



Changing accountability regimes in hospital governance: Denmark and Norway compared

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Published in:
Scandinavian Journal of Public Administration

Publication date:
2011

Document version
Publisher's PDF, also known as Version of record

Citation for published version (APA):
Byrkjeflot, H., Neby, S., & Vrangbæk, K. (2011). Changing accountability regimes in hospital governance: Denmark and Norway compared. *Scandinavian Journal of Public Administration*, 15(4), 3-23.

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Keywords: Accountability, reform, hospitals, governance, democracy

Nyckelord: Ansvar, reform, sykehus, styring, demokrati

Offentlig förvaltning
Scandinavian Journal of
Public Administration
15(4): 3-23

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ISSN: 1402-8700
e-ISSN: 2001-3310

Abstract

As modern welfare states are reforming, relationships and processes of accountability in public sector systems are transforming. This transformation has consequences for the relationship between the public, political and administrative institutions as well as service production, and ultimately concerns democratic legitimacy. In this article we focus on the hospital systems in Norway and Denmark, and explore the changes in accountability relationships that have come about in conjunction with reforms over the last 10-15 years. Departing from the theoretical idea that accountability serves several different functions and the empirical observation that recent reforms in the two systems are diverging as much as converging, we find that health care reforms provide fruitful cases for studying changing accountability relationships. We argue that the Norwegian and Danish hospital sectors, in spite of reform variation, are both moving from a situation characterized by democratic-administrative accountability mechanisms towards an increased focus on performance-oriented accountability mechanisms that combine and intersect with more traditional notions of democratic and administrative accountability. Finally, and based on this finding, we explore the implications for further research on accountability changes and reform.

Nye ansvarsregimer i styringen av sykehus: En sammenligning av Norge og Danmark

Reformer i moderne velferdsstater fører til endringer i ansvarsrelasjoner og prosesser for utkreving av ansvar i offentlig sektor. Disse endringene har konsekvenser for forholdet mellom befolkningen og offentligheten, politiske og administrative institusjoner, og angår til syvende og sist systemets demokratiske legitimitet. I denne artikkelen setter vi fokus på sykehussystemene i Norge og Danmark, og utforsker endringer i ansvarsrelaterte prosesser og relasjoner i forbindelse med de store reformene som er innført de siste 10-15 årene. Med utgangspunkt i en teoretisk tanke om at ansvarsrelasjoner fyller flere viktige funksjoner i disse to systemene og det empiriske faktum at reformene i de to landene er like divergerende som de er konvergerende, finner vi at reformer i helsetjenestene gir gode eksempler på endringer i ansvarsrelasjoner og ansvarsprosesser. Vi argumenterer for at de norske og danske sykehussektorene i dag legger mer vekt på et mer prestasjons- og målingsorientert system som kombineres med og griper inn i mer tradisjonelle former for demokratisk og administrativt ansvar, til tross for tydelig variasjon i de senere reformenes innhold og innretning i de to systemene. Til sist diskuteres konsekvensene av disse funnene for videre forskning på endringer i ansvarsrelasjoner og reformer.

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Introduction

The rhetoric of reform usually poses questions of accountability in terms of whether government employees are more accountable after the reform than they were before. While it is not impossible to discuss accountability in terms of more or less, doing so implies a uni-dimensional, linear concept that does not reflect the complexity of public management. (...) A more useful approach, (...) recognizes the various dimensions of accountability and the complex context of public accountability. (Romzek, 2000: 22)

Around the millennial turn, both Norway and Denmark implemented reforms justified with the need to make hospitals more accountable. In spite of several studies on health sector reform in the Nordic countries (see e.g. Magnussen et al., 2009), previous studies have not focused on changes in accountability relations. Accountability is a promising entry point for analyzing developments in modern welfare systems, as it illustrates dilemmas between control and autonomy, political and administrative governance, professions and citizens (Thomas, 2003). Healthcare is at the core of the public welfare states, and both Denmark and Norway belong to a group of public integrated health systems with a strong public role in stewardship, financing and delivery of services, emphasizing democratic governance at both central and decentralized levels. These two cases thus provide important insights into developments in systems that have relied strongly on democratic and administrative accountability.

Both systems have undergone recent large-scale administrative reforms within healthcare, whereas other Nordic countries have been more reluctant to undertake such reforms (Magnussen et al., 2009). They have also followed international trends to emphasize output accountability combined with new forms of procedural accountability through standards and guidelines (Bureau & Vrangbæk, 2008). Performance- and output-oriented organization and management models have indeed become more important in the Nordic countries, but are often characterized in terms of the specificities of national context (Johnsen & Vakkuri, 2006). Comparing two reform oriented cases increases the likelihood of capturing state of the art trends within this category of health systems.

Accountability is a multi-faceted phenomenon (Dubnick & Fredericksson, 2011) reflecting specific types of relationships between actors and levels within systems, where actors have obligations to account for their decisions and behavior. Actors may have to explain and justify their behavior in forums of different kinds, and such account giving may actually have consequences (Bovens, 2007). However, such relationships play out in different, interrelated spheres of society and take various forms. We distinguish between democratic, administrative, management and clinical accountability forms, arguing that the configuration of accountability relationships in modern societies and the interaction between them is important for understanding contemporary societal developments. Introducing the concept of accountability regimes (Goodin, 2003; Tuohy, 2003;

Mattei, 2009) to describe the combination and relative weight of different forms of accountability over time, we analyze the impact of health system reforms on the accountability regimes in Denmark and Norway.

Our principal research questions are: How have recent health system reforms in Denmark and Norway affected democratic, administrative, managerial and clinical accountability relations, and how can we characterize the emerging accountability regimes for health care in the two countries?

The following section presents the analytical background for the study in more detail, followed by a section on design and methods, and subsequently an analysis of the dynamic relationship between reforms and accountability relationships in the two hospital systems. We move on to present our findings, before closing with a discussion about implications of the findings in a theoretical and empirical light.

Analytical approach: Understanding accountability

Bovens' (2007) definition of accountability¹ is based on the distinction between an actor and a forum, and includes the precondition that some form of instrumental authority is involved: The actor may face consequences on the basis of being held accountable by the forum, and the forum has the necessary authority to both demand accounts and impose sanctions.

At the core of accountability relations is a "speech act" associated with social rituals such as excuse making, face-saving or acts of rationalization and justification. Involved in each of these is the capacity of one party in any social relationship to offer an account of their actions to the other parties, based on social expectations of account giving (Dubnick & Frederickson, 2011). This occurs in a variety of ways, depending on the institutions, regulatory frameworks or even the subject matter in question (Kearns, 1996, Johnson et al., 2011), just as expectations of timing, the content of accounts and the types of potential sanctions vary over time and across social spheres. Formal rules for accountability relationships represent conscious attempts to establish such expectations and obligations. Formal rules are constantly interpreted and applied in practice, however. Referring to Deborah Stone's definition of policy instruments as "ongoing strategies for structuring relationships and coordinating behavior to achieve collective purposes" (Stone, 2002: 262), we argue that accountability forms can be viewed as strategies for forming legitimate expectations of when and how account giving should take place and for structuring relations between actors and forums. Following Bovens and Schillemans (2011), modern societies contain a multitude of such accountability forms, which analytically can be related to different social logic systems. We find distinguish between democratic, administrative, management and clinical/quality related accountability forms.

By *democratic accountability* we underline the relationship between political leadership and citizens; that politics and policies are displayed and performed in a variety of areas where citizens may act as a forum towards political leaders. One thing is the formal connection between assemblies and elections, another is more informal relationships and processes that exist and take place within a

greater political context, e.g. civil interest groups, the media and politicians. By *administrative accountability* we emphasize the relationship between administration and political leadership, where the dimension of interest is accountability exercised within the “chain of command”, e.g. between ministries, directorates and audit agencies, and in turn between such agencies and the hospital entities. Administrative accountability has a strong focus on legality and due process. By *management accountability* we hint at the introduction of new types of relations based on contracting and performance management within hospital organizations and between hospitals and their principals. *Clinical/service quality accountability* refers to accountability relationships that oriented towards operational quality performance and professional standards. The following table illustrates core dimensions in each of these accountability systems, although the reader should keep in mind that they interact, and that real life distinctions are more blurred than ideal types.

Accountability also takes different directions: Schillemans (2011) distinguishes between horizontal and vertical accountability relationships. Vertical accountability refers to situations where a superior demands an account from a subordinate. As with classical hierarchy, authority and distribution of roles are formalized or of a strong character. In horizontal accountability mechanisms, the situation is rather an absence of hierarchical relations. Instead there is an accountability relationship to a third party, a peer, or a non-hierarchical forum. The relationship may or may not be formalized; there is no subordination of one actor towards the other, as in the relationship between a semi-autonomous audit agency and an administrative institution. Bovens (2007) includes the possibility of a diagonal arrangement where the forum is not hierarchically superior to the actor, but still has sanctioning powers and acts on behalf of another authority. Ombudsmen or independent complaint boards could be examples of such accountability arrangements; they are not superior to the actors the hold accountable, but act on behalf of “the system” or “the public interest.”

We introduce the term accountability regime to capture the combination of different accountability systems at any given point in time. Reforms may shift the relative importance of different accountability logics explicitly through new formal rules, or implicitly by introducing new institutional structures and relationships. Based on our presentation of theoretical concepts we propose the following general expectations: 1) accountability relations have become more complex and interlinked over time (Bovens & Schillemans, 2011), 2) management accountability has become more important within contemporary accountability due to NPM style reforms particularly in Norway, 3) clinical/quality accountability has changed from being an internal professional matter to being a more general, public and integrated part of management, administration and even democratic accountability relations, 4) vertical accountability forms are increasingly substituted by diagonal or horizontal forms due to NPM style decentralization reforms.

Table 1: Core types and dimensions of accountability

	Democratic	Administrative	Management	Clinical/quality
Structural dimension: Who is accountable, and what forum? for?	Voters ↔ parliament Parliament ↔ government Government ↔ administrative	Administrative chain of command: Higher level ↔ lower administrative staff/units	Administration ↔ management Management ↔ organization	Administration ↔ clinical staff and subunits
Procedural dimension: How are actors held accountable?	Elections Parliamentary scrutiny, no-confidence votes etc Budgets and budget control	Hierarchical or diagonal and intervention	Contracts and targets Benchmarking	Professional peer review Benchmarking of clinical services
Focus: What are actors held accountable for?	Political control and system integrity	Due process, legality Administrative targets and integrity	Economic “bottom line” Organizational performance targets	Clinical quality and safety

Design and methods

The data for this study primarily comes from written sources (public documents, secondary literature, and media). We have not collected new data from interviews, surveys, etc, but draw on previously collected survey and interview data for background information. This approach was chosen for two reasons: Firstly, the number, size, scope and timing of the reforms and institutional changes in question necessitated an aggregated and relatively broad approach, as does the general complexity of themes associated with the development of accountability mechanisms in the Norwegian and Danish hospital systems. Secondly, we take a descriptive analytical approach; we are interested in understanding and exploring what the developments in accountability are about, rather than providing explanations or analyzing effects.²

Both countries' hospital systems belong to a 'family' of systems often described as decentralized NHS-type or Beveridge systems, although with a distinct Scandinavian twist (Blank & Bureau, 2004). The research undertaken thus draws on a design where differences in accountability relations developing over time between the two relatively similar systems are highlighted, in order to explore the effects of reforms on accountability relations. When it comes to reforms, this 'most similar case' design allows analytical control for contextual variation that a 'most different case' design does not.

Analytically, the idea is to identify converging and diverging accountability patterns across reforms and across countries. The approach is based on theoretically defined parameters, and has two tiers. Firstly, defining contents of accountability relationships are used as intakes to find arrangements that are relevant. Secondly, we classify the functions that accountability mechanisms serve through predefined categories – democratic, administrative, management and clinical accountability functions.

Accountability regimes in Norway and Denmark

Both hospital systems existed within relatively stable structural frameworks from around 1970 and until the millennial turn. Hospital services were generally connected to local communities and, in particular, to the regional democratic level. In terms of *democratic accountability*, both countries from the early 1970s subscribed to a two-step electoral assembly system, with county councils directly involved with hospital governance, but where the national assemblies and governments also had influence through policy and financial schemes. The county councils were accountable for hospital matters and subject to elections, just as the national assemblies.

In Norway, the 1970 hospital act formally placed hospital responsibilities at the county level, and a local government reform in 1975 introduced elected rather than appointed county councils (Angell, 2012). Counties became the primary democratic actor in hospital governance as local and regional politics became more relevant, in spite of mandatory central approval of plans (Byrkjeflot & Neby, 2008). County level politics directly influenced the outcomes of health

policies, increasingly leading to conflict-ridden blame-games around finances, hospital (re-)location and closures.

The formal accountability relationships in Denmark, prior to the 2007 structural reform, closely resembled those in Norway. County councils were formal hospital owners and the national government formulated general policies, assemblies on both levels subject to elections. Thus, citizens could hold both county and national politicians accountable for hospital-related matters. Relationships between parliament and government were defined by the principle that a government can stay in power as long as they do not have a majority against them. Minority governments may be sanctioned politically by the parliament; parliament may use i.e. formal questioning, interpellations and hearings for holding government to account.

Both countries employ ministerial rule, whereby a minister is ultimately accountable for decisions made within her sector, following the possibilities for intervention and instruction that the minister has.³ These two features of parliamentarism created strong accountability links between parliament and government (and single ministers) in both countries. Ministerial rule opens the possibility that even detailed matters can become political and, ultimately, democratic accountability issues.

Administrative accountability has also been similarly organized in Norway and Denmark. Politicians serve as heads of the bureaucratic administrative system, e.g. the Minister of Health holds subordinate organizations accountable for implementation of policies, regulation, budgets and standards of due process. In both countries, the organization of ministries and the division of labor between them is in principle decided upon at the government's discretion. Norway has a longer history for a Ministry of Health, where the Danish solution until 1987 and in the periods 2002-2007 and 2010-2011 was a coupling between health and interior affairs in one ministry.

Another difference was the organization of superior professional-administrative authorities on the one hand, and audit agencies on the other. The Danish Board of Health answers for professional advice and development, but also has central tasks concerning audits and inspections. In Norway, these responsibilities were distributed between two institutions; the Norwegian Directorate of Health had professional administrative responsibilities, whereas the Board of Health Supervision was the prime audit agency (Neby, 2008). Both the Danish Board of Health and the Norwegian Directorate of Health fell within a vertical administrative accountability relationship towards government, however. The governance of *the hospital level* from these institutions' point of view rested with advice on policy interpretation, guidelines, legal considerations, as well as communication of professional standards. These are relevant for hospital operation and provide a background against which hospitals and managers could be held accountable, within the regional political chain of command and by the electorate in general through displays of performance measurements, or administrative and professional audit mechanisms.

In terms of *management accountability* and *clinical accountability*, hospital managers were primarily held accountable by their political superiors, the coun-

ties, whereas internal departments and professionals formally were accountable to hospital managers. Both in Norwegian and Danish hospitals a dual management structure, in which doctors and nurses managed their own professional hierarchies, had developed (Jespersen & Wrede, 2009). For healthcare professionals, horizontally oriented peer and best practice standards were carried by professional associations, but also coupled with formalized public accountability measures (licensing and authorization). Clinical accountability was thus both a matter of the professionals' relationship to the hospital management and of audit or inspection by agencies, mainly coupled with malpractice and adherence to professional standards.

Describing the Norwegian and Danish hospital systems in the thirty-odd years before 2000 in terms of an *accountability regime*, both countries were marked by a politico-administrative arrangement where democratic accountability on the regional and national level was combined with administrative accountability. The main accountability directions were vertical, with the notable exception of a more diagonally oriented Norwegian health audit system and the role of the Danish National Board of Health in surveillance of regional hospitals and individual health professionals. There was a close proximity between healthcare politics at the regional level and hospital operation in both countries, representative of the two-tiered democratic accountability.

Reforms and changes influencing accountability regimes

Norway

In Norway, an important change in *democratic accountability* came with the 2002 hospital reform⁴. As a response to pressures for increasing efficiency, governability, quality and cost reduction, the reform replaced county governance of hospitals with a system of state-owned regional trusts that in turn own local hospital enterprises.⁵ Both levels are managed by executive officers, and governed by boards that are accountable to the minister of health. The minister is accountable to parliament; democratic accountability is placed at the national level. Finances now come directly from the state through a combination of block grants, specific grants and activity based financing; before 2002, counties allocated funds. The portion of activity based funding has varied since 2002, subject to budget negotiations in the Storting. Detailed financial questions have become issues of national democratic attention and activated several accountability measures. The number of formal questions about hospital matters raised in the Storting has increased markedly and been maintained at a high level since the introduction of the 2002 reform (Neby, 2008; Opedal & Rommetvedt, 2005). This escalating exercise of democratic accountability could also be interpreted as a consequence of the removal of the county level, however: Matters of local character are frequently debated in the Storting, indicating that politicians seek to remedy the lack of local and regional democratic accountability.

The formal organizational structures of the regional health trust and local enterprises (led by boards) have implications for both *administrative and man-*

agement accountability. Originally, the composition of boards and appointment of managers aimed at a ‘professional approach’ in the sense that experience and competence from similar arrangements was to be weighted heavily. Politicians were never excluded from the boards (Hegrenes, 2008), but were in 2005 introduced as mandatory regular board members (Haug et al., 2009). Listings of board members after 2005 include party affiliation (Byrkjeflot, Christensen & Læg Reid, 2011).

The 2002 reform was as a response to blame-games and conflicts crossing institutional and political boundaries between the county councils and the state (Byrkjeflot & Neby, 2008). Accountability still crosses institutional boundaries, however. By example, in the 2011 local elections, a municipality with a traditionally strong support for the labor party witnessed a massive drop from 26,5% to 8% in support for the labor party and a 5,9% to 43,9 % increase in support for the social liberal party. The election’s results are widely interpreted as a democratic reaction against a decision about closing the local hospital’s maternity ward⁶ – although local politicians had no influence over the decision. In effect, voters symbolically and practically sanctioned the labor party, which currently holds main positions in the national government (including the minister of health).

These developments coincide with diagonal *administrative accountability* is becoming increasingly important (Neby, 2009). Administrative accountability processes take different forms; sometimes case-specific and retrospective in orientation, sometimes general and scheduled. Professional conduct is an important accountability theme: Critical cases regularly reach the media, raising questions of accountability touching upon professional standards, regulation, administrative responsibilities and politics. Such cases illustrate that bureaucratic, managerial or professional matters can become political; state ownership of hospitals has not reduced the importance of democratic accountability.

There is also the possibility that different accountability relations may be combined. After the 2002 reform, the Auditor General is responsible for the central audit of Norwegian hospitals, a consequence of state ownership of the hospital trusts and enterprises (counties were subject to the audits of the regional state representative). The Auditor General’s reports are directly available to parliament. By default, the Auditor General is important for government, serving a democratic function based on its functional affiliation with parliament.

In terms of the Board of Health Supervision, a new arrangement was introduced in 2012: The central agency now holds superior audit responsibilities for health specific matters, but the actual inspections are performed by the regional state representative. The Board of Health Supervision no longer has regional representatives performing individual audits.

The governance of Norwegian hospitals is based on a system with letters of instruction stating policy aims for the hospitals (Byrkjeflot & Guldbrandsøy, forthcoming). Hospital enterprises and regional trusts answer to the minister of health concerning the fulfillment of these aims, which in turn makes a comparison to contractual relationships relevant. Although the relative distance between government and hospitals is large, the coupling between national policy and

implementation in hospitals is more direct than it used to be. This allows politization of administrative or management issues at the hospital level.

The Norwegian regional trusts and local enterprises were established as publicly owned companies, and, in accordance with the NPM ideals, management became a central issue (Byrkjeflot, 2005). Dual management was replaced with a unitary management scheme, in combination with the board system of the regional trusts and local enterprises. The idea was that management should be conceived as a professionalized responsibility, independent of the traditional medical managers (Jespersen & Wrede, 2009). This corporate-style structure differs from traditional approaches to public administration in welfare provision, as seen in areas such as immigration or social security. Although the health enterprises are not directly influenced through elections, they are open for political intervention. It seems apparent hard for politicians to distinguish between principal cases and matters of detail (Danielsen et al., 2004; Byrkjeflot & Grønlie, 2005), indicating a connection between administrative and management accountability relationships through the structural anatomy of the system on the one hand, and the demands for a more measurable management practice on the other.

The introduction of activity based financing (ABF) schemes and the DRG-system came in the period between 1997 and 2001. Coding of treatments directly intervenes with the daily work of healthcare professionals and managers, and cases where coding practices have been misused or faulty, influencing cash flows to hospitals, have occurred (Lægreid & Neby, 2012). In these cases, the boards and managers of the local enterprises are held accountable, e.g. by the Auditor General – in turn effectively creating a link between administrative accountability and democratic accountability at the national level. Large-scale schemes such as ABF and DRG systems influence accountability connections between clinical, managerial and administrative parts of the hospital system.

Denmark

The Danish structural reform of 2007 was a general public administration reform affecting all sectors of the welfare state, particularly along the lines of democratic accountability. The reform introduced a system with five regions (replacing 13 counties) and 98 municipalities (replacing 275 smaller municipalities). Elected politicians head the new regions, which have taken over the role as hospital owners. Finances for hospital services come partly from the state, partly from the municipalities. Thus, democratic accountability is both tied to election of regional political representatives, and to local municipal and national level politics. The regions are financially dependent on two different democratically accountable levels, but retain responsibility for the operation of hospitals.⁷

Municipalities and regions negotiate mandatory agreements that set operational and financial frames for their interaction. These agreements are approved by the Board of Health, which couples administrative accountability on the state level with democratic accountability on the local and regional level. The agree-

ments also could be taken to indicate that procedural and formal matters become more central to accountability in the Danish system.

The Danish system is practically a three-way system where citizens may hold all three tiers accountable: Local, regional and national politicians all deal with health matters, and they are all forums for actors within the health care system. Importantly, whereas the 2002 reform in Norway was a hospital reform only, the 2007 structural reform is a reform of the entire local and regional governance system as much as of hospitals. Matters of democratic accountability in Danish regions and municipalities thus extend beyond hospital matters.

Vrangbæk (2011) argues that there is more to this picture, stressing the importance of accountability connected to performance. In Denmark, a range of national quality criteria has been introduced and user evaluation surveys are produced regularly. Hospitals are evaluated on a regular basis. There is a system for accreditation and hospitals are benchmarked. Such benchmarks and standards have been met with criticism, but authorities have responded by promising to improve them in order to achieve the stated goals. Jespersen (2008) argues that whereas the Danish quality system is of a grander scale, it also relies on the medical profession to a greater extent than the Norwegian system.

Increasing focus on quality measurements, user satisfaction surveys, patient rights and waiting time guarantees serve to introduce standards to which different actors within the hospital system may be held accountable. Managerial and clinical action relates to performance indicators relating to efficiency, budget discipline, quality, clinical guidelines and standards for best practice. This drive towards performance complicates the democratic and administrative accountability dimensions in part by cutting across policy decisions.

Three other developments are important when comparing the Danish and the Norwegian cases. Firstly, much like the Norwegian case, the National Accounting Office has gained more importance as an accountability forum for the regional and municipal health services. This new role is a result of the change from regional to state financing of health care, and provides a stronger diagonal accountability influence. Secondly, the National Board of Health gained stronger formal powers to oversee the regional and municipal health authorities as a consequence of the 2007 structural reform. This means that the Board takes a more active role in developing standards and guidelines, and in establishing framework structures for measuring and comparing performance at the regional and municipal levels.

Lastly, the activity based financing system until recently played a lesser role in Denmark. Originally introduced as an information system in 1995, it was coupled with financial schemes in 2000 – for reimbursement of cross-county choice patients (Vrangbæk, 2004). From 2004, 20% of hospital reimbursements were activity based, following an agreement between the central and the local level. From 2007, when municipal and regional organization changed drastically, regions now redistribute 50% of the funding along an activity-based scheme. Moreover, as the central state and municipalities have shared financial responsibilities for hospitals (80/20, respectively), 5% of government and 10% of municipal reimbursement is activity based, resting on the DRG system (Magnussen et

al., 2009). In addition, there is an activity based governmental pool, reimbursing regions for increases above normal activity. Hospital financing thus reflects both the accountability relationships in the system and the direct linkage between performance and incentive. There are three tiers: The central state, the regions and the municipalities.

Discussion: Comparing accountability

Initially, we asked two basic questions to guide our exploratory approach: How have recent hospital system reforms in Denmark and Norway affected democratic, administrative, managerial and clinical accountability relations, and how can we characterize the emerging accountability regimes for health care in the two countries?

Similarities: Towards more complex and performance oriented accountability?

Firstly, in terms of similarities there are some shared developments relating to increased use of managerial accountability. Reliance on economic incentives, managerial accountability and more flexible administrative steering systems is greater where formal hierarchical accountability is replaced by procedural and output/outcome related accountability. Such solutions are visible e.g. in the Norwegian combination of semi-autonomous corporate-like structures with agencies auditing hospital performance: Patient choice creates mobility amongst patients, in turn creating a need for redistribution of funds. Patient choice also rests on the precondition that information regarding e.g. waiting times and quality of care is available to potential “choosers” – requiring monitoring of hospital performance. This monitoring connects to accountability, as low scores on important performance indicators typically will lead to increased attention on potential shortcomings. This loops back to policymakers and becomes part of democratic and administrative accountability processes. In Denmark too, ABF schemes, patient choice and transparent use of quality indicators are becoming more important, underlining the importance of performance-oriented accountability mechanisms. The more complex financial situation of Danish hospitals also shows how this connects to democratic accountability functions. Municipal co-financing is also being implemented in Norway from 2012, however, which will lead to further similarities between the systems.

Secondly, the shift towards a stronger emphasis on procedural and output/outcome-related accountability is a driver for change in accountability relationships. From filling predefined hierarchic roles, managers and professionals now to a larger extent adhere to standards that are imposed horizontally. Such adherence is also adopted on a more systemic level, for instance through institutional arrangements for ensuring evidence based practices, quality and value for money (e.g. the Norwegian Knowledge Centre for the Health Services and the Danish Centre for Health Technology Assessment). Patient complaint boards

and ombudsmen are becoming increasingly important in both systems, providing diagonal accountability relationships.

Thirdly, there is a layering of accountability principles for health care professionals. Professional accountability is combined with other accountability relations manifested through accreditation and quality control systems. Such regulation is intended to increase adherence to professional standards that are basically created by the professionals' peers, but accreditation and quality controls are typically located within the vertical administrative system. Professional conduct is a matter of both adherence to normative professional standards and administrative accountability.

Fourthly, professionals are increasingly engaged in economic and output based accountability forms. Professionals devote more time to tasks related to coding, registration, record-keeping and so on, i.e. as budget responsibilities are delegated to clinics, departments and even bed posts, or as the difference in income for the hospital to a larger extent relies on registering diagnoses and treatments to be coded in the DRG system. Shifts in responsibility cause shifts in accountability, it seems: Where healthcare professionals are "forced" to perform new tasks, it is likely that accountability mechanisms follow the tasks that are actually performed.

Fifthly, a gradual reconfiguration of the balance of power between the different levels in these multilevel governance systems seems to occur, implying more strict accountability relationships between state and decentralized authorities. This corresponds to a central hypothesis following the NPM development, that creating more autonomous subordinate organizational units entails strengthened efforts of control. The increasing use of formal accountability mechanisms may well be such a response, not least as the themes and subject matters of accountability become more articulated.

Sixthly, this reconfiguration also implies new types of second order accountability, where the state regulates the regulators or structures the horizontal relationship between different actors in the system, e.g. through establishing routines for negotiations and contracts or by establishing partnerships or project networks. This means that accountability arrangements will revolve indirectly on set aims for performance, by focusing on how networks and horizontal relationships actually help produce desired end products.

In sum, these six changes constitute the contours of an emerging new accountability regime with more complex and layered accountability forms, and where political-administrative accountability changes and interacts in new ways with professional and quality based accountability. The distinction between democratic, administrative, management and clinical/service level accountability become more blurred, e.g. as performance accounted for at the level of service producers may in turn become a matter of democratic accountability for national politicians.⁸

Differences: Something old, something new

In terms of *differences* between the changing accountability arrangements in the hospital systems, there are two general points to note. Firstly, the recent reforms (particularly the 2002 and 2007 reforms) may well signal that differences between the two systems are becoming more pronounced, but, secondly, it should be noted that some of the observed differences may have historical roots older than the years passed since 2002 and 2007.

The most striking contrast is, firstly, the difference in the formal organization of democratic accountability relationships in the two countries' hospital systems. In Norway, democratic accountability is principally and formally constrained to the national level. In practice, the situation is more complex, as democratic accountability tends to cross institutional and principal borders. The board structure in Norway represent a different form of accountability than that of Denmark, where the structural reform upheld the three-way tiers of democratic accountability linked to regional and local democracy. In spite of a drift towards centralization and a redistribution of roles between the three levels in health matters, Danish citizens still elect officials with influence over hospitals. It has been argued that the drift towards centralization in governance of hospitals has a longer historical foundation in Norway than in Denmark (Byrkjeflot and Neby, 2008).

Secondly, there is a difference in the approach to hospital management. While management has received considerable attention in Denmark, unitary management schemes have not been introduced by law as in Norway. In Norway, the implementation of unitary management has been a priority in hospital reorganization. This also means that the substantial contents of management accountability may vary between the Norwegian and Danish case: In Norway, single managers are perhaps more likely to be accountable for a wider range of issues than Danish managers are. It could also indicate that leading medical professionals in Denmark maintain a more traditional medical-professional role than is the case in Norway.

Thirdly, there is a difference in how second-order accountability relationships are organized and play out. In Denmark, the state holds both the regions and municipalities accountable for establishing and sustaining mutual coordination efforts, such as the negotiated agreements between regions and municipalities. These agreements are mandatory, and the state oversees that they are in place and function as intended. The regions and municipalities are not only accountable for their dispositions in the democratic sense – there is a more administrative form of accountability relationship to the state combined with the principally horizontal accountability relationship between regions and municipalities. In Norway, second-order accountability of this type relies on the hospital trusts. The local enterprises are accountable to the regional trusts, which again are held accountable to the minister of health. The differences from the Danish case rest with the absence of a democratic element at the local and regional levels, and with the hierarchic relationship between regional trusts and local enter-

prises. Nevertheless, regional and local matters are often politically (Neby, 2008).

Summing up, it does seem that accountability relationships are becoming more complex, but also more important as tools of governance. The overlaps and links between different types of accountability on different levels within both hospital systems seem to have become more pronounced: This could be interpreted as a consequence of the NPM-style reforms undertaken in the last couple of decades with an increase in external, diagonal and horizontal accountability relationships. The 2002 hospital reform in Norway and the 2007 Danish structural reform contributed to this, not least as the reasoning underpinning these reforms focuses on performance: From being a matter for professionals, performance now cuts across distinctions between democratic, administrative, management and clinical accountability relationships.

We also find some evidence that clinical/quality accountability has changed from being an internal professional matter to being a more general, public and integrated part of management, administration and even democratic accountability relations. Management/performance accountability has become more important, and diagonal and horizontal forms complement vertical accountability forms.

Implications

In terms of generalization, the accountability changes discussed above relate to a larger discussion on how the balance between super- and subordinates is organized, a discussion about the scope of governmental control on the one hand, and subordinate autonomy on the other (see e.g. Christensen & Læg Reid, 2001). Thus, legitimacy becomes a concern: Accountability relationships are both designed and implemented to contribute to higher levels of legitimacy, certainly true for *democratic accountability*. If subordinated entities become more autonomous, policymakers need to ensure some other form of control. Accountability relationships could ideally contribute to legitimacy as they can be seen as structural and functional insurance against malpractices, or as balancing the relationship between those who govern and those who are governed. This could be true from either a politicians or a citizens' perspective, where the performance of the hospital system is as important as its organization.

The challenge is, however, that the opposite situation is equally likely: Accountability relationships and the functions they serve can contribute to creating a state of distrust, where the rationale is that actions and actors *must* be checked and scrutinized: There are always incentives or possibilities for undesired behavior. This raises questions about whom we are to trust or distrust: Doctors, politicians, administrators, or economists? Trust or distrust towards public systems are in the end matters of democratic influence, and a question following this is whether highlighting issues of legitimacy has the potential to influence democratic governance in general and exercises of accountability in particular.

Moreover, the increasing use of *administrative accountability* contributes to complexity in governance, as the functions and direction of the arrangements are

ambiguous. Accountability relationships cross different areas of the welfare state, and have potential for highlighting problems and challenges to a larger extent than successes and achievements. Thus, these arrangements may drive the development towards what is newsworthy, and not necessarily what is important. A good scandal sells more newspapers, and newspaper reports trigger questions about consequences for involved actors. Accountability arrangements and the attention they generate may have the capacity to change the attention of politicians and bureaucrats away from what has previously been regarded as central issues in health policy. This means that arguments about accountability may be used as part of strategies to change the focus of health politics.

Building on the previous point it seems accountability cannot be understood as a singular or simplistic phenomenon, but must be treated as a multidimensional feature of governance. In terms of *management* and *service/clinical accountability*, this is the case where medical, managerial, administrative and economic tasks meet and intersect, partly as consequences of reforms and policy change. As doctors become professional managers and are given economic tasks, the scope of the accountability relationships they take part in become broader. How are considerations related to accountability balanced with central values concerning medicine, management and finance, and how do these elements contribute to the overall development of the system?

All in all, there is a shift away from a democratic-administrative focus, towards a focus on combinations of performance accountability and democratic accountability, where output dimensions play a stronger role combined with systems for holding health professionals and organizations accountable for adhering to standards and guidelines. Whereas there are a few important differences between the Norwegian and Danish hospital systems, this shift is a common development.

In the hybrid nature of Norwegian and Danish hospital governance, vertical, horizontal and diagonal arrangements are combined; multiple variants of accountability have become a feature of these systems. This underlines the intersection between politics and administration, between complexity and more singular objectives in each arrangement. Important questions are whether the lines between politics and administration in terms of accountability are challenged, and whether such changes have potential consequences for governance. An approach to this discussion is to relate the findings about accountability changes to the broader literature about new governance forms (Christensen & Lægreid, 2007; Peters, 2001; Fredericksson, 2005; Lynn et al., 2001). Accountability falls well within the definition of governance offered by Lynn et al. as “regimes, laws, rules, judicial decisions, and administrative practices that constrain, prescribe and enable the provision of publicly supported goals and services” (2001:7). Yet, as noted by Fredericksson (2005:293) this broad definition should perhaps be narrowed down to understand public governance as “sets of principles, norms, roles and decision making procedures around which actors (managers) converge in a given public policy arena”. This comes close to our understanding of accountability as strategies for forming legitimate expectations of

when and how account giving should take place and for structuring relations between actors and forums. In this sense, our study of accountability speaks to the core of the understanding of new governance forms, as it includes formal rules as well as the more informal expectations, norms and practices developing on the basis of such rules. Studying new accountability forms is thus a key topic for understanding new governance relations. This is particularly important since the emphasis on accountability seems to be at odds with another characteristic often associated with governance as “steering at a distance” (Kickert, 1997), or facilitating “self steering” (Kooiman, 2003). Accountability seems to have elements of more “hands-on control”, and the rising interest in accountability could be seen as an antidote to the loss of direct control introduced by decentralization and delegation.

Lastly, there is a need for understanding and explaining the forces that drive this development in accountability relations, provided that the descriptions and classifications we have are good enough. Explanation on the one hand includes the introduction of theoretical perspectives that suggest causal relationships and principal approaches to understanding governance. On the other, explaining accountability developments most likely entail an inclusion of a broader set of empirical elements, in order to understand the processes and contexts that recent developments in accountability take place within. Analysis of consequences should include the administrative or transaction costs involved in running accountability schemes, and the more difficult issues of whether the increased accountability focus actually contributes to greater satisfaction among the users, and whether it strengthens the legitimacy of public health systems.

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Notes

¹ The word 'accountability' has no direct translation in Norwegian or Danish. The words 'ansvar' or 'ansvarlighet' are often used, but are not precise enough for our purposes. Bovens (2007) maintains that 'accountability' is a word of Anglo-Norman origins, referring to the 11th century Domesday Books, which served as a *count* of what was in the king's realm and thus was a foundation for royal governance.

² This article is written as part of a project funded by the Norwegian Research Council: «Reforming the Welfare State: Accountability, Democracy and Management», headed by Professor Per Lægreid.

³ In Sweden, such instruction is unlawful, and the government as a collective assumes responsibility (and accountability) for the government apparatus. The Swedish model thus has a more strict approach to delegation of responsibilities.

⁴ Ot.prp. nr. 66 (2000-2001) *Om lov om helseforetak m.m.*, Lov av 15. Juni 2001 nr. 93. *Lov om helseforetak m.m.*

⁵ We apply the term “trust” for the regional level and “enterprise” for the local level. The term “trust” refers to an entity that assumes responsibility for certain activities on behalf of its owners, but that does not carry out the actual operational tasks itself. The “enterprises”, however, have such operational responsibilities.

⁶ Source: TV2 Nyhetene 12.09.2011. URL:

<http://www.tv2.no/nyheter/innenriks/politikk/valg2011/439-prosent-til-venstre-i-eid-3582922.html>

⁷ Lov nr. 537 af 24-06-2005 om regioner og om nedlæggelse af amtskommunerne, Hovedstadens Udviklingsråd og Hovedstadens Sygehusfælleskab.

⁸ The authors are aware of a potential connection to the wider debate on different forms of governance, e.g. the discussion of governance modes (see e.g. Pierre and Peters 2000). We see accountability as reflecting particular types of relationships and processes within a larger context of governance, understood as “All means by which the behavioral regularities that constitute social institutions are maintained and reinforced” (Crouch 2004:105).

