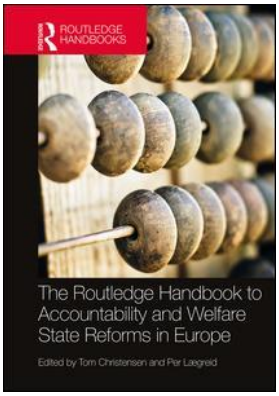

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Dimensions of Accountability in Healthcare

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DIMENSIONS OF ACCOUNTABILITY IN HEALTHCARE[1]

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Introduction

Several researchers have pointed out that the accountability discourse has expanded and that accountability has become a 'magic word' (Pollitt and Hupe 2011) associated with a multitude of reforms and organizational changes in the public as well as private sector. This has spurred a massive increase in the use of the term, but also a clustering on analyses centered on 'a minimal conceptual consensus', which we will also take as our point of departure (Bovens *et al.* 2014). A central part of the concept of accountability is the specification of relationships between actors and levels within systems, where actors have obligations to account for their decisions and behavior. Actors in these systems must explain and justify their behavior in forums of different kinds, and their account-giving may actually have consequences (Bovens 2007). Such general accountability frameworks are useful for overall analysis of accountability. Yet, they may not be equally applicable to all sectors and task areas, due to institutional peculiarities and functional differences. The aim of this paper is to explore how this accountability framework can be adapted to a specific sector – healthcare – and explore the usefulness of including concepts of function and direction in order to grasp the complexity of accountability regimes. The guiding question is: *How can existing, general accountability frameworks be adjusted to capture important dimensions within the healthcare sector?*

To answer this question, we first summarize key aspects of the academic debate about accountability in healthcare. Based on this, we discuss a set of possible adjustments to general accountability frameworks to accommodate the specific nature of healthcare.

We use to the two Nordic countries of Denmark and Norway to illustrate selected aspects of this comprehensive framework, and we address the issue of whether the traditional trust-based (Mansbridge 2014) and somewhat informal (Romzek 2014) accountability logics within the public decentralized health systems in Denmark and Norway have changed in terms of form, direction and function. We ask the following question: *Have recent reforms implied a change towards more formalized and sanctions-based accountability forms in Denmark and Norway?*

Accountability concepts for healthcare

Accountability in healthcare is a relatively unexplored field, yet it is possible to find examples of literature at least back to the 1970s that refer to the concept (Etzioni 1975; Day and Klein 1987; Relman 1988; Emanuel and Emanuel 1996; Tuohy 2003; Brinkerhoff 2004; Rosen *et al.* 2012; Denis 2014). The medical profession has been at the core of healthcare, but with the growing attention to patient experiences and perspectives there has also been a change from trusting to checking. External scrutiny and account-giving plays an ever-stronger role compared to trust in the traditional responsibility (Relman 1988). The traditional approach in many health systems was to rely on professional self-regulation, where the state delegated decision-making authority to the professional bodies of medicine. This worked as long as the quality of the relationship between individual doctors and patients was in focus, although it also implied a strong bias in power relations, and limited options for comparing different doctors and delivery organizations. The expansion of health systems implied rising expenditures and demands for health services. At the same time, the culture among users of health systems changed. This meant that both public principals and civic society actors started to demand more insight into the performance of healthcare delivery organizations (Tuohy 2003). Inspiration for such new ways was often found in the toolkit of New Public Management, with its emphasis on measurement, management and markets. The role of indirect instruments and third parties for maintaining accountability was brought forward as many governments developed a policy for information gathering and performance management. One way of framing the issue was to see the new regime as part of an 'audit society' where control was pushed further into organizational structures, inscribing in it systems that could be audited (Power 1997: 42).

Many scholars have pointed to the potentially negative consequences for established trust relations when introducing systematic external scrutiny (Rosen *et al.* 2012). But there are also significant differences among scholars in the way they frame the accountability discussion within healthcare. Some have been more preoccupied with context and how accountability has been related to national and organizational cultures (Saltman 2012) and politics (Mattei 2009), whereas others are more prescriptive in their approach, seeking to develop the ideal model of accountability across national systems, focusing more on the variations among the various domains of the healthcare systems in any country (Emanuel and Emanuel 1996). It is clear from these contributions that accountability is at the nexus of several dilemmas in the current governance of healthcare systems (Thomas 2003). While some researchers see external scrutiny as 'the answer', others see it as a symptom of underlying problems in trust relationships. Still others focus on the potentially negative side effects, including a self-reinforcing dynamic of generating ever more skepticism and control. To analyze developments in accountability, we depart from the framework for studying accountability developed by Mark Bovens and presented in the introduction to this volume. At the core of this framework is a set of formal accountability relationships that represent conscious attempts to establish social expectations and obligations. But accountability also has a more informal and dynamic side, since the formal rules are constantly interpreted and applied in practice. Indeed, some types of accountability primarily rest on informal and normative basis (Romzek 2014), where social sanctions are the main mechanism for ensuring trust-based relationships. Such informal, trust-based accountability (Mansbridge 2014) has been particularly important within the field of healthcare. This can be explained by the high degree of information asymmetry between managerial/public principals and professional agents as well as the relative strength of health professions. Information asymmetry makes it difficult for principals to monitor behavior and makes the cost of monitoring and sanctioning relatively high.

Furthermore, it can be argued that the content of work functions within healthcare requires a high degree of professional, discretionary decision-making. Disease patterns and patients are individual. Some respond well to given treatments; others do not. A significant part of the professional expertise deals with the adaptation of general diagnostic and treatment recommendations to specific situations, and a certain degree of professional discretion is needed in this process. Traditionally, this discretion has been based on trust in the process of selection and socialization through the formal education and subsequent licensing of medical professionals. Individuals that are admitted into the profession – symbolically illustrated by the formal commitment to the professional oath – are entrusted with treating patients and become part of the medical community. Within the medical community, a number of informal norms exist to reinforce a constant focus on applying the most up-to-date evidence in treatment practices. This informal pressure operates through medical communities and on-the-job training within the specific organizational settings for delivering healthcare. It is further reinforced by practice guidelines and more generally by ethical standards within the profession. Ideally, this ensures a high level of professional ethics and quality of practice. However, one might argue that the degree of actual scrutiny of practices in peer-based systems can be relatively weak, and that there are few formal opportunities for sanctioning if things go wrong. Sanctions are often relatively subtle and relate to lack of promotion and gradual exclusion from the social community. The efficiency of this type of accountability scheme is thus based on the premise that there are a significant number of agents with trustworthy internal motivations for delivering high-quality services, and that these internal motivations are backed by widely accepted social norms within the profession to ensure a high level of quality. This premise has been questioned particularly in the past three decades for a number of reasons. First, the availability of information about performance is much greater today than in previous decades. This means that poor performance is much more likely to be discovered by the public. Several highly publicized scandals (e.g. in England and Norway) bear witness to this (Lægreid *et al.* 2014), but discussions about comparative performance have also been important drivers of health policy in the Nordic countries. Second, although the medical profession may consist of many idealistic and intrinsically motivated individuals, their normative orientation tends to be focused on clinical issues for the individual patient and not the broader and sometimes conflicting societal goals within health systems. Healthcare professionals may thus work hard to optimize within their clinical performance, but at the same time the system may fail to live up to broader objectives of cost containment, equity, responsiveness and coordination of care (Papanicolas and Smith 2013). To ensure such broader objectives and to reinforce the internal normative structures within health professions, there has been a pressure to introduce additional accountability structures within healthcare over the past three decades.

A likely result of such changes is that the core of trust-based accountability in regards to the professional staff increasingly become circumscribed by political, administrative/managerial or market-based mechanisms to scrutinize performance and issue sanctions, if particular health professionals or organizational units fail to live up to standards (Mansbridge 2014). Some of these new accountability structures are generated by developments within the healthcare sector itself, while others are a product of general trends in public administration, which has meant that many parts of modern societies have become characterized by a multitude of accountability forms. Such general reforms have introduced new governance forms, which have added to the complexity and ambiguity of the overall accountability structure (Lægreid 2014).

To disentangle the complexity of the new accountability structure, we find it useful to introduce an analytical distinction between several different accountability forms (Mulgan 2000; Willems and Van Dooren 2012). The forms in the typology are meant to be exclusive, but as

will be noted below, there may be empirical cases that fall into overlapping subcategories. An example is the use of 'contractual accountability' as part of a public managerial approach. It is thus an empirical matter to further define the concepts in specific cases.

Political accountability refers to the relationship between political leadership and citizens, where citizens come to act as a forum towards political leaders when politics and policies are displayed and performed (Table 8.1). Important political accountability mechanisms include: (a) elections, where voters hold politicians to account; (b) parliamentary scrutiny and questions; (c) the political allocation of budgets and parliamentary budget controls; and (d) transparency rules and administrative policy regulations for steering the bureaucracy. Political accountability is relevant in all health systems due to public involvement in regulation and to varying extent in financing of health services.

By *administrative accountability*, we emphasize accountability relationships inside the administration or by external audit institutions. Important relations are thus between higher- and lower-level administrators in hierarchical relations, and between auditors and public organizations. Internal administrative accountability is particularly relevant in health systems with a high degree of public involvement in delivery and financing of services. In terms of content, administrative accountability often focuses on procedural and formal legal issues such as due processes, compliance with rules and procedures.

Managerial accountability focuses on performance measurement and results. The traditional emphasis on the process and input dimensions has been downplayed as the output and efficiency dimensions of public sector organizations has become more central. Managerial accountability is sometimes institutionalized into contractual relationships, and in such instances overlap with contractual accountability to form a subcategory of managerial public contract accountability. However, managerial public accountability is broader than contracts, and some contracts in healthcare do not involve public actors, as described below.

Professional accountability refers to accountability relationships that are oriented towards clinical procedures, professional standards and (clinical) quality enhancement. Much of this takes place internally within professional ranks, through peer reviews and on-the-job training. Much of it is informal and norm-based, but some elements are formalized in terms of assessments of adherence to clinical guidelines and input to recertification programs. Professional accountability can be external to the organization (e.g. in the form of accreditation programs, whistleblower arrangements and professional bodies that provide input to patient complaints assessment).

Civic society accountability refers to the external scrutiny of healthcare administration and organizations by more or less organized civic society groups, such as patient organizations and mass media. Both play an important role in healthcare, although in a rather ad hoc fashion. Civic society groups also differ significantly in their resources and capacities to exercise this type of accountability. Civic society groups, such as patient organizations, and media can use general transparency regulation to demand information. They have limited formal sanctioning ability, but the reputational effects of poor media coverage and civic society scrutiny can be quite powerful, particularly in systems where patients can choose between different treatment facilities. Media and civic society attention may also generate more formal political or judicial interventions, and can thus feed into the other types of accountability.

Contract accountability is found in health systems where purchasers/insurers can enter contracts with multiple independent delivery organizations. This situation is common in market insurance systems, but increasingly also social health insurance and public health systems. The relationship between purchaser/insurer and provider is based on formalized contracts that include an opportunity for the purchaser/insurer to request information about performance. Sanctions may be specified in the contract and also consist of the threat of deselection for subsequent contracts.

Another type of market accountability exists between shareholders or professional boards and managers in private health delivery organizations and independent public organizations based on an 'enterprise' model. General managers are responsible for organizational performance and adherence to the general strategy of the organization. Boards and general assemblies of shareholders can demand information, and can hold management accountable. They may sanction by interventions in management autonomy or ultimately by firing managers.

As described above, one may also find contractual relationships within the public sector or between a public sector principal and a private sector organization. In such cases, contractual accountability becomes a subcategory of managerial accountability, but with many of the same features as private-private contracts. It is therefore important to declare which type of contract is in focus when using the typology for empirical purposes.

Judicial accountability concerns the use of formal legal interventions through civil and administrative courts. This type of accountability has traditionally played a less prominent role in the Nordic, universalistic health systems than in insurance-based systems, as the legislation typically specifies general obligations for public health systems rather than specific rights. However, there has been a tendency to inscribe more individual rights into the health legislation in recent years (waiting time guarantees, choice of provider, information and informed consent, etc.).

The distinction between political, administrative, managerial, professional, civic society, contractual, and judicial accountability provides a detailed instrument for classifying accountability relationships. Most modern health systems include all of these accountability types, although their importance differs depending on the specific institutional composition of the health systems. The various types of accountability are associated with different types of underlying rationality and support different core values associated with the public sector. We will refer to this as the normative basis for accountability.

Normative basis for accountability

Classical accounts of accountability distinguish between a constitutional, democratic and performance function of accountability (Willems and Van Dooren 2012). Each of these three 'functions' refers to a distinct set of underlying normative ideas of the public sector.

An important set of normative ideas for the public sector revolves around the 'constitutional' safeguards for citizens. This perspective emphasizes procedural rules regarding due process, equal treatment, openness and impartiality. 'Constitutional' rules are meant to provide boundaries for the exercise of public power and to safeguard rights for the individual. Public authorities are held accountable for a variety of well-established rules and procedures to prevent unfairness and abuse of power. Such concerns are also important within healthcare. The principle of equal rights is safeguarded in universalistic health systems, and all European health systems have a set of minimum requirements for healthcare insurers and providers. But the issue of 'policing the boundaries' of professional conduct and safeguarding rights has a deeper meaning within healthcare. This is based on the high degree of information asymmetry between professionals and patients, and by the potentially severe consequences for the individual if professionals fail to live up to general standards. This accountability relationship deals with protection of personal integrity, dignity and safety in all relationships between professionals, pharmaceutical and medical device producers and patients.

The 'democratic' function refers to the interest of citizens (or elected representatives) to be able to control the legislative and executive powers of the state. Citizens should be able to hold representatives accountable for decisions and to select other representatives if necessary. Within

healthcare, this means having the means to control and select the formal democratic decision-makers that set the regulatory boundaries for healthcare and determines principles for allocation of public resources in the sector. In public integrated health systems such as the Nordic systems and the UK, this also extends to controlling the public healthcare delivery organizations and their employees.

The normative idea of 'output performance' is based on the underlying understanding of the public sector as primarily responsible for organizing the delivery of services in selected areas. Healthcare is characterized by a set of 'market failures' based on the high degree of information asymmetry between delivery organizations and those in need of care. Furthermore, there are significant externalities associated with healthcare delivery and consumption. This means that public authorities must play a role in safeguarding the performance of delivery organizations, both public and private. Emphasis is therefore on the output dimension of public activities (Scharpf 1999), and accountability is focusing on securing the best possible output performance. Applying this to healthcare means that public authorities, as well as citizens and patients, should be able to hold healthcare providers accountable for the results they achieve. Collectively, we should be able to judge whether we get optimal societal value for the resources allocated to healthcare. The types of measurements to support accountability for output of healthcare organizations range from quality data reported in clinical databases to process data (e.g. waiting times and adherence to standards) and service quality data (e.g. measured as patient perceived quality). Performance data are often made publicly available to allow comparisons and questioning and to support efforts to develop incentive schemes and sanctions by political, administrative or private principals.

The output performance has gained importance as the normative basis for the public sector in general (Hood 1991; Van Dooren *et al.* 2010). This is expressed in a significant growth in monitoring and auditing mechanisms focusing on the three Es of efficiency, economy and effectiveness. Within healthcare, we have seen an explosion in performance-measuring systems focusing on quality, service and efficiency.

Direction of accountability

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 hierarchical accountability, a defining characteristic is that authority and distribution of roles are formalized, as is the case between a minister and a ministry. In horizontal accountability mechanisms, the situation is rather an absence of hierarchical relations. Instead, there is an accountability relationship to other organizations within a network or peer group structure. The obligation to provide information is usually based on collaborative norms and the sanctioning mechanisms are usually not clearly specified, and mainly consist of the threat of exclusion from future collaboration and networks. Schillemans emphasizes the voluntary and informal nature of horizontal accountability. We suggest that the situation is a bit more complicated. In a networked society, we see many examples where local or regional organizations enter more formal agreements. In other cases, they are held jointly accountable, and may therefore have stronger interests in holding each other accountable for the joint goals. This represents a situation where vertical and horizontal accountability are combined.

Marc Bovens (2007) introduces an additional possibility of a diagonal arrangement: in diagonal accountability relationships, the forum is not hierarchically superior to the actor, but still has the power to request information and to pass judgment, which may or may not lead to formal sanctions. Ombudsmen or independent complaint boards could be examples of such

accountability arrangements. Within healthcare, we also find 'national boards of health' or similar scrutinizing agencies. Such agencies are not superior to the actors they hold accountable, but act on behalf of 'the system' or 'the public interest'.

Summarizing the dimensions of accountability in healthcare

We now have several dimensions to describe accountability within health systems. First, we can distinguish between different accountability *forms*, each with several different forums and account-givers and associated accountability mechanisms. Second, we distinguish between different *normative functions* of accountability. While democratic and constitutional functions have traditionally been closely linked to political, judicial and administrative accountability forms, and performance more closely to market and professional accountability forms, it is important to realize that different forms may include concerns for several different functions. For example, professional accountability typically is concerned with due process, equity and impartiality, as well as performance. Similarly, it can be argued that the performance function of accountability has gained importance in public health systems over the past three decades with the introduction of New Public Management perspectives and tools, and that this is combined with different forms of administrative accountability. Third, we distinguish between different *directions* of accountability. We suggest that horizontal accountability forms have gained importance over time, as more services are delivered in networked structures and as traditional forms of government are giving way to new types of 'governance' relations.

In this sense, there tends to be a dynamic interaction between the different dimensions, as pointed out by Willems and Van Dooren (2012), and accountability regimes can be seen as snapshots of forms, normative basis and direction of accountability in a particular context, at a given point in time (Goodin 2003; Tuohy 2003; Mattei 2009). Reforms can then shift the relative importance of different forms, normative basis and directions over time. This may happen through formal rules, or more implicitly by introducing new institutional structures and relationships. The result can be new configurations of accountability, and specifically within health one may hypothesize that recent reforms have led to new ways of balancing the trust based professional accountability, which has traditionally been at the core of healthcare, and the more formal, sanction-based administrative, political, contract and judicial accountability types (Mansbridge 2014).

The following table summarizes the presentation.

Examples of reforms and accountability changes in healthcare in Denmark and Norway

The health systems in Denmark and Norway are characterized by a high degree of public involvement in financing, planning and delivery of services. Unlike the NHS in England, there has historically been a strong element of decentralized governance based on democratically elected councils at regional (Denmark) and local levels (Denmark and Norway). The decentralized delivery structure in a multilevel system creates particular accountability relations between state, regions and municipalities as regions/municipalities operate in the 'shadow of the hierarchy' and according to political directives and agreements, which sometimes resemble formal contracts.

Professional accountability has traditionally played a central role in the Nordic countries. Professional accountability is nested within the democratic/political and administrative governance structures at national and regional levels. Judicial accountability has been of limited importance, and private sector contract accountability has been of limited relevance due to the

Table 8.1 Dimensions of accountability in healthcare

Accountability form	*Accountability forum ↔ account-giver*	*Account mechanism*	*Normative function*	*Typical direction*
Political	Voters ↔ parliament Parliament ↔ government Government ↔ administration	Elections Parliamentary scrutiny, questions, votes of no confidence, etc. Budgets and budget control	Democratic Constitutional	Vertical
Administrative	Higher-level ↔ lower-level administrative staff/units (administrative chain of command) Internal audit ↔ public organizations/hospital units External audit ↔ administration/hospital units	Hierarchical scrutiny and intervention Hard or soft contracts Internal or external audit, accreditation, etc.	Democratic Constitutional	Vertical Diagonal
Managerial	Higher-level ↔ lower-level administrative staff/units Administrations ↔ arm's-length agencies or external organizations	Performance monitoring and sanctions Benchmarking Contract management	Performance	Vertical
Professional	Formal or informal profession groups ↔ individual professional Profession-based external committees for evaluation of complaints, malpractice, etc. ↔ individual professionals Administrative bodies ↔ individual professionals	Professional peer review Whistleblowers Profession-based external scrutiny (e.g. through complaint procedures) Administrative examination of professional conduct of individual professionals	Constitutional Performance	Horizontal Diagonal (Vertical)
Civic society	Mass media ↔ health administration, organizations and professionals Organized civic society ↔ health administration, organizations and professionals 'Ad hoc' action groups or individuals (e.g. e-based) ↔ health administration, organizations and professionals	Framing, agenda-setting, information channel, watchdog Monitoring, critical dialogue, petitions, protest campaigns, etc. Growing importance of e-based virtual communities and communication forms	Democratic	Horizontal
Contractual	Purchasers/contracting agencies/insurers ↔ health organizations Shareholders/owners/boards ↔ health organizations	Monitoring adherence to performance targets in contracts – deselection for future contract Performance monitoring Profits	Performance	Horizontal Vertical
Judicial	Judicial courts ↔ health administration, organizations and professionals Administrative courts ↔ health administration, organizations and professionals	Formal judicial trials and procedures	Constitutional	Diagonal

Source: A modified version of this table is presented in Vrangbæk and Byrkjeflot (2016).

dominance of public financing and public provision. This is in stark contrast to, for example, the US healthcare system. Prior to the 1980s, the public had limited insight and limited options for comparing health services, and thus played a relatively indirect role in accountability terms, primarily as voters at local, regional and national levels (political accountability) and, in some cases, as members of civic society groups and interest organizations (civic society accountability).

However, a number of changes have been introduced from the 1980s onwards in the Nordic countries, the UK and most other European healthcare systems (Vrangbæk 1999; Magnussen *et al.* 2009; Byrkjeflot 2011; Olejaz *et al.* 2012; Ringard *et al.* 2013; Lægreid 2014; Peckham 2014). The dominant change trends include the introduction of NPM style reforms from the 1980s onwards, emphasizing choice, economic incentives, performance measurements and transparency (activity, service and clinical quality). NPM reforms have been supplemented by structural reforms changing the balance between central and decentralized governance. A major structural reform was implemented in Denmark in 2007 and a smaller reform in Norway in 2012. These reforms were, among other things, motivated by an ambition to improve coordination of care across sectors and delivery platforms. This is seen as a necessary response to ageing populations with more chronic care needs and higher prevalence of multi-morbidity. The coordination efforts generated more formal horizontal accountability relations between regions and local authorities, and intensified vertical accountability for achieving joint results. The vertical accountability is located within a hierarchical setting in Norway, but with clear managerial traits. In Denmark, the situation is complicated by the fact that regions and municipalities formally have independence, but in reality depend on the state for financing, and also operate in a context where the national authorities may intervene through legislation at any time. In this sense, the accountability relationship is administrative and hierarchical at its core, but with a strong element of managerial accountability based on negotiations and agreements, rather than formal contracts.

Another reform trend in both countries has been ongoing changes in the public/private mix of healthcare by introducing more private providers and encouraging voluntary private insurance. Many of the ongoing reforms have been supported by more extensive digitalization and e-based solutions for communication, monitoring and delivering services.

The many reforms and ongoing changes have led to several changes in accountability relations. At the general level, we have moved to a situation where accountability relations have become more explicit than in the previous era, where many accountability issues remained unarticulated and assumed to be taken care of within the professional ranks or internally in the hierarchical public structure. The overall result is a system that is more complex and layered over time (Bovens and Schillemans 2011). This is seen in the interaction between horizontal and vertical accountability forms. It is also apparent in the ongoing struggles over the boundaries of professional accountability, and in the introduction of managerial accountability, backed by the threat of political/administrative intervention.

One major development trend is thus that administrative accountability has changed to incorporate a more managerial dimension with increasing reliance on performance dimensions and contract/market accountability. In some cases, these NPM-related accountability types have replaced more traditional forms, but more often they have been added on top of existing forms, sometimes creating tensions and lack of clarity for the involved account-givers (Vrangbæk 1999; Byrkjeflot 2011; Lægreid 2014). Examples of increased managerialism can be found in the Norwegian 'enterprise reform', which, in 2002, created semi-independent delivery organizations with boards rather than politically elected management and governed through detailed 'steering documents' with performance demands from the state level (Byrkjeflot and Neby 2008; Mattei *et al.* 2013). In spite of the stated intention to give the Norwegian health enterprises a high

degree of autonomy within this framework of managerial goal-based steering, there have been several examples of hierarchical interventions in operational decisions at the hospital level, for example in regard to closure of hospital units.

Denmark has similarly seen experiments with publicly owned 'free hospitals' operating with less tight hierarchical control, and Denmark has also used contracting of private hospitals as part of the national waiting time guarantee.

Performance is monitored in significant levels of detail in both Denmark and Norway, and results are made available on the Internet to support external (civic society) scrutiny and facilitate choice (e.g. www.esundhed.dk). But performance data are also used extensively in the accountability relations between state and regions. Activity data are used for resource allocation in both countries, and performance in regard to implementation of state policy directives, such as guidelines, recommendations and policy directives, are monitored and subject to discussions between state and regional/local level actors.

In both countries, we see indications that professional accountability is increasingly challenged by attempts to superimpose external administrative or contract-/market-based accountability forms. Professional accountability has in itself become more formalized, standardized and transparent (Timmermans 2005). Examples of this development trend include the formulation of clinical treatment guidelines and the surveillance of their implementation through the extensive accreditation program for Danish hospitals, which was implemented between 2007 and 2015 (Burau and Vrangbæk 2008; Vrangbæk 2009), but is currently undergoing reconstruction. Clinical guidelines are also implemented in the Norwegian case along with detailed patient pathway descriptions for particular patient groups.

In both Denmark and Norway, there is a tendency for civic society accountability to play a stronger role. This is enabled by improved transparency and the general development towards a civic society that is more knowledgeable and less inclined to accept variations in quality. Patient organizations continue to play a significant role within health policy (Opedal *et al.* 2012), but they are increasingly joined by ad hoc e-based virtual interest groups and campaigns that have supplemented traditional civic society interest organizations and mass media in the accountability functions of demanding information and passing judgments.

Judicial accountability in general still plays a minor role, particularly in the two Nordic health systems. Yet, there is a tendency to develop more specific rights within healthcare, for instance in relation to waiting time guarantees, rights to information, etc. Although such rules are not formal judicial rights in all cases, they are still part of a trend towards more explicit formulation of patient rights supplementing the general obligation of the healthcare system. This trend points towards increasing judicialization of healthcare (Hogg 1999). Another driver behind this development is the adaptation to EU legislation, for instance on cross-border healthcare. This creates a new type of mixed judicial and political accountability between citizens, the national health authorities and the EU institutions (Court of Justice and Commission), with the effect of reducing national political sovereignty (Martinsen and Vrangbæk 2008; Vollaard *et al.* 2013).

Another common trend in the two countries is an increasing importance of horizontal accountability. This can be interpreted as post-NPM efforts to reduce the fragmentation created by previous reforms, and to accommodate the demands from ageing populations with more chronic care needs. Both countries have introduced reforms to encourage more seamless service delivery across different health and social care levels (Rommetvedt *et al.* 2014). Intergovernmental relationships have become tighter with more formalized mandatory collaboration between regions (hospitals) and municipalities. Regions, municipalities and delivery organizations engage in 'dynamic accountability' relationships based on networks, recursivity, deliberation, innovation, inclusion and publicity (Sabel and Zeitlin 2008; Mansbridge 2014). Interestingly, these horizontal

accountability structures are to some extent accompanied by stronger accountability pressures from the state level in terms of monitoring and sanctioning mechanisms for the joint performance of regional and local level delivery organizations. The result is a dynamic interaction between horizontal and vertical accountability involving state, regional and municipal actors.

Based on these observations, we can conclude that there are indications of circumscribing the traditional core of selection and trust-based accountability with a thicker, more complex and more penetrating layer of monitoring and sanctioning accountability (Mansbridge 2014). This can be seen at the clinical level, where traditional reliance on selection and trust-based accountability forms is challenged by IT-based systems for monitoring performance, and by the widespread use of clinical guidelines, standards and operation procedures. In terms of the criteria developed by Mansbridge, this can partly be explained by a reduction in the price of monitoring due to the introduction of IT solutions and collection of 'big data'. Alternatively, one can argue that some of the cost has been shifted to those being monitored, as they are responsible for taking the time to enter data and thus supply the basis for (self) monitoring.

A similar development has taken place in the accountability relations for hospitals and public authorities (regions and municipalities). Rising expectations among patients and in the general population contribute to this development. The authority of healthcare professionals has been weakened and people are less inclined to accept quality differences or failures. In accountability terms, this leads to strengthening of both civic accountability and managerial accountability, in both cases utilizing the increased availability of performance data. A third impetus for the development is thus that politicians and bureaucrats at state and regional levels, as well as hospital managers, are pressured to find effective ways of managing increasing demand for health services. Increasing demand is fuelled by aging populations, rising expectations among citizens and medical technology advances. This has necessitated a tighter control regime and better monitoring of activity and economic performance. This development can also be found in the relationship between the state and regions/municipalities, where the state in both countries have implemented stronger governance of economic performance and tougher sanctions for budget overruns. Productivity increases are mandatory, and failure to deliver such increases results in economic sanctions. In addition, the two Nordic states also use softer means in the form of benchmarking and publication of comparative data in order to hold regions/hospitals accountable and to enable citizens/patients to do the same.

Conclusion

In this chapter, we asked two questions. The first was how existing general accountability frameworks should be adjusted to capture accountability dimensions specific to healthcare. We took Boven's accountability framework as our starting point. Based on this, we argued that there are seven forms of accountability that are particularly relevant in healthcare. Professional accountability has historically been a very important factor in health care based on the strength of health professions and the information asymmetry inherent to the highly technical and complex production of health services. Professional accountability is still very important, but has increasingly become circumscribed and supplemented by other types of accountability relating to public/patient demands for insight into health sector performance and a tightening of the steering relationships between insurers (public and private) and delivery organizations. The configuration of these types of accountability varies somewhat across countries depending on the institutional setup and historical heritage of different healthcare systems. To capture this complexity, we suggested that it is useful to distinguish between political, administrative, managerial, professional, civic society, contractual and judicial accountability, and that understanding the normative basis

of each of these is important to go beyond surface labels. Finally, we argued that analysis of the direction of accountability can reveal important information about the actors and the relationship between them within a given accountability regime.

This elaborate framework for studying accountability in healthcare makes it possible to move beyond existing studies, which have tended to focus on the relationship between the medical profession and a few of the other dimensions mentioned (e.g. state or market). Developing a framework is an important step in the process of developing comparative studies of accountability regimes. Until now, there have been few comparative studies of accountability regimes in healthcare (but see Tuohy 2003; Byrkjeflot *et al.* 2013, 2014). Such studies and also historical case studies of single systems may be useful in understanding the relationship between reforms and accountability relations in theory and practice.

The second main question for our chapter was whether recent reforms have implied a change towards more formalized (Romzek 2014) and sanctions-based (Mansbridge 2014) accountability forms. Using the two Nordic countries of Denmark and Norway as examples, we conclude that a number of reforms have been introduced within healthcare, including: (a) NPM-style reforms from the 1980s and onwards introducing choice, economic incentives, performance measurements and transparency (activity, service and clinical quality); (b) structural reforms changing the balance between central and decentralized governance; (c) changes in the public/private mix of healthcare by introducing more private providers and encouraging voluntary private insurance; (d) various reforms and changes to promote integration of care; and (e) digitalization and e-based solutions for communication, monitoring and delivering services.

These different reforms have resulted in gradual changes of accountability relationships with a growing reliance on formalized transparency measures and a growing emphasis on political, administrative, managerial, contract and legal accountability forms. Yet, within the Nordic systems, this has only partially been accompanied by a clearly articulated sanction-based approach. Sanctions remain somewhat internal, and subject to ad hoc negotiations within the political, administrative and professional steering systems. There is limited upfront definition of criteria and sanctioning levels. The overall result is a rather complex and multidimensional accountability regime where the different actors face increasing scrutiny combined with some uncertainty as to when and how sanctions may be imposed.

Note

1 Parts of this chapter have previously been presented in Vrangbæk and Byrkjeflot (2016).

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