economic sectors) were met. Underlying the notion of performance management is the implication that intrinsic or extrinsic motivations and incentives - such as
professional pride, or satisfaction in a job well done, or the market-driven competitive threat of bankruptcy or unemployment - are not necessarily sufficient to ensure that organisations and individuals ‘do the right thing’ to ensure that organisational goals are met. Moreover, even when these incentives and motivations are all maximised and aligned with goals, knowledge as to the best way to achieve objectives may be lacking. In these circumstances, some degree of active management of performance is needed.

Building on the contributions by Van Dooren et al and Daniels, we define performance measurement as:

(sub)system wide collection of standardized performance data using some type of common template.  
The collection of data is imposed through an authoritative (political) decision at some level, with the purpose of facilitating insight into performance.

Performance management is:

the incorporation and use of performance information by internal management or external stakeholders for decision-making or intervention in order to ensure that practices support public values, goals and objectives.

Performance management framework

To facilitate a structured analysis of the different dimensions of performance measurement and management we draw upon selected previous presentations of descriptive frameworks. Bouckaert & Halligan (2008) and Pollitt (2012) have presented useful frameworks for general public sector performance management schemes. While these frameworks present an excellent starting point they are too generic to capture the specificities of health care and to allow for a detailed comparative perspective. We therefore suggest adjustments to, and expansions in, their dimensions with a set of key issues that are particularly relevant for PM schemes within health care. A basic question for any PM scheme is the purpose it is supposed to serve. Our initial empirical investigation suggests that at least three purposes are commonly stated within healthcare. Firstly, PM systems may serve the purpose of securing the financial viability or robustness of providers within the system. The focus here would be on economic measures of in and outflow of money and various measures of financial robustness in regards to the tasks at hand. A second, and perhaps more common purpose of PM schemes in health care is to improve quality. Quality can be measured in many different ways as discussed below, but it is useful to distinguish between the purpose of raising quality in general ("policing", "grooming") or the purpose of identifying exceptionally poor performance to avoid accidents and malpractice incidents ("fire fighting"). The two purposes may share some types of data, but it may be useful to collect them in slightly different ways, and possibly also to select specific indicators for each purpose. A third purpose of PM systems is to secure sufficient value for money. This requires collection of data about both resources and outputs(activity)/outcomes (results). In both cases an economic dimension is combined with assessments of results to serve the purpose of evaluating how the third party payer can get the most value for the money invested. Behind all three purposes is a broader concern for maintaining trust between the users of health organizations and the health providers. This is essential at the micro level for the interaction in treatment pathways. But it is also important in a broader sense for securing the stability of the system and a willingness to finance health services whether through taxes or insurance contributions.
A second core issue for characterizing PM systems concerns the assumptions about mechanisms and causality for achieving their purpose. Traditional public hierarchies operate from the assumption that scrutiny by administrative superiors backed by the threat of (ad hoc) interventions can influence performance in public organizations. In this sense PM schemes serve the purpose of reducing the information asymmetry inherent to bureaucratic principal-agent relationships. Others argue that bureaucratic superiors often lack the resources to make interventions sufficiently targeted and threatening. Furthermore, the lack of transparency about criteria for intervention can make it difficult to know which level of performance to strive for. Subordinate organizations are likely to evaluate the risk of detection and intervention carefully against the costs of undertaking quality enhancing activities. This has led some to argue for a system where automatic sanctions replace the discretion of superiors when selected indicators fall below a particular level.

A third position is that PM schemes primarily work through reputational mechanisms. In this case benchmarking and publication of data is enough to encourage providers to consider their standing in regard to others and to react accordingly. This mechanism may be reinforced through choice mechanisms, whereby providers face a potential threat of losing "customers" if their reputation deteriorates. This threat works best if some particular types of economic incentives are present (as discussed below). The core argument is that transparency of performance in itself will enable patients (as decision makers) to de-select particular providers, and that the threat (realized or not) of losing business (and hence income) will incentivise providers to strive for optimal performance (or at least address the reasons for losing custom).

Some systems operate with purchasing agents - such as primary care practitioners. In this case the PM schemes serve to support the evaluation of potential contracting partners, and also for the ability of purchasers to follow up on the fulfillment of requirements in the contracts. Such mechanisms mainly rely on external assessments of performance followed by some kind of intervention as well, of course, on purchasers having a clear objective to act in the best interests of their members/residents. However, many observers argue that the most important mechanism for PM schemes is to enable self-assessment and provide feedback to support self-development within organizations. This might lead to a different philosophy about disclosure of information as discussed below.

**Performance management data**

While the dimensions discussed so far have dealt with the underlying rationality of the PM schemes, the next set of dimensions are about the specific issues concerning performance data: In particular, who collects it, how, and the way it is processed – including its dissemination.

An important comparative question concerns the agencies that are responsible for holding hospitals and professionals to account. The issue here is about the formal responsibilities and rights to demand information and to monitor performance.

**Scope and measurement** are the next important dimensions for understanding PM schemes. The issue here is the content of measurements. What is measured and how? PM schemes may include one or more of the following areas for measurement: activity level, process quality (compliance with pre-defined standards, guidelines or procedures for administrative and/or clinical activities), service quality (waiting times, information), clinical outcomes, patient experiences or economic performance. – Regardless of which
indicator is used it is relevant to discuss the criteria applied for assessment. Performance may be measured against standards, minimum levels, averages or specific targets. Each of these has different impacts on the motivational structure of the actors being monitored.

*Depth/unit* concerns the level for data collection. Is data collected at the individual level or at the organizational level? Who is responsible for delivering, collecting and using performance data? Such issues are important for understanding how PM schemes work in practice. Equally important is the issue of disclosure/publication: Depending on the purpose and assumptions about causality mentioned above, one might choose different publication strategies. If the emphasis is on PM as an administrative control system within a traditional hierarchical structure it is sufficient to present the data for administrative and political superiors. If, however, the emphasis is on benchmarking and choice it becomes important to make data available to the general public, and to present them in a manner that is easily understandable. If on the other hand the PM scheme emphasizes organizational self-learning it may be better to keep the data within the organization, using longitudinal designs or blinded comparisons with other organizations.

Whether performance data is put into the public domain or retained within provider organisations, how the data is presented and summarized is important. Different types of aggregation, indexes or composite measurements may provide an apparently simple way of comparing performance. However, it also raises issues about the risk of hiding variation and about the criteria for selecting and weighing the different data within the indexes or composite measures.

**Using performance data**

Three specific issues complete our list of dimensions for the descriptive analysis of PM schemes. The first relate to the question of whether performance data is used for systematic external control of health care organizations and if so, how frequent and comprehensive is the control scheme. Related to this is the question of sanctioning. Ad hoc sanctions may be applied through the management chain in response to sub-standard performance. Some systems operate with automatic sanctions, which gives more transparency for the organization.

Sanctions may be of many different types including reduction in autonomy and management scope for the organization, changes in leadership og changes in allocation of funds. Using economic incentives can be seen as a type of automatic sanctioning mechanism.

Even if there are no explicit sanctions the publication of data can serve as a sort of public "naming and shaming" function if performance data is publicly available or at least available to relevant professional groups and peer organizations. In order to fill this purpose one must be careful in deciding on the way data is presented. Too much technical detail makes it harder for the general public to understand the data. This can lead to the use of aggregated data and composite measures blending several different dimensions. This, however raises new issue on the methods for selecting weighting indicators for the composite measure.

**Summarizing the framework for descriptive analysis**

At a general level, the seven dimensions discussed above and presented in summary in Table xx below map onto three overall questions that are central for understanding PM systems:
What is the rationale of the PM scheme – eg promotion of efficiency, ensuring high quality

How is data to support the PM scheme collected?

How is data used for performance management – eg as part of economic incentives, benchmarking, public consumption?

The following table provides an overview of the dimensions discussed so far.

Table xx: Dimensions for descriptive analysis of performance management schemes for hospitals

<table>
<thead>
<tr>
<th>What is the underlying rationale?</th>
<th>Purpose/objectives:</th>
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<tbody>
<tr>
<td></td>
<td>• Financial viability and sustainability</td>
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<td></td>
<td>• Quality improvement (clinical and patient experience)</td>
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<td></td>
<td>• Avoidance of accidents, and malpractice incidents.</td>
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<td></td>
<td>• Value for money (activity/resources or quality/resources)</td>
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<td></td>
<td>• Maintenance of trust and legitimacy</td>
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<tr>
<td>Mechanisms and assumptions about causality:</td>
<td>• External (hierarchical) scrutiny and threat of interventions</td>
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<td></td>
<td>• Automatic sanctions</td>
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<tr>
<td></td>
<td>• Benchmarking, &quot;naming and shaming&quot;</td>
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<tr>
<td></td>
<td>• Transparency to enable choice or selective contracting</td>
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<td></td>
<td>• Enable self-assessment and support organizational development</td>
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<table>
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<tr>
<th>Who collects data? How is it collected?</th>
<th>Agencies</th>
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<tbody>
<tr>
<td></td>
<td>• Which agencies are responsible for collecting and using performance data</td>
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</table>

| Scope and measurement: | • What is measured: activity, process quality (compliance with pre-defined standards, guidelines or procedures for administrative and/or clinical activities), clinical outcomes, patient experiences, economic performance? |
|                        | • Which criteria are applied for assessment (averages, standards, targets etc.)? |

| Depth/unit: | • Are data collected at the individual level or at the organizational level? Who is responsible for delivering, collecting and using performance data? |
| Control/sanctioning: | • Are there explicit or implicit sanctions related to the PM scheme? |
|                                        | • Which agencies are responsible for control and intervention? |

| Disclosure/publication: | • How are data published (presentation, aggregation, composites, weighting)? Who has access to data? (public in general, public principals, peer organisations, own organisation etc.). |

| Economic incentives | • Are economic incentives (rewards/punishments) part of the PM scheme? |

As noted above, there is limited systematic comparative knowledge about the way performance management ideas are translated into specific designs in specific sectors and national institutional settings, and even less information about the effect of such schemes in practice. The following sections present a preliminary illustration of the framework as set out in table xx above through a comparison of key features of the performance management schemes for hospitals in three Northern European countries. We conclude with a discussion about the linkages between underlying institutional design of the three health system and the specific performance management schemes.

Methods
There are a number of challenges in developing comparative analysis of PM schemes across countries. First, although the definitions are fairly clear at a general level there is significant variation in the interpretation of the different elements in different countries and different sectors. Historical developments, political traditions and institutional contexts influence the development of particular performance management regimes and the understanding of various PM terms. It can therefore be difficult to draw the line between what is PM and what is not PM. The definition presented above provides some hints in regards to the selection of phenomena to investigate. It identifies performance measurement as (sub)system wide collection of standardized performance data using some type of common template. The collection of data is imposed through an authoritative (political) decision at some level with the purpose of facilitating insight into performance. And performance management is defined as the incorporation and use of performance information by internal management or external stakeholders for decision-making and adjustment of organizational practices in order to ensure that practices support public values, goals and objectives.

We are looking for schemes that fall within these definitions within the three countries. We will use expert assessments from the three countries to find the schemes and we will seek validation of our findings through presentations in relevant academic and practitioner forums.

A second methodological challenge is that there may be a wide gap between the rhetoric of PM schemes and the reality of implementation into practice (Pollitt xxxx). In this preliminary overview we are forced to rely on official presentations of PM schemes. Subsequent papers within this research program will address issues of implementation and impact.

The specific method in the paper is then to use the descriptive dimensions presented in the previous section to guide a systematic collection of written information about performance management schemes in the three countries. The collection of data has been facilitated by the fact that all four authors are embedded in national research environments with experts in health systems analysis and performance assessment. The written material has been structured and presented in descriptions of each of the three national using the same dimensions and headlines for all three. These descriptions have been validated through presentations for national level experts. They will subsequently form the background for qualitative semi-structured interviews with key policy actors in the three countries to facilitate the interpretation of the different schemes and address the questions about the drivers behind the schemes and the degree of implementation and effects.

**Descriptive analysis of performance management**

**Denmark**

**Introduction**

The Danish approach to performance management reflects the multilevel governance structure with decentralized responsibility for health care delivery (regions and municipalities) and central state level responsibility for general regulation, overall political strategy and coordination of public finances. Performance management in the form of quality assessment has been introduced gradually trough negotiated agreements building on bottom up experiments and pilot projects at the decentralized level.
The role of the state has been to develop guidelines and standards, and to facilitate the development of an overall framework for collecting the different decentralized initiatives. The resulting "Danish Quality Assessment Model" is based on self-assessment within hospitals combined with external accreditation and monitoring through clinical quality databases, patient satisfaction surveys etc. The core philosophy is to support self-development at hospital and regional level. Yet, at the same time the state has opted for publication of some quality data in national web portals. The publication of such data is supposed to facilitate choice of (public) hospitals and create some level of reputational competition.

Furthermore, clinical and process related quality data are used by national and regional authorities for management and comparisons within regions and across regions. There are no explicitly stated or automatic national level sanctions related to quality performance, but such issues will usually be part of the performance contracts for hospital and department level managers. The national authorities have the power to investigate quality breaches and may intervene in cases of poor performance. Yet, in most cases this is handled at the regional level, which may react to negative performance measures by dismissing the hospital management, implementing more detailed monitoring and steering and thus reducing the autonomy of the hospitals. In a general context of reductions in hospital facilities another option for the regions is to close down departments or hospitals.

Performance management in regards to productivity (value for money) is an integrated part of the economic steering system between state and regions, and within regions (between regions, hospitals and GPs). The activity of hospitals and regions is measured through a DRG system, and productivity (activity/input) is measured regularly and published in national level publications. While the bulk of the state financing of regions is in the form of block grants, a minor, yet important, portion comes through activity based funding. The regions will only receive this funding if their activity is above a certain target level. The target level is raised by 2% annually pushing the regions and their hospitals to increase productivity. Most regions have opted for higher levels of activity based financing for their internal management of hospitals. This is implemented through hospital level steering contracts and agreements with hospitals. The level of activity based financing often varies between different departments with areas like orthopedic surgery being most subjected to activity based payment.

The following figure provides an overview of performance management relations in Denmark
What is the underlying rationality behind the Danish PM schemes?

The purpose of PM schemes in Denmark is to improve quality (clinical and patient experienced), to reduce the risk of accidents and malpractice incidents and to evaluate that the regions and their hospitals deliver value for money. – Financial viability and robustness is not an explicit part of the national performance management schemes as this is the responsibility of the regions. The regions manage hospital economy through contracts and ongoing (hierarchical) monitoring and interventions when necessary.

The assumptions about mechanism and causality in Danish PM schemes are mixed and to some extent also ambiguous. This reflects the step-wise development and the need for compromises between national and regional levels and health professionals. The official rhetoric behind the "Danish Quality Assessment Model" is to enable self-assessment and support organizational development, yet the process also enables
external (hierarchical) scrutiny with an implicit threat of interventions if hospitals fail the accreditation exercise or consistently fall behind on various parameters.

It appears that the potential threat of intervention and the ongoing pressure exerted by the state on the regions is effective in pushing the regions to focus on quality management. The collection, monitoring and periodic publication of comparative quality data serves to reinforce this relationship as the regions are quite sensitive to the risk of attracting negative attention as their overall legitimacy in the system has been contested. In this sense a "naming and shaming" logic is important.

Like Germany there have been no highly publicized scandals in regards to hospital quality (although some local issues of below-average outcomes e.g. of surgery for breast cancer in Bornholm have surfaced). Developments are to a larger extent driven by state level steering needs in regards to regions and municipalities, a need to maintain legitimacy and support for regions and a drive within professional elites towards increased use of clinical performance systems (clinical databases).

The decentralized structure for public management of hospitals means that Denmark, like Germany, operates a system of multilevel governance. Yet, in contrast to Germany the coordination across levels takes place in national level negotiations and national level agreements within the public sector. Such agreements between regions and municipalities create a relatively uniform national reference point and enable the national level to impose general quality management schemes.

While the stated philosophy in regards to quality development in "The Danish Quality Development System" is to support self-development at the organizational level, it seems that the concurrent practice of national level monitoring of quality indicators exerts an external pressure on the regions, which is mirrored in the regional level steering of hospitals.

Free choice of hospitals upon referral was introduced in Denmark in 1993. This was gradually accompanied with various kinds of performance data. Initially mostly process data and hospitals’ estimated waiting times. Later this was supplemented with access to various types of quality data. The overall rationale behind choice was primarily to increase the service level and flexibility for patients, and only secondarily to improve performance.

*How is data collected and published in Denmark?*

*Which agencies collect data?*

The figure above illustrates that there are two main streams for performance management in Denmark. The Economic and general management stream have the five regions as central agents. The regions operate under general legislation and budget laws and are responsible for delivering healthcare through their hospitals and through planning and financing relationships with general and specialist practitioners. Performance information is fed through bureaucratic channels and has historically been focusing on activities, service quality and some quality measures.

The other stream is centered around the Danish Health and Medicines Agency and its sister organization SSI (Statens Serum Insitute). DHMA is responsible for surveillance of individual health professionals and health
organizations. It is also the locus for developing clinical guidelines and reference programs. SSI is charged with data collection and publication. Data is collected through a variety of channels including the general activity registries, the clinical databases and the general patient experience surveys.

IKAS (The Danish Healthcare Quality Programme) is another major player. It was established as a collaborative agency by the regions and the state, and is charged with developing standards and indicators for accreditation of all health organizations (hospitals, GPs, pharmacies, municipalities), and for conducting accreditation at regular intervals.

**Scope and measurement:**

Performance information has been collected for a number of years within the administrative systems and used within the steering relationship between the government and regional and local level governments in charge of delivering health services. Data about waiting times and a limited number of quality indicators have also been available on official national websites in various forms since the mid-1990s. However, the data collection has not been part of a grand design, but has rather grown out of different political initiatives (choice, quality improvement, patient orientation etc.) and various local, regional or national projects. Streamlining of data collection practices and formats across the regional and municipal administrations has been an ongoing challenge. Many limitations exist in regards to tracking activity and outcome at the municipal level, while national patient registries are fairly detailed in regards to regional (hospital) level activity and outcomes. The use of personal ID numbers in all public registries facilitates analysis of activities and outcomes but this potential is not yet used in a systematic fashion.

A more comprehensive approach to national level performance measurement appears to be emerging as the government and the regional and municipal authorities in 2013 agreed to establish a set of 50 key indicators of health system performance. The 50 indicators reflect the overall objectives of improved population health, patient satisfaction and efficient use of resources. They cover key themes such as public health, workforce participation, prevention of unnecessary (re-)admissions, patient safety, quality (functional ability after rehabilitation in municipalities, rate of re-operation after selected procedures, adherence to clinical guidelines, mortality for selected diseases including cancer and heart disease, 1 year survival rates for cancer and heart diseases), patient satisfaction, waiting times, collaboration and communication across regional and municipal care providers, productivity and expenditure levels (http://www.regioner.dk/~media/Mediebibliotek_2011/SUNDHED/Kvalitet%20og%20forskning/Indblik%20sundhedsvesenet%20resultater.ashx). The first report based on currently available indicators was published in May 2014. It caused considerable debate as it clearly illustrated the differences in results across the regions and municipalities of Denmark.

More specific performance measures have been developed to monitor progress in implementing cancer and heart ‘packages’. These packages include detailed specification about maximum waiting times in different stages, communication etc. A similar set of indicators is currently being developed for psychiatric care. This will extend the current national indicators for waiting times in this field.

Another recent initiative is related to the increasing focus on integrated care. Denmark has implemented mandatory health agreements between regions and municipalities in order to improve patient and
information flows across the different care providers. Progress in regards to core elements of these agreements is measured through 11 national indicators that are published on a national web site (eSundhed.dk). The 11 indicators include measures of "unnecessary (re)admissions, unnecessary waiting time after finished treatment, waiting times for rehabilitation services, implementation of e-communication standards, patient experienced collaboration and communication.

Clinical databases have been established for a number of medical specialties (currently 55 officially approved databases exist). These databases have generally grown from local and professional initiatives, but subject to approval and financial support from the state. A cross regional coordination agency (Regionernes Kliniske Kvalitetsudviklingsprogram (RKKP)) provides infrastructure, quality support and access to the databases. Information from the clinical databases is used for research projects, regional management of hospitals and as input to the accreditation of hospitals.

**Depth/unit:**

Activity data at hospital and department level is collected routinely by the regions using DRG classification.

Hospitals undergo tri-annual accreditations based on national standards. Accreditation status and reports are published on national websites (sundhed.dk and ikas.dk). The accreditation process takes place in close collaboration b/n hospitals, regions and accreditors and with an emphasis on self-improvement.

Hospital staff report information to clinical databases. Clinical databases are approved and financially supported by national authorities. A cross regional coordinating agency provides infrastructure and quality support for the databases (RKKP). Information from clinical databases is used for research projects, regional management of hospitals and as input to the accreditation process.

Departments and hospitals report waiting time information. This information is collected and posted in the Internet from a national level database.

A national survey of patient experiences is conducted on an annual basis. It contains a set of core questions that are repeated every year and additional specific themes and items.

There is no systematic collection and disclosure of performance for individual doctors/nurses. Performance assessment of individuals and teams is an integrated part of department level management.

Evaluation of malpractice or misconduct takes place through the complaints system and with the National Board of Health and Medicines as the controlling agency. Information about the total number of complaints and decisions are published regularly.

**Disclosure/publication:**

Information about activity, productivity, service and quality is collected by national authorities through national patient registries, DRG payment systems and specific reporting by regional and local authorities. They also feed into a recently system of 50 indicators covering broad areas of population health, treatment
quality, patient experiences and efficiency. These indicators are published in regular reports (Ministry for Health and Prevention 2014).

Selected indicators (waiting times and some quality indicators) are also published on national level websites with interactive facilities to enable comparison and choice (eSundhed.dk: Sundhedskvalitet.DK). More indicators will gradually be added to the websites as they are developed and tested. eSundhed.dk also contains a set of 11 indicators that are specifically aimed at measuring the interaction between municipalities and regions (hospitals) on a number of process dimensions.

Accreditation reports at hospital level are published by IKAS.dk.

**How is data used for performance management?**

*Are there explicit or implicit sanctions and are economic incentives (rewards/punishments) included in the PM scheme?*

Hospitals are managed by the five regional authorities. Their activity is measured through a DRG classification system, which is also used by the individual regions for designing economic incentives for hospitals and departments.

The level of activity based payment varies across the five regions, but for all five regions the bulk of the income for hospitals comes through block grants.

All regions use some level of performance data (activity, waiting times, some quality indicators) for their internal steering of hospitals. This may be formalized in written agreements (soft contracts) between hospital management and regional authorities specifying targets and incentives. Performance data is also used in steering interaction between state and regions and municipalities.

Activity information is used to determine a minor part of the allocation of funds from the national level to the regions. This is based on target activity levels, which much be reached in order to obtain funding from specific activity funds (approximately 5% of regional income).

Activity information is also used to determine the municipal co-financing of hospital treatment (approximately 20% of regional income).

There are no explicit incentives or sanctions related to service and quality indicators. However, they are part of the ongoing monitoring and steering of regional and municipal activities, and are discussed in coordination forums.

Quality indicators are also used as part of the information base for making decisions about which hospitals are allowed to perform highly specialized treatment procedures.

No performance incentives for individual health professionals as they are employed on a salary level.

Control and sanctioning is an integrated part of department and hospital level management. Issues of misconduct or malpractice may be evaluated through complaint procedures organized by national
authorities. The National Board of Health and Medicine is responsible for surveillance of medical conduct and can revoke licenses to practice medicine.

All in all the formal use of performance data for economic incentives is limited. Only a minor part of funding for regions and hospitals are allocated according to activity levels. Although this is only a minor portion of the funding for hospital care, it is an important variable for regional steering.

There are no formal sanctioning or incentive mechanisms for hospitals or hospital employees based on quality performance data. However, such data is used in the ongoing (informal) steering relations both within hospitals and between regions and hospitals. Comparative quality performance data are also used to monitor overall developments and to compare across different regions and municipalities. A system of 50 key indicators is currently being developed to facilitate a more systematic and multidimensional monitoring of system performance.

**Germany**

The governance of the German hospital sector is characterized by a multi-centered power structure emphasizing relatively independent "self-governing" relationships between sickness funds and providers. The multi-centered power structure is also expressed in the relatively high degree of autonomy for the German Bundesländer. The "self governance" structure and the discretionary the Länder enjoy in hospital policy means that national level authorities have limited direct power to impose large scale national systems, and that such systems must be negotiated with both the Länder and the actors of self-governance. Furthermore, the heterogeneity of provider organizations with private not-for-profit, public and private for-profit hospitals means that solutions must be adjusted and streamlined, and that compliance is less secure than in a "command and control" system.

Different to NHS, the German hospital sector has not experienced highly publicized scandals in terms of poor quality. Cases of medical malpractice are handled within the complex system of self-governance and are thus non-transparent for the wider public. A new law on patients’ rights has been implemented in 2013, allowing them inspection of their individual patient file and easing the burden of proof in case of conflicts. However, the major burden of proof still lies with the patients. As a result, incidents of poor quality are comparatively seldom discussed in regional or nationwide public media.

Accordingly, the general sentiment remains that the quality of the system is high (even though Germany is rarely placed among the top of the OECD or EU15 countries, but usually below the average, Busse & Blümel, 2014, p. xxvii). This means that politicians have not been pushed by a hot public debate to introduce continuous new versions of quality assessment on a continuous basis as was the case in England. This, as well as the complex governance of the hospital sector might explain that Germany is a late comer in the field of national level performance management initiatives.

In recent years, however, performance and quality of inpatient care has come on the political agenda. As a result of the multi-centered power structure we find a variety of different actors being active in the field of performance management, though. Performance management schemes have been introduced by the actors of self-governance (health insurance funds, hospital umbrella organizations) as well as individual
hospitals, in particular for-profit providers. Historically many of the quality management schemes in Germany have been developed regionally or within particular groups of providers. Indeed, many of the current initiatives have the same characteristics and they remain voluntary and limited in scope. Yet, it is an important turn in the German system over the past decade that national quality monitoring has actually been developed. The government in charge at the time of writing, a grand black-red coalition, as even announce to put hospital quality in the centre of attention. For the time being, the following performance management schemes can be considered as the most decisive ones:

- **Legally required performance management tools:** Hospitals are legally required to implement an internal quality management system (since 2000, § 135 a SGB V). In addition, they are since 2005 obliged to publish regularly quality reports (§ 137,3 SGB V). Finally, hospitals are obliged to participate in an external and industry-wide comparative quality assessment (§ 137 a SGB V).
- **Voluntary assessments on the meso-level,** which are for instance conducted by professional associations or by joint initiatives of umbrella organizations of funders and providers (e.g. KTQ (Kooperation für Transparenz und Qualität im Gesundheitswesen, Cooperation for Transparency and Quality in Health Care)
- **Voluntary initiatives by single hospitals,** e.g. the online platform ‘Qualitätskliniken.de’.

**What is the underlying rationality behind the German PM schemes?**

As there are not one but many different performance management schemes, their underlying rationality differs. Seen from the perspective of health policy at the federal level the prior objective of performance management schemes is to improve quality and to avoid accidents and malpractice incidents. Health insurance are obliged by law to cooperate with the German hospital federation in the Gemeinsamer Bundesausschuss ("Joint Health Commission") and are in charge to develop the guidelines for the national hospital performance schemes. However, as health insurance funds operate in a competitive market, they have also a strong interest in securing value for money and have thus initiated additional schemes such as the AOK Routine data quality assessment. What’s more, as competition has become fierce not only on the side of the funders, but also between providers, single hospitals have discovered performance as a competitive advantage, publishing performance data to demonstrate their clinical integrity. In particular for-profit providers consider quality management as a mechanism to build trust and gain legitimacy. Even tough their share (in terms of units) has exceed the share of public hospitals in recent years, for profit hospitals are still objected in large parts of the society and are thus in search for mechanisms to increase public confidence.

All initiatives, whether they have been introduced by the Joint Health Commission, by health insurance funds or by single hospitals, are based on the idea to enable self-assessment. There is a shadow of hierarchy behind the external and industry-wide comparative quality assessment according to § 137 a SGB V as an external inspection can follow in case the assessment reveals irregularities. In addition, the regular examinations by the Medical Review Board of the Statutory Health insurance Funds (MDK, see below) are an instrument of external hierarchical scrutiny with the according threat of interventions. However, in a comparative perspective, a fierce control and sanctioning philosophy which is characteristic for the British NHS, is lacking in Germany. To the contrary, ideas of promoting organizational learning prevail.
How is data collected and published?

The corporatist nature of the German health care system shapes also the procedures of data collection and data analysis. The most comprehensive national performance management system (structured quality reports and the industry wide external quality assessment) is backed by legislation but is implemented by the partners in the Gemeinsamer Bundesausschuss ("Joint Health Commission"), who have the discretionary to make appropriate formal arrangements. Performance data are collected primarily on the organizational level. So far, there is no systematic collection and disclosure of performance for individual doctors/nurses. As shown in figure two, the G-BA commissions the development of quality indicators to be monitored, the practical data collection and the analyses of the data to a private consultancy and research institute (the AQUA Institute). This solution of using an external "contractor" on a temporary contract to do the quality assessment rather than a public agency as in Denmark and England is illustrative of the legacy of the German corporatist rather than state controlled approach.

It might be expected that this setup creates a situation where the AQUA has less actual power to enforce data collection and make decisions regarding design than in the Danish and English cases. While this may be true to some extent, it is important to notice that the operation of AQUA is backed by legislation mandating all hospitals that receive reimbursement to report to the system. The operation of AQUA is also
backed by the Länder which provide administrative support (Landesgeschäftsstellen für Qualitätssicherung).

Another important actor in the governance of performance management schemes is the Medical Review Board of the Statutory Health insurance Funds, which is the main controlling agency in cases of malpractice or misconduct. Information about the total number of complaints and decisions are published regularly, however again only on an aggregated level.

Scope, measurement and disclosure/publication:

The AQUA institute collects outcome data for 30 selected treatment procedures. Since 2011/2012 patient surveys are used as an additional data source for external assessments. In 2013, the data set as again been enlarged by integrating data collected by health insurance funds into the external comparative assessments. Thus, the performance measurement scheme of the AQUA institute is a rather ambitious scheme. Yet, in terms of disclosure the information is mostly published at the aggregate level and without direct possibility for comparison. Peers and public authorities and the public in general only have access to general information about how many problems have been identified, and not about which hospitals or regions do better or worse. This is probably a reflection of the "negotiated" nature of the system with many stakeholders.

The structured quality reports, which hospitals are required to publish regularly, allow assessments of single hospitals. However, no direct comparison between hospitals is possible. The general idea of these reports is that quality data should be accessible for the general public (for patients) and public principals (health insurance funds, GPs/outpatient care, bodies of administrative oversight). Hospitals have to deliver their quality reports to a regulatory office (which is part of the umbrella organization of the health insurance funds). However, only detailed information about input and process parameters are collected and published. The quality reports inform amongst other things about the size of the hospital in terms of number of beds and employees, its technical equipment and its activities in terms of number of cases, but do not give information on output or outcome.

In addition to these mandatory measures there are several voluntary systems covering networks of providers in particular areas. KTQ (Kooperation für Transparenz und Qualität im Gesundheitswesen, Cooperation for Transparency and Quality in Health Care) and Qualitätskliniken.de (quality hospitals) are two well established examples for such voluntary initiatives. KTQ performs quality certification; information on 63 indicators is gathered by self-assessment and external auditors (http://www.ktq.de/).

Qualitätskliniken.de, too, offers quality certification, thereby considering 400 indicators in different dimensions (e.g. medical quality, patient security, patient satisfaction, ethics). In contrast to KTQ, Qualitätskliniken.de lays also a strong emphasis on benchmarking and choice (http://www.qualitaetskliniken.de/). To increase transparency in the hospital sector and to foster patient choice the quality results are published on an online platform, which also allows hospital comparison. While KTQ is a joint initiative of the Federal Association of Sickness Funds, the Federal Chamber of Physicians, the German Hospital Federation and the German Nursing Council, Qualitätskliniken.de is run by a consortium of private and voluntary hospital providers.
A third example for a voluntary quality assessment is Quality Assurance Based on Routine Data, which has been developed in close cooperation by the Scientific institute of the General Regional Funds and the Helios Clinics. Secondary routine administrative data such as data concerning diagnoses, procedures or demographics) contain information about long-term outcome (mortality, subsequent revision and the need for care following surgical treatment) and thus allow an assessment of the outcome hospital treatment (Heller, 2008). Hitherto, the results of the assessments are only available for the hospitals themselves.

How is data used for performance management?

Control/sanctioning and economic incentives

So far, sanctions related to poor quality results are rare in Germany indicating that data collection is not guided by a control and sanctioning philosophy to the same extent as in England. Health insurance funds and umbrella organizations of the outpatient sector are allowed to compare hospitals, to give recommendations for patients on the basis of the quality reports, and to publish their recommendations on their homepages (hospitals have to be informed before publication). Up to now, health insurance funds are somewhat reluctant with the publication of hospital rankings. They rather provide online tools which enable the insured to search and assess hospitals according to the structured quality reports. However, as the structured quality reports contain mainly information based on input indicators it is questionable whether these reports and the online tools are helpful instruments to give the general public sanctioning power in a competitive hospital market.

While the sanctions following the structured quality reports are limited in scope, sanctions related to hospital evaluations by the Medical Review Board of the Statutory Health Insurance and to the external industry wide quality assessment are more explicit. In case the MDK reveals situations of misconduct or malpractice, licenses to practice medicine can be revoked by the responsible authority at state level (§ 12, 4 BÄO). In addition, financial sanctions can be applied. Financial incentives play also a role in evaluation conducted by the AQUA-institute. All hospitals receiving remunerations from the health insurance system (in 2012: 1.658 hospitals, (AQUA, 2013)) are obliged to document the data and to make them available for the external assessment. Hospitals are expected to document 100% of the data of the agreed 30 procedures assessed by the AQUA-Institute. If less than 80% of the data are made available for the AQUA institute, financial sanctions are applied. In case the quality assessment reveals irregularities and hospitals are identified as underperforming, they are invited to enter a so-called structured dialogue (§ 10 QSKH-RL). In a first step, the hospital is requested to explain the irregularities. In case the explanation is not compelling, the case is discussed with the hospital management. An inspection can follow, presumed the hospital management agrees. All in all, the sanction mechanism reflect very much the corporatist nature of the German hospital sector with its consensus oriented decision making style, which persists even though the system has experienced a shift towards market-based governance (Bode, Lange, & Märker, 2013).
England

Introduction:

The NHS is often considered a fairly centralized system with much power at the central level due to national level public financing and state ownership of hospitals. Yet the introduction of the commissioner/provider split, patient choice and autonomous Foundation Trusts has necessitated the development of an alternative PM framework to ensure quality and financial viability of the trusts.

National level administrative power is not as strong as might be expected. Performance management has been delegated to arms-length bodies (Monitor, TDA) and it is unlikely that power will ever shift back to the Department of Health. The result has been a process of continuous adjustment, with new institutions functioning on top of those which already exist. The complexity and inherent inconsistencies of the regulatory structure generates an ongoing pressure for adjustment.

The high political salience of health care and relatively strong support for the NHS in the population presents a dilemma for national level politicians are frequently held accountable for health system performance, but in fact no longer have the direct control over the commissioning and delivery of services. The institutional structure with relatively large (monopoly) hospitals exacerbates this need for control, as hospitals failures would be unacceptable in many English cities.

The parliamentary system and the centralized ownership/governance structure means that majority governments have the power to introduce radical changes in PM schemes without extensive negotiations with opposition parties and interest groups. The general political salience of the health sector (the special status of the NHS) makes it important for politicians to signal that they have control over the NHS (financially and in terms of quality). Introducing new PM schemes can serve as (symbolic) levers to achieve this.

The result is a performance management setup composed of several institutions having somewhat overlapping mandates related to different and to some extent contradictory underlying objectives in the system. The system is further complicated by the fact that somewhat different regimes and institutional setups exist for “foundation trusts” and “non-foundation trusts”. Furthermore the institutional roles are divided between Monitor and the Trust Development Authority and the Care Quality Commission as illustrated by the following figure:
Re Regional/Area Teams
Clinical Commissioning Groups

Primary care
Secondary care
Health & Wellbeing Boards
Local Authorities
Public health

NHS England
Public Health England
Department of Health
Secretary of State
Parliament

Care Quality Commission
Trust Development Authority
Monitor

Performance management system for secondary care providers
What is the underlying rationality?

Due to the proliferation of different PM schemes in England it is hard to point to a single underlying purpose. Rather, the different systems reflect different underlying objectives and also a variety of different assumptions about mechanisms and causality. In comparison to Denmark and Germany the explicit focus on financial viability and robustness stands out. In Denmark such issues are part of the management obligations of the five regional authorities, and are handled internally as a relationship between the hospital management and the regions. In Germany, financial issues are negotiated between (associations of) sickness funds and (associations of) providers.

Another feature that makes England different from Denmark and Germany is the top down formulation of an explicit annual “Mandate” from the Government sets to NHS England which is intended to set the strategic direction for the NHS The decentralized nature of the Danish and German systems means that there is less of tradition of legally binding directives issued at the national (Denmark) and federal (Germany) level. Rather the central level relies on framework legislation while many specific issues are handled through negotiated agreements. However, there has been a tendency also in Denmark to formulate more explicit targets, and to make them subject to monitoring schemes and implicit threats of economic sanctions against the regions.

But financial viability is not the only purpose of the English PM schemes. An equally important objective is to improve quality both clinical and patient experienced and to increase value for money. Both of these purposes are pursued through the collection of quality data by CQC, Monitor (for Foundation Trusts) and NHS-Trust Development Authority (TDA) (for non-foundation trusts).

The assessments of CQC, Monitor and TDA exemplify the focus on several purposes in the sense that both financial robustness, value for money, quality and safety are emphasized.

Mechanisms and assumptions about causality:
In line with the multiple purposes we can also observe multiple assumptions about mechanisms and causality. TDA is characterized by a rather tight de facto hierarchical control and intervention system. Monitor operates a licensing scheme with routine evaluations and the threat of losing autonomy (“trust” status) if the hospital organizations do not live up to standards.

England has also introduced a choice of hospitals, and publication of quality data to support patient choice. “Naming and shaming” has previously been part of the star rating scheme in England.

Much of the thinking is based on control and sanctioning rather than "self- development". This is partly due to a number of highly publicized scandals involving poor quality or malpractice (Bristol, Staffordshire etc) that have negatively affected the general trust in the system. The "low-trust" environment creates a climate that pushes governments to intervene with new (symbolic) PM institutions and schemes. We have thus seen a string of successive changes, adjustments and additions to the performance management regime. New features have been added on top of other features. While in other cases existing institutions have been changed modified in terms of their mandate and modus operandi.

Who collects data? How is it collected and published?

As noted, FTs and non-FTs fall under two different PM regimes governed by two different bodies. For FTs tis is Monitor and for non-FTs the Trust Development Authority (TDA). A key task for the TDA is to work its way out of existence by helping non-FTs prepare to become FTs.

Monitor, meanwhile, has accreted a variety of regulatory roles over time – eg setting prices for most secondary care services as part of the Payment by Results tariff regime, and, importantly, assessing trusts for FT status, then 'licensing' FTs (a new measure introduced by the Health and Social Care Act 2012 to set out new objectives/conditions for Monitor in relation to the way they performance manage FTs. Summary details below) and involvement in assessment of possible anti-competitive behaviour and patient choice as part of the work of the Competition and Markets Authority (CMA – a body which oversees competition issues across the economy as a whole and which has recently come to oversee the NHS.

Monitor assesses trusts for FTs status against three criteria:

- whether a trust meets the required quality performance threshold (working closely with the Care Quality Commission (CQC) to determine this);
- how well run the trust is;
- the financial viability of the trust to ensure it can continue to deliver high quality care on a sustainable basis

The idea of a ‘license’ grew out of a need for someone, somewhere in the system, (in this case Monitor) to have powers to routinely review/performance manage trusts once they had become FTs.

The power to license trusts was extended to all NHS trusts (ie non-FTs) by the H&SC Act 2012 to enable Monitor to fulfil its powers as part of the licensing regime viz: the power to:

- set prices for NHS-funded care in partnership with the NHS England;
- enable integrated care;
• safeguard choice and prevent anti-competitive behaviour which is against the interests of patients;
• support commissioners to protect essential health services for patients if a provider gets into financial difficulties; and
• oversee the way that NHS foundation trusts are governed.

However, while an apparently arms-length relationship, Monitor was encouraged to develop a Compliance Framework. This was a measurement of how well a Foundation trust was run but the measures it contained include e.g. waiting times standards. This meant that poor performance against national standards and targets would lead an FT to being declared in breach of the compliance framework (i.e. badly run) and thereby open to intervention by Monitor. In general Monitor modelled the Compliance Framework on the annual `plan' for the NHS as set out in the Operating Framework (to 2013) and in the national planning rounds for NHS England (in 2013 and now). In theory the compliance framework was only supposed to be temporary, however, it has yet to be removed.

NHS-TDA oversees the remaining Trusts. NHS-TDA inherited many of the broad powers of SHAs and can directly intervene against Trusts who it considers to be poorly performing and has done so since its introduction – Trusts are effectively in a line-management relationship with TDA.

Another key regulatory organisation in terms of performance management is the Care Quality Commission (CQC – as noted above). The CQC is the latest of a long(ish) line of quality management/promotion organisations stretching back to the original 2001 ‘improvement’ organisation – the Commission for Health Improvement (CHI, 2001-2004) CHI was superseded by the Commission for Healthcare Audit and Inspection (CHAI) - renamed the Healthcare Commission (2004-2009) – which in turn was replaced by the CQC from 2009 onwards. All were/are non-departmental government bodies. The role of the CQC now is to:

• Regulate and inspect public and private health and social care services in England.
• Register all providers of care based on an ongoing demonstration that they meet or already meet various care standards (cf http://www.cqc.org.uk/about-us/how-we-do-our-job for details of the CQC’s role and process)

Scope, measurement and unit:

Financial regulation:

*Foundation Trusts* submit quarterly returns containing information that Monitor uses to assess any risk to continuity of services, specifically, liquidity and capital services coverage.

Annual returns cover income and expenditure, cash flow against annual plans, and commentary on exceptional costs. FTs must provide information on exceptional circumstances such as an unplanned reduction in income or a significant increase in costs.

*NHS Trusts (non-foundation trusts)* are monitored on their in-year financial delivery

• Bottom line income and expenditure compared to the plan submitted by Trusts to NHS TDA
• Actual efficiency (cost improvement programme) compared to plan
• Forecast underlying surplus/deficit compared to plan
Forecast year end change to capital resource limit

How is data used for performance management?

As described above data is used to license foundation trusts at regular intervals, and to control the performance of non-foundation trusts on an ongoing basis.

NHS England is legally obliged to follow the direction and to hold local NHS organisations to account according to the priorities set out in the Mandate. The performance of providers is measured against outcomes objectives, set out in the Outcomes Framework This sets out indicators under five domains.

See table x. An example of an indicator would be under domain 5, measure of pressure ulcers, or of healthcare associated infections (HCAI). A technical appendix outlines the detailed indicators. (Department of Health 2013a)

Table xX The NHS Outcomes Framework

- Domain 1 Preventing people from dying prematurely
- Domain 2 Enhancing quality of life for people with long term conditions
- Domain 3 Helping people to recover from episodes of ill health or following injury
- Domain 4 Ensuring that people have a positive experience of care
- Domain 5 Treating and caring for people in a safe environment and protecting them from avoidable harm

NHS England also monitors pledges contained in the NHS Constitution (Department of Health 2013b)

Some of these pledges are legally binding, others of which “the NHS is committed to achieve supported by management and regulatory systems.” (NHS England 2014). Most of these targets relate to access.

Legally binding pledges

- 90% of admitted patients to start treatment within a maximum of 18 weeks from referral
- 93% of patients to have a maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP (legally binding)
- 95% of patients to have a maximum four-hour wait in A&E from arrival to admission, transfer or discharge (legally binding)

Non legally binding pledges

- 95% of non-admitted patients to start treatment within a maximum of 18 weeks from referral (pledge – ie not legally binding)
- 99% of patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral – (pledge – ie not legally binding)
- 93% of patients to have a maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) (not legally binding) – (pledge – ie not legally binding)
Control/sanctioning

The following would trigger governance concerns

- Inadequate planning processes
- Breaching continuity of services license condition

Economic incentives

Under Commissioning for Quality and Innovation (CQUIN), payment for 2.5% of the value of services commissioned under the NHS standard contract is dependent on a provider meeting certain quality improvement standards. At least a fifth of this value (0.5% of overall contract value) is to be linked to national CQUIN goals. The remainder can be set locally by CCGs.

In 2014/15 the national goals were: performance against the friends and family test, improvement against the NHS safety thermometer, improving dementia and delirium care and diagnosis in mental health.

Conclusion

What are the similarities and differences in the design of performance management systems for hospitals in England, Denmark and Germany? How can we characterize the three different regimes? Speculation about the reasons for differences...

Similar data units at the basic level, but different aggregation and utilization depending on institutional structure and the purpose/theory of PM in the different countries.

The case studies have revealed important differences between performance measurement of hospitals in Denmark, Germany, and UK. The international trend towards the implementation of encompassing performance management schemes is translated very differently into the national institutional landscapes of the three countries under consideration. Differences can be seen with regard to both the general logic of the performance measurement (focus on control and sanctioning versus support of organizational learning) and the governance of performance measurement (centralized versus decentralized solutions). In this respect, UK and Germany can be considered as ‘most dissimilar cases’ with the UK having implemented a centralized command and control system while performance measurement of German hospitals relies on the idea of self-governance granting hospitals considerable room of maneuver. The German system is characterized by trust in the hospital’s own initiatives; organizational learning is not systematically enforced from ‘above’, neither with positive or negative sanctioning instruments. The UK approach differs significantly as it employs a range of sanctioning mechanisms Denmark is somehow in the middle between UK and the German model, combining powerful actors at the central level with the encouragement for individual organizational learning at the hospital level. Further research is needed to assess the effects of the different approaches on hospital performance.

How can we explain the different roads the three countries have taken in designing and implementing hospital performance management schemes? The paper suggests that two dimensions are decisive for understanding the shape of performance management schemes: firstly, national characteristics with regard to the adoption of ideas of New Public Management, secondly, national characteristics of health care. Following the comparative literature on New Public Management (Christensen, Laegreid, Roness, & Røvik,
2007; Pollitt & Bouckaert, 2003), it seems to be likely that countries with early and extensive implementation of NPM such as the UK are more open to comprehensive performance management schemes with disclosure strategies to support contracting and choice, and with more emphasis on economic incentives and NPM-late comers like Germany. The differences in terms of scope, depth and the underlying rationalities of performance management schemes we have found in the three countries are also supported by the literature on health care regimes (Blank & Burau, 2014). The UK with its highly integrated NHS system seems to be more likely to develop universal and integrated performance management systems than the German fragmented health care system with grants actors of self-governance considerable room of maneuver. Denmark, in turn, is a public, integrated but relatively decentralised NHS system, which might explain its middle position. Again further research is needed to verify these assumptions.
References:


