

Title: Reshaping public accountability: Hospital reforms in Germany, Norway and Denmark

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Abstract:

The paper contributes to the literature on multi-level welfare governance and public accountability in the context of recent European hospital reforms. Focusing on the changing dynamics between regional and central governance of hospitals in Germany, Norway and Denmark, we raise concerns about the reshaping of traditional public accountability mechanisms. We argue that, triggered by growing financial pressures, corporatization and professionalization have increasingly removed decision-making power from regional political bodies in hospital funding and planning. National governments have tightened their control over the overall trajectory of their hospital systems, but have also shifted significant responsibility downwards to the hospital-level. This has reshaped public accountability relationships towards more managerial or professional types embedded within multi-level forms of governance.

Points for practitioners. Our study may be taken to suggest that if reforms are responses to policy pressures, the accompanying changes in accountability relationships and arrangements in turn contribute to altering the pressures and constraints that form the context for administrative, managerial and professional work. As reforms in Norwegian, Danish and German healthcare contribute to corporatization, centralization and economization, there is reason to expect that what officials are held accountable for, and how, is also likely to change and to accentuate the span between policy aims and actual managerial and professional performance.

Keywords: accountability, Multi-level government, Public Administration, Public finance

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Introduction

The provision of adequate and accessible hospital care is a central responsibility of the modern welfare state. Mounting internal and external pressures put on healthcare systems in recent decades have prompted European governments to play a greater role in the planning and steering of hospitals. In promoting reforms, governments have faced the task of squaring their responsibility for high-quality provision of care with policies that aim at greater efficiency and responsiveness (Ettelt et al. 2008). The implementation of a series of such reforms, focusing on decentralization and autonomization, has potentially disrupted traditional accountability relations within publicly organized health systems.

New Public Management (NPM) has been seen as one ‘solution’ to the many vicissitudes facing public hospitals in order to promote economic effectiveness. According to Mosebach (2009) NPM revolves around the creation of competition through privatization, quasi-markets and service contracts for achieving greater efficiency. One of the key elements in this movement has been a call for decentralization of decision-making towards political and non-political institutions and actors. At the same time greater centralization and steering of the system through strong guidance and control has been prompted (Hood, 1995; Christensen and Lægreid, 2001)ⁱ. This has resulted in the process of *welfare-state governance* becoming a process of *multi-level governance* ‘in which authority and policy-making influence are shared

across multiple levels of government - subnational, national, and supranational' (Hooghe and Marks, 2001: 2), as well as across different private sector agents – managers, professional experts or organisations (Rhodes 1994; Salamon, 2002). In the context of welfare provision, this implies the devolution of governance 'vertically', towards more local levels, as well as 'horizontally,' towards third parties such as regulatory agencies and independent evaluators (Salamon 2002; Hooghe and Marks 2004; Schillemans 2011). The concept of multi-level welfare governance thus provides a crucial analytical insight into the study of European hospital planning. It serves to highlight the nature of policy decision-making and aids in a thorough assessment of the various actors and mechanisms involved.

This paper contributes to the growing literature of multi-level welfare governance in healthcare systems across three European countries: Germany, Denmark and Norway. More precisely, we aim to analyse the impact of successive, partially NPM-inspired reforms in healthcare over the past decade, on accountability relations within a multi-level governance setting. Focusing on the dynamics between local, regional, and central governance of hospitals in these countries, we seek to highlight new strategies of coordination, steering and networking that have led governments to engage in accountability restructuring (Bache and Flinders 2004). These processes are analysed at the institutional level through the study of hospital reforms, focusing specifically on how investment decisions are made. Investment funding is a crucial means of assessing

political questions concerning multi-level governance: where investment decisions are located impacts the institutional relationships that ‘shape and constrain’ political action (March and Olsen 1989; Peters and Pierre 2004). Moreover, the level at which investment funding decisions are made is also essential for understanding how new types of governance interact with traditional forms of public accountability. With reference to the healthcare sector, the research presented here thus intends to explore not only the question of political control, but also the wider implications of new forms of welfare governance in complex accountability relationshipsⁱⁱ.

Our hypothesis is that institutional changes introduced in successive and partially NPM-inspired reforms over the past decade have led to a stronger emphasis on managerial accountability in the healthcare systems of Germany, Denmark, and Norway, potentially to the detriment of traditional public (political) and professional accountability.

We use the lens of investments in order to see manifestations of tensions between NPM ideas of corporatization/autonomization, economization and the concern for public accountability for ensuring proper use of taxpayer money to develop high quality and equitable healthcare services. Investments thus provide an entry point to exemplify this and are particularly interesting because they have not previously been studied in terms of accountability relations, especially in a comparative light.

Conceptual Framework

We discuss our findings with reference to different notions of accountability. At the outset, we adopt Mulgan's minimal definition of 'accountability' - the opportunity for 'calling somebody to account,' to have them provide information about and justification for their actions (Mulgan 2000: 555). External scrutiny, social interaction and potential sanctions for those accountable are essential elements of this core understanding of accountabilityⁱⁱⁱ. Accountability mechanisms can involve different actors ('accountors') accounting to different 'forums' ('accountees') (Bovens 2005: 182; Schillemans 2011: 177). This is clearly illustrated by the hospital sector, which is organized around a complex system of accountability relationships that are political, administrative, managerial, legal, or professional in nature. In this system, a variety of actors (politicians, bureaucrats, managers, and health professionals) are held to account on the basis of different criteria such as political, economic or financial, clinical quality or other service provision (Byrkjeflot, Neby and Vrangbæk, *forthcoming*). They must give account to citizens (i.e. patients, voters, taxpayers, healthcare customers etc.) politicians, or external regulatory institutions. Thus, there exists a plurality of different, though at times overlapping or competing, accountability relationships.

We focus on the changing dynamics between public, managerial, and professional accountability in this paper. In particular, we wish to assess whether welfare state reforms have a deleterious effect on public accountability. We use 'public accountability' to refer to processes in which accountors are elected politicians or public

managers who spend public money, exercise public authority, or manage a corporate body under public law. Account giving is ‘done in public, (...) open or at least accessible to citizens’ (Bovens 2005: 183)^{iv}. The most important function of public accountability is, at least in principle, that of democratic control (Bovens 2005: 192; Mair 2005). Voters ‘make elected representatives answer for their actions’, while politicians in turn can hold those accountable upon whom they entrusted certain powers (Mattei 2009: 37). But for democratic control to function effectively, ‘there must be a line, no matter how convoluted, running from any act of a public administrator to the electorate’ (McGarvey 2001: 26). It is crucial that citizens are able to identify and monitor the direction of this accountability relationship (Finer 1941).

However, as suggested above, policy-making is being increasingly restructured toward a system of multi-level governance driven or reinforced by NPM reforms promoting economic efficiency (Christensen and Lægreid, 2007). It follows that traditional forms of direct public accountability are becoming more fragmented. In the process of governance delegation from politicians towards semi-autonomous agencies, they become ‘uncoupled from official representative bodies towards more professional actors’ (Papadopoulos 2010: 1034). Effectively, ‘politicians displace public accountability to senior civil servants’ who may possibly be assessed by an NPM performance culture based on the achievement of targets and outputs ‘rather than by the quality of the democratic process’ (Mattei 2009: 25). This marks a shift from political

toward managerial accountability with the aim to make welfare organisations more ‘productive’ and cost effective (Hood, 1995; Sinclair, 1995). It is also characterized by a greater involvement of the private sector, which has been argued can be accountable to citizens as ‘customers’ yet may tend to lack mechanisms of public accountability as we have defined it (see Mulgan 2000)^v. A final accountability relationship that is referred to in our analysis is that of professional accountability, where professionals (e.g. doctors, teachers) define their own interests and codes of standard without any vertical link of accountability to political or bureaucratic office-holders (Mattei 2009: 45; Bovens 2005: 188). The accountees are either professional peers or other professional bodies and organisations (Ibid.). This type of accountability is horizontal (Day and Klein, 1987) and the emphasis when making investment decisions is on medical or clinical evidence. According to Mattei (2009: 45), ‘being professionally accountable means to represent the interest and values of particular occupation groups [...] rather than the public interest.’ Overall, the lacking distinct legal frameworks and a reliance on more informal negotiations between accountor and accountee may reduce public scrutiny, which is necessary for public accountability to function in a democratic system (Peters and Pierre 2004).

To summarise, this paper looks at the impact of hospital reforms on accountability relations in three health systems by focusing on investment decisions within healthcare.

The link between accountability forms and investment decisions can be exemplified through ideal types as follows (see Table 1):

Types of accountability for investment decisions			
	Public	Managerial	Professional
Direction	Clear democratic accountability lines from electorate to elected politicians	Accountability to owners/shareholders (private) or autonomous boards if public.	Accountability primarily to professional forums and logic
Logic	Emphasis on broader public good/interest	Emphasis on “business opportunity” and “bottom line”	Emphasis on medical/clinical evidence for investment decisions.
Focus	Process dimensions (openness, involvement, due process etc.) and politically-determined substance goals	Output dimensions: bottom line, business strategy	Clinical output/outcome

Table 1: Types of accountability for investment decisions

Method

In exploring the various dynamics around the reshaping of accountability mechanisms, we compare healthcare reforms in Norway, Denmark and Germany. These countries were selected based on the existence of multi-level governance structures operating within healthcare provision. Governments in all three countries have been influenced by NPM reforms that have inspired considerable administrative and managerial healthcare

restructuring at the hospital level, although the ways in which these countries employ NPM tools in their overall governance remain different. Further, while Norway and Denmark have a universal healthcare system, the federal system of Germany has produced a more fragmented and pluralistic healthcare service. We seek to compare these similarities and differences in order to assess what general patterns in hospital reformation have emerged across European welfare states. We first contextualize the healthcare provision within these three countries, all of which have conventionally involved the interaction of actors on a local, regional and state level. Against this political backdrop, we continue to focus on hospital reforms implemented over roughly the last decade. The core of the empirical investigation focuses on the transformation of investment funding within hospitals.

A variety of secondary literature as well as primary documents released by the national ministries for health, Parliament, hospitals and international bodies such as the OECD and WHO have informed our findings. New legislation was particularly crucial for documenting the recent content of reforms and salient issues for political debate. When analysing documents, we primarily conducted a qualitative content analysis. This approach allowed us to analyse the research in an explorative way given the unknown and under-researched nature of the field.

Using both empirical evidence and secondary literature, we show that central control over healthcare delivery is growing in Denmark, Norway and Germany, while power at

the regional level is being increasingly undermined in all three countries. The German case is particularly interesting because centralisation is manifested primarily in the form of the centrally controlled DRG logic. NPM reforms in Norway, Denmark and Germany appear to have, in the main, *removed* decision-making power from the regional level as economization and corporatization of hospital planning and funding gain ground.

Economization increases the dominance of economic motives and financial considerations in the organisation and provision of healthcare (Mosebach 2009) and involves the creation of hospitals as independent business units governed by economic incentives and performance targets. This in turn impacts processes of corporatization: the organisation of public institutions along business lines where profitability and fiscal responsibility are key aims. Having evolved as a way of mimicking the efficiency and structure of a private organisation while ensuring equity aims are maintained through the continuation of public ownership (Harding and Preker, 2000), corporatization involves a high degree of autonomy for management decisions and the use of contracts (internal/public or external/public/private) with economic and performance management criteria to hold hospital managers accountable. Encouraging organisations to behave in a more business-like manner is key in allowing competition between public and private sector organisations^{vi}. Corporatization and economization can thus increase the role of the management profession as well as introduce more economic incentives for reform. We raise concerns about the undermining of public accountability in this process as the

accountability thread linking decision makers to the electorate becomes increasingly unclear.

Changing hospital landscapes

Hospital systems in Norway, Denmark and Germany differ widely from each other, and are embedded within their national political contexts. It is important to understand how each context has evolved, at least in outline, before we can consider the reform processes themselves. The Norwegian and Danish systems are national health services that are owned, run and funded by the public sector, whereas the German system is of a more diverse, corporatist nature - ‘corporatist’ referring to the relationship ‘between the state and encompassing interest organizations’ or private agencies in the process of decision-making (Micheletti 1991: 148-149). Even among the Nordic countries, Norway and Denmark are those where the state plays the strongest role. This can be seen in the heterogeneity of both “third party payers” (sickness funds) and hospitals (public, private not-for-profit and private for-profit), and the involvement of “societal partners” in the management of these institutions in Germany in contrast to the predominant public payers and delivery organizations in the two Nordic countries (Saltman, Busse & Figueras, 2004).

Historically the Norwegian health system developed from below. From the early 1970s until 2002, hospitals were for the most part owned and run by the counties (Byrkjeflot

and Neby, 2008). The state took over ownership in 2002 through the Health Enterprise Act as part of a large-scale hospital reform. Five regional health trusts were introduced and, under them, local health enterprises responsible for the management of hospitals. Since then, the organisational framework of hospitals has, at least formally, been determined by these trusts operating, in principal, at 'arms length' from political control. They hold the decision-making power regarding the organisation and distribution of clinical services between semi-independent local enterprises. The local health enterprises, accountable to regional trusts, are responsible for actual hospital performance^{vii}.

A decentralized management of hospitals, similarly, has historically characterized the Danish healthcare system. However, organisational restructuring took place during the 1990s in most of the 13 constituent counties. The basic philosophy behind the changes was to centralize and establish coherent "functional units", which would include departments in different hospitals, and to introduce management ideas inspired by the private sector including free choice of hospitals, economic incentives through DRG based payment schemes, performance management linked to internal contracts, process engineering e.g. through LEAN etc. The process of restructuring continued in the 2000s up until a major reform of the Danish administrative structure in 2007, which reduced the number of regional authorities from 13 counties to 5 regions. The number of municipalities also reduced from 275 to 98. Both the regional and local levels are still

governed by directly elected politicians, unlike Norway, where health enterprises have been de-linked from political representatives. The main responsibility of the regions is to 'provide health services, while the municipalities are responsible for prevention, health promotion and rehabilitation outside of hospitals' (Martinussen and Magnussen, 2009: 35). Municipalities are also in charge of elder care, while chronic care is a shared responsibility. In order to ensure coordination between the administrative levels, binding partnerships between municipalities and regions have been created through health coordination committees (Ibid).

The German hospital system diverges significantly from those in the Nordic countries in that it is made up of a plurality of state and non-state providers with hospitals running as independent economic entities. Public, non-profit and for-profit hospitals have co-existed in Germany for decades. Formally, the German Ministry of Health is responsible for many crucial health policy areas and administrative regulations that the 16 Länder have to abide by. In 1972, a federal law on hospital financing was passed to ensure a needs-based hospital provision for the German population, aiming to secure the existence of the hospital sector financially and economically. It introduced a dual financing system in which initial investment for hospitals is provided for by federal tax revenues allocated through Länder parliaments, with subsequent running costs carried by health insurance providers. This federal law is complemented by individual legislation by each Länder, who produce reports on their hospital financing plans.

Effectively, therefore, the hospital sector is managed in a dual system where considerable financial decision-making power is devolved to individual states. But corporatist actors such as statutory health insurance companies, medical practitioners' associations, and hospital associations may exert considerable pressures on the relevant decision-making processes.

Hospital planning within multi-level governance

Healthcare systems in Norway, Denmark and Germany, have historically evolved within a complex policy context fraught with a large number of interests with decisions made on different levels and in different (physical) locations (Banting and Corbett 2002). Within all three countries governance of the hospital sector is not merely divided between hospitals and the central state, but also between regional entities, and in Germany, corporatist actors. In theory, such a system should increase responsiveness to regional needs. But in any system of multi-level governance, the fragmentation of powers also creates internal conflicts of interest and potential ambiguity for citizens with regard to accountability relations.

Within Denmark, the 2007 reform shows an attempt to create a structural (institutional) framework more streamlined than before for making infrastructure decisions and better equipped to deal with the demographic transition that required improved long-term and chronic care programmes. This was to be achieved by amalgamating the existing 13

counties into 5 regions and giving these new regions the dominant responsibility for healthcare. At the same time, the existing 271 municipalities were amalgamated into 98 new and larger units, taking on a range of tasks including public health and long-term care functions. One of the first tasks of the new regions was to design regional hospital plans to distribute, among themselves, a total of 25 billion DKK, and invest, eventually, a total of 41.4 billion DKK, the difference being made up by loans and regional surpluses. The government-appointed Juhl Commission, named after a former medical director of the Copenhagen hospitals, played an important role in this process. The commission had to approve regional investment plans before money could flow into them. Core principles that were followed indicated that regional plans would work towards further concentration of infrastructure and the closure of smaller and older facilities to ensure centralization of treatment facilities within regions. Thus, effectively, regions were expected to organize their hospital systems based on principles of specialization and benefits of scale. However, this was hotly contested in the first round of funding distribution negotiations. The result was that in 2008, several plans were rejected so that regions had to adjust and submit them again. The advice of experts was heeded to in a second round of negotiations in 2009 when final approval to regional investment plans was given. This was characterized by a more limited understanding of regional autonomy, with regionally-elected politicians effectively bowing down to the authority of centrally-appointed experts, with regions passing judgments based on

professional norms of evidence-based decisions, and operating within the mandate set by central-level politicians (Vrangbaek and Nielsen 2011).

Similar to the Danish case, the Norwegian hospitals were, from the early 1970s until 2002 owned and run, for the most part, by counties (Byrkjeflot and Neby 2008). With the 2002 Health Enterprise Act, the central state effectively took over hospital ownership. However, hospitals, instead of being simply incorporated into the central government administration, turned into separate legal entities. A novel legal form of health enterprises was created, marking a clear departure from the Norwegian tradition (Martinussen and Magnussen, 2009). While being owned by the central state, health enterprises were formally granted considerable autonomy in using expert judgment rather than central directives, removing (at least in theory) some political control from elected politicians. The Health Enterprise Act, e.g., stated that management should control all input factors and independently choose an optimal organisational structure - neither local nor regional health boards were initially open to politicians. Nevertheless, the Ministry of Health could still interfere, for, as Martinussen and Magnussen (2009: 33) observe, 'the central keywords [of the Health Enterprise Act] are precisely the same as those associated with the NPM doctrine,' with considerable ambiguity over questions of autonomy and control. This can be seen to bear out in the hospital planning process. Although regional health trusts were tasked with the development of plans for restructuring hospital services, on some occasions, the Ministry of Health and Care

Services directly intervened in local decision-making processes, contributing to uncertainty within hospital policy implementation. Consequently, regional boards have become more reluctant in taking initiative for developing their own restructurement plans, focusing more strongly on securing political support before venturing into such a process. Furthermore, in 2006, amidst increasing fears of a 'democratic deficit,' the separation of the health boards from politics was further diminished as enterprises were opened up to (appointed, not elected) politicians. Thus, despite corporatization of hospital management, politicians remained important actors at all levels of hospital governance.

In Germany, changes in the governance of hospital planning were less explicit, in part because the complex set-up of the hospital sector left comparatively less scope for fundamental steering reforms from above. Since 1972, the responsibilities of Länder governments and the principle of statutory health insurances were set out within the dual financing system. The national legislature entrusted decision-making power on federal parliaments (for initial investments), as well as on public and private health insurance companies and private investors (for running costs). According to the 1972 act, Länder governments are to consult, if possible, all actors and agencies with a stake in the hospital sector. As such, responsibility is given primarily to regional politicians, but a close collaboration with managerial and professional experts is also recommended. The central government also plays a role in directing the hospital sector by initiating

changes to the healthcare system at large. In 1993, the national government passed the Structural Health Reform Act, which contained both a significant short-term effort to stabilize costs, and a long-term strategy of structural reform, culminating in the transition towards universal activity-based funding system. The most recent adjustment in hospital finance arrangements by the federal government, the hospital finance reform law came into force in 2009. The consequential shifts in funding arrangements have pressured state parliaments and hospital managements to focus to a greater extent on efficiency and productivity, processes in which costs are capped and constrained in various ways. As of 2010, 56% of German hospitals had already set themselves explicit profitability targets (Blum 2010: 19)^{viii}. Länder governments still draw up hospital plans with suggestions on investment strategies, but are required to pay closer attention to the effects on costs accrued by health insurances. Further, they need to take into account national-level funding mechanisms to ensure that plans can be implemented within existing constraints. Within this funding scheme, the actual scope of planning by Länders is relatively limited and their power arguably reduced^{ix}. The central government maintains some influence by setting financial targets or benchmarks, and implementing national reforms. However, at both the national and particularly the Länder level, politicians are put under intense pressure from lobbyists, insurance and pharmaceutical companies, as well as medic associations. This suggests that the

influence of corporatist actors with private and professional interests has risen at the expense of the power of directly-elected politicians, particularly at the Länder level.

Investment funding within multi-level governance

In order to bring hospital plans to reality and allow individual hospitals to adapt to changing patient needs, major financial investments are necessary on a regular basis. Expenditures on new technology have become a chief cost driver (WHO 2011), widening the gap between desirable and feasible levels of investment funding. New life-saving technologies such as sophisticated coronary artery bypass grafts are entering the market annually, increasing the pressure for hospitals to adapt and modernize. At the same time, the need for basic investments (e.g. for building maintenance) is growing, as hospitals get older. In Germany most current hospitals were built in the 1960-70s. In Norway, around half of hospital buildings are said to be in a 'poor' condition (Office of Audit General, 2011). As such, a more detailed analysis of investment funding allocation seems crucial. It is among the most important mechanisms for determining the future trajectory of individual hospitals and the system as a whole. Most importantly, recent developments in investment funding illustrate the consequences of multi-level governance changes.

In the following section, we show that governance mechanisms in our case studies continue to differ sharply and appear to follow no uniform trend. Nevertheless, within

all three countries investment decisions are situated below the national level – in Norway and Denmark they are formally the prerogative of the regions; in Germany, they are subject to Länder governments and individual hospitals. However, the powers of regions in the Nordic countries are not limitless – in Denmark, regional powers are explicitly constrained by an independent professional commission to ensure that regions meet national priorities. Although the commission refers to national-level politicians, experts continue to play a greater role to the detriment of political accountability at the regional level. In Norway, the powers of the national government are less transparent, but the national ministry of health continues to control the decisions of regions through financial levers and the ever-present opportunity for ministerial intervention in relatively detailed matters (Neby 2009). In Germany, the dual financing system and inter-Länder differences make generalization difficult, but at least in some Länder, decision-making powers in terms of meeting investment costs have been effectively devolved to hospitals, similar to the decentralization of operational responsibility in Nordic countries. However, this has served to constrain the scope for regional or Länder political involvement even further, thus serving to undermine public accountability.

Both Norway and Denmark maintained decentralized (regional) governance in the reforms of 2002/2007. Regions in both countries have considerable budget autonomy regarding operational issues, with Danish regions being subjected to more

central/national democratic control when it comes to larger investment decisions and highly specialized services.

In Denmark, the central government provides a number of grants as direct transfers to earmarked investments in health areas with special political focus, such as medical equipment to improve cancer care services. In Norway, central influence is shown by hospitals' continuing reliance on supplementary funding from the state due to the insufficiency of accumulated surplus within regions to cover major investments. As a result, Norwegian regional enterprises continue to depend on loans from the central government, or at least the central government's approval of investment loans gathered elsewhere. As these loans may constitute up to 50% of overall investments, the state arguably retains a considerable grasp on the hospital system.

Moreover, national control operates through the reliance on national investments in outdated hospital buildings in both Norway and Denmark. In Norway, guidelines from the ministry of health tie the autonomy of regional and local health enterprises to specific financial solutions for investments in hospital buildings, limiting their freedom to examine alternative development strategies. In Denmark, financing of large-scale buildings is accomplished through a combination of state contributions and regional funding through general revenue, savings and loans, with regional management, in principle, holding control over large infrastructure projects. However, in reality, in both countries, the national Ministry of Health and the National Audit Office closely monitor

plans. This means that all major investments continue to be separately approved by the national Ministry of Health. Similar to the liquidity control of general investment funding, this shows that tendencies to centralize and control financial management have become more prevalent in both countries, increasing national-level political accountability, but diminishing regional-level public accountability. In Denmark, though, centralizing tendencies have been accompanied by the rising importance of experts vis-à-vis regional investment plans. With the introduction of the Juhl Commission, e.g., investment plans made by democratically-elected politicians at the regional-level were effectively put in check and the influence and legitimacy of political representativeness in these institutions reduced.

In Germany, the governance of hospital funding shows similar tendencies to devolve decision-making away from regional political actors towards other institutions. It is the responsibility of the Länder to allocate investment funding in Germany, e.g., including long-term funding through awards to specific hospital project proposals. Nonetheless, often regional governments fund only part of the overall financial investment, leaving the remainder to be funded through private capital or the accumulation of surpluses.

Additionally, the Länder's authority has been challenged by the national government, advocating a departure from the dual funding approach established in 1972 towards monistic activity-based funding as operating in Norway and Denmark, in which health insurance payments cover both treatment and investment costs. However, an

intergovernmental consensus required for seeing through such changes failed. The Länder were thus able to retain ultimate responsibility for hospital planning and investment funding (*Letztverantwortung*, AOLG, 2007) although, arguably, this influence has been counteracted by the federal Hospital Act passed in 2009, which the Länder can adopt individually. A framework for activity-based lump sum funding of investment costs has developed since. This will allow Länder from 2013 to pay out their entire investment funding as a lump sum to hospitals that can then make their own investment decisions. North Rhine-Westphalia and the Saarland are pioneering such a system, which aims to strengthen hospital autonomy^x. Additionally, co-financing strategies adopted by German hospital operators and the current transition towards lump sum funding has introduced more private sector actors into the healthcare system. In 2006, the percentage of private expenditure on healthcare (as a percentage of total expenditure) stood at 24%, up from 18% in 1996 (World Health Organisation, 2012). In particular, the role of banks in hospital investment has grown significantly. From 2002-2007, hospital expenditure on loans increased by 57% (KPMG 2009: 10), six times as fast as total costs, with policy makers asserting that banks can play an important role in reducing the investment backlog (MAGS 2007: 7). However, because banks generally do not accept future public investment funding as securities for loans, hospitals that command larger assets, particularly those owned by private chains, are at an advantage and are able to invest more (Klenk, *forthcoming*)^{xi}. However, both the rise in hospital

autonomy and the arrival of more private actors puts pressures on public accountability processes in investment decisions. Furthermore, with the national government taking a greater interest in steering the German hospital sector, and the introduction of lump sum funding, the authority of the Länder appears to be increasingly undermined. Whether or not overall centralization has occurred, there seem to be more attempts, similar to Norway and Denmark, to centrally control hospital finances. On the other hand, the emergence of private sector actors such as Banks is a distinct process unparalleled in the Nordic countries, the impact on public accountability of which remains to be seen.

The impact of hospital reform: The reshaping of public accountability

We have, so far, taken note of reforms in hospital planning and funding within the context of multi-level governance in three countries – Norway, Denmark and Germany. All three show tendencies of both: (i) decentralization, flexibility and autonomy, and, (ii) centralization, regulation and control. This dual development pattern has been associated with NPM in other sectors as well (Christensen and Laegreid, 2007)^{xii}.

Our analysis of current reforms reflects that centralization rather than decentralization has become the dominant tendency although the German case stands out distinctly in having this happen only in a particular sense. Centralization has manifested in terms of a greater attempt to control costs, and increase performance and outputs (by granting greater autonomy at the local level), especially given the financial pressures currently

facing healthcare systems. Reforms tend towards economization and corporatization of hospital planning and funding, although in somewhat different forms across the three countries. In Norway and Denmark corporatization has implied more autonomous management of hospital operational issues, while in Germany it has meant greater scope for private providers. As suggested at the outset, the growth of economization and corporatization may impact public accountability detrimentally, as decision-making is shifted to managers, experts and technocrats rather than political representatives.

Economization^{xiii} has been observed in the reformist discourse among all three countries. In Denmark, e.g., specialization and economies of scale have become crucial criteria for the central approval of hospital plans in addition to other measures ‘broadly related to a reduction in bureaucratic costs and taxation levels’ (Martinussen and Magnussen, 2009: 34). Similarly, in Norway, the creation of fewer but larger administrative units through centralizing processes reflect a desire to support future specialization of healthcare in a cost-effective manner (ibid.). In Germany, centralization to control costs has been less evident but financial criteria have become dominant in hospital planning with the adoption of private management styles including profitability targets and growth strategies.

The effects of corporatization^{xiv}, however, have taken distinct trajectories. In Denmark corporatization has been less strong and the 2007 reform had no new business-practice modelled hospital organisational forms. In contrast, in Norway, the addition of health

enterprises to the public hospital apparatus encouraged the moving of hospital responsibilities to new corporate-style organization, exemplifying this trend. At least in theory, this has meant a reduction in the political engagement of these enterprises with the state, with a focus, instead, on steering letters that are general guidelines rather than bureaucratic orders. Enterprise meetings between the health minister^{xv} and regional enterprises follow the letters^{xvi}. Local enterprises report to regional enterprises, which report to the state (Pettersen and Nyland 2011; Byrkjeflot and Gulbrandsøy 2009). In Germany, hospitals have always been independent economic entities and corporatization occurs very specifically, through the adoption of micro-economic entrepreneurial agency. This has been witnessed in the transformation of hospitals from public agencies into companies taking on private sector legal structures similar to a limited company, even when remaining in public ownership^{xvii}.

National divergences in organisational practice reflect how NPM approaches do not follow specific paths but involve a dynamic interplay between different factors (Christensen and Laegreid, 2007; 2001). Indeed, the transformative approach (Christensen and Laegreid, 2001) highlights how political, cultural and institutional traditions can affect reform processes. While the factors influencing national reforms are beyond the scope of this paper, it is clear that Denmark has in general been more cautious in introducing corporatization, even though the Juhl Commission served as an advocate for many of the economic values inherent in corporatization. In contrast, new

institutional and administrative models can be seen within Norway and Germany; although only in Germany has corporatization been combined with a greater trend towards privately-funded hospitals.

In Denmark, technocratic actors are linked to the state and reinforce centralization tendencies. However, generally - and looking across all three countries - the greater role played by managerial and technocratic actors weaken the transparency of democratic accountability, particularly at decentralized levels. In Norway, e.g., the transfer of hospitals into state ownership in 2002 was combined with a decreasing influence of regional politicians and an increase in decision-making power of managers within regional health enterprises. The dominant role of the Juhl Commission in Denmark also shows a similar shifting of power towards policy ‘experts’ at the expense of local politicians. In Germany, decline in decision-making power at the Länder level has reflected in the movement towards complete lump sum investment funding, with a significant amount of power devolved to hospitals owners. Table 2 summarizes these trends:

Accountability in investment decisions: Pre- and post-NPM reforms		
	Pre-NPM reforms	Post-NPM reforms
Germany	Dual financing system comprised by federal parliament and Länder, and private investors All actors and agencies with a	Centrally-imposed DRG system with increased focus on corporatization, privatization and economization (through efficiency, productivity, profitability targets and activity-based lump sum funding to private hospitals)

	<p>stake in the hospital provide input but responsibility lies with regional politicians</p> <p>Voters oriented towards regional politicians for accountability</p>	<p>Länder governments held accountable by financial benchmarks/targets set by the Central government. Corporatist actors may exert some pressure.</p> <p>Ambiguity among voters because of decision-making by stakeholders that lack democratic legitimacy e.g. private hospitals</p>
Denmark	<p>County politicians (minor investments) and National politicians (major investments)</p> <p>Professional accountability forums provide input</p> <p>Voters predominantly oriented towards county democracy for accountability (Ministry of Health created in 1987 opening a more national accountability line)</p>	<p>Hospital managers and regional politicians (minor investments)</p> <p>Regional politicians held accountable by technical committee emphasizing professional accountability norms, and working within a mandate from national politicians (government)</p> <p>Some ambiguity among voters on who to hold accountable. Technical committee used to shift blame.</p>
Norway	<p>County politicians (minor investments) and National politicians (major investments)</p> <p>Professional accountability forums provide input</p> <p>Blame games between national and local/regional level politicians</p>	<p>Regional (major investments) and local enterprises (minor investments), national politicians (all investments).</p> <p>No formal political accountability component on regional and local level (boards and managers)</p> <p>Blame games continue</p>

Table 2: Accountability in investment decisions: Pre- and post-NPM reforms

The reshaping of public accountability at the regional level is neither irreversible nor inevitable. The Norwegian case shows that reforms promoting corporatization and

economization may face resistance for reasons related to the political and cultural context of the country. Intense public concerns about the increasing democratic deficit in health enterprise boards, e.g., brought appointed politicians to them in 2006. Additionally, in spite of the growing importance of bureaucrats and managers, hospital planning issues have been repeatedly pushed onto parliamentary agenda, particularly with regard to hospital closures. The *Storting*^{xviii} thus continues to play an important role in adjusting hospital funding arrangements. Norwegians seem to hold elected politicians accountable even when they formally wielded no power over hospital planning decisions^{xix}. Distinctly, in Denmark, elected politicians in regional councils have remained key players responsible for the hospital planning process. Yet their effective subordination to the Juhl Commission has raised interesting puzzles for public accountability. Did the national-level politicians introduce experts to divert blame for difficult decisions? This argument fits in with a growing body of literature on the concept of ‘blame avoidance’, suggesting that because voters are believed to be more sensitive to real or potential losses than they are to gains^{xx} (Hood 2007: 192), it may be in politicians’ best interest to shift responsibility to various subordinated or supra-national actors and institutions (Weaver 1986; Hood 2007; Bartling 2012). Rational-choice approaches to institutional management imply, therefore, that decentralization and devolution of responsibility in the process of increased multi-level governance

constitutes a strategy deliberately adopted by politicians to weaken the accountability line running from the electorate to politicians.

In Germany, the trend certainly appears to have gone furthest with regard to the diffusion of decision-making power to various stakeholders that lack direct democratic legitimacy. In a system where economic imperatives involve the national-level, Länder hospital plans and owners' particular agendas, it is often impossible to identify the thread that links a change at the frontline to a specific group of elected politicians. Such ambiguity will only increase if Länder continue to roll back hospital planning with the maturing of a system of lump sum investment funding. Such a shift of decision-making power towards hospitals would appear to inevitably weaken public accountability (Wallrich et al. 2011).

Conclusion

Hospital reorganisation and investment planning is a relatively under-researched area outside the field of health economics, but one that is critical for understanding how hospitals adapt to pressures for becoming more 'efficient' and 'responsive' in the face of financial constraints, growing technology costs and investment backlogs. Indeed, it is a profoundly political process imbued with tension in addition to being a technical or professional exercise (Mattei 2009: 1).

Our initial hypothesis was that institutional changes introduced in successive and partially NPM-inspired reforms over the past decade have led to a stronger emphasis on managerial accountability in health systems of Germany, Denmark, and Norway, potentially to the detriment of traditional public (political) and professional accountability. We found that there has been a trend towards economization and corporatization in all three systems^{xxi}, as a consequence of which there has been an increased emphasis on managerial and professional accountability, which has weakened established institutional mechanisms for public accountability.

In all three countries under consideration, hospital planning had been historically decentralized – in Germany because of its federal make-up, and in Norway and Denmark due to traditionally decentralized hospital provision. It is important to acknowledge, however, that there are important differences among these countries. While national governments have asserted influence through recent reforms in all three countries, only in Norway has this governance been entirely centralized. Even there, organizational separation of regional health trusts and local enterprises has introduced new ways of understanding the existing distinction between the ‘activity and the superior political body’ (Martinussen and Magnussen, 2009: 32). These observations highlight the growing importance of multi-level governance where a plurality of public and private actors exercise different types of accountability both ‘vertically’ and ‘horizontally’. In Denmark, the five new regions have maintained considerable

operational and budget autonomy, but all planning and investments have to be scrutinised by a government-appointed professional committee, with final approval by national-level politicians. Public control in Germany's hospital sector is growing distinctly, through the centrally imposed DRG logic, other solutions being more decentralized. Whether centralization has effectively occurred in Germany is not yet entirely clear, although increased use of funding mechanisms at the federal level point indicate that the national legislature is tightening its grip on financial resource-allocation mechanisms, at least.

These transformations in the loci of governance have been complemented by the greater need to control costs, with economization and corporatization impacting hospital planning and funding processes. This trend, we argue, may serve to undermine public accountability at the regional level, with decision-making increasingly relocated to a greater array of technocratic and managerial actors using professional judgment or managerial accountability, precisely because such processes are not open to public scrutiny as defined by Mulgan (2002). Neither can managers or private actors be held accountable for their actions through democratic processes. Furthermore, with a greater number of elected and non-elected actors involved in hospital governance, there may be less clarity about responsibilities for decision-making, ultimately weakening the thread linking decision-makers to the electorate.

In this light, the current tendency to devolve decision-making on hospital running costs in Germany should be seen critically. There are already indicators of hospitals misusing lump sums at the expense of patient care and medical quality. In Denmark, policy experts rather than politicians are now playing a bigger role in hospital planning and administration. In Norway, conversely, democratically-legitimated actors have retained greater control, despite the reforms in place, retaining traditional lines of hierarchical and political accountability.

Overall, we have identified pressures towards centralization, corporatization and economization in Denmark, Norway and Germany in the process of multi-level welfare governance. In doing so we have sought to enrich the theoretical debate on accountability by showing how these tendencies gradually weaken public and political accountability at regional levels in favour of the managerial and professional types. However, the comparative approach shows that the extent of reshaping of public accountability will depend on the national and cultural institutional environments in which NPM-motivated reforms have taken shape.

ⁱ Majone (1994) describes this as the ‘...rise of a regulatory state to replace the *dirigiste* state of the past’ (p.97).

ⁱⁱ It is important to reiterate that this paper examines the concept of NPM with reference to the reforms that have taken place in this sector, rather than through an analysis of the instruments of these changes (e.g. implementation of contracts, pricing etc.).

ⁱⁱⁱ For the sake of retaining analytical clarity, other aspects such as individual moral responsibility are excluded, as they do not involve external scrutiny or meaningful sanctions (Finer 1941; Mulgan 2000).

^{iv} Public and political accountability are at times used interchangeably by various scholars and at times as distinct accountability mechanisms (See for instance Sinclair 1995:225-226; Bovens 2005: 183; or Mattei 2009: 37). Political accountability, in our understanding, refers more narrowly to the relationship between the legislature and the executive, that is, between elected politicians, and bureaucrats, or other appointed civil servants who 'exercises authority on behalf of [these] elected representatives' (Day & Klein 1987 cited in Sinclair 1995: 25). Although political accountability thus arguably presents a sub-group of public accountability, the latter is comparatively more informal but also more directly linked to the public (Sinclair 1995: 25).

^v This may, of course, not entirely hold true in some cases – the interaction between different kinds of stakeholders (public funders but private providers), for instance, within the same health service (e.g. Davies, 2001).

^{vi} Saltman et al (2011) shed more light on this issue by discussing the process and implications of Corporatization in Europe.

^{vii} It should be noted that the enterprise model entails a corporate-style ownership structure, where the Minister of Health in effect functions as the general assembly, and where ownership is a mechanism for exerting influence.

^{viii} In Denmark, in contrast, budget keeping rather than profitability targets remains the key steering focus, although new incentive structures mean that hospitals must also look at their income when steering towards their budget-keeping goals. Profitability targets are also not the primary focus in Norway, the most important requirement being that enterprises apply private accounting principles so that deficits/profits are made visible to stakeholders (primarily the state).

^{ix} Indeed, much of the planning takes place during regional hospital conferences attended by corporatist actors - hospital associations, physicians' associations and statutory health insurance companies.

^x In North Rhine-Westphalia, the Land that has gone furthest, 95% of hospital investment funding is now disbursed to hospitals as an activity-based lump sum. This funding can be autonomously used for investments, and can be saved up or used to service loans that fund larger investments.

^{xi} The percentage of privately-funded hospitals has increased between 1991 and 2005 from 15 to 27% (Deutsche Krankenhaus Gesellschaft 2007: 17) - at a much faster rate than in Norway and Denmark.

^{xii} Majone (1994: 97) uses the concept of deregulation and re-regulation to explain this phenomenon, with the former being the first step to the latter – a shift in means to achieve the desired end.

^{xiii} To reiterate, Economization refers to the focus on economic motives and financial considerations (Mosebach, 2009) in the organization and provision of healthcare.

^{xiv} To clarify, corporatization refers to the organizational changes within the context of economization, specifically the managerial changes that come into place once public institutions are considered as businesses.

^{xv} Representing the state as the sole owner

^{xvi} The steering letters are better perceived as a sort of a combination of policy statements and soft contracts, where aims are specified and demands pointed out.

^{xvii} By 2009, 59% of German public hospitals operated in this manner - up from 28% in 2002, with the pattern continuing unabated (Statistisches Bundesamt 2011).

^{xviii} The Norwegian national parliament, literally meaning “the grand assembly”

^{xix} For example, in an interesting case, a hospital closure led to an effective “punishment” of the Labour Party in the 2011 local elections in one city for a decision that was taken by bureaucrats but not blocked by the Labour party ruling at the central level. This case demonstrates the sustainability of more traditional public accountability relationships and mechanisms (Neby 2011).

^{xx} A phenomenon known as ‘negativity bias’

^{xxi} Economization has meant an emphasis on specialization and economies of scale, whereas corporatization has meant the establishment of organizations with their own capacities for decision making and planning

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