Assessing political accountability in the German public hospital sector.

Peter Lango, PhD-Candidate
peter.lango@aorg.uib.no
UoB, Department of Administration and Organization Theory.

Paper for the 7th ECPR General Conference, Bordeaux, 4-7 September 2013

Introduction

Accountability relationships are a precondition for political legitimacy in democratic states. In a democratic context, accountability is a way of monitoring the conduct of governments, and public agencies. Mechanisms of accountability give us the possibility to control the input into public policies, as well as the output. When accountability relationships become unclear it may have consequences for how public organizations behave and how governments, but also indirectly citizens, can control and influence them. If the relations become a tangled web it also can become unclear who is accountable to whom, and for what, and even why. It is for this reason that this paper aims to address the state of political accountability relationships in the hospital sector in Germany. Hospitals play an important role in the health care system since it encompasses large financial investments and expenditures, many employees, and it plays an important part of many peoples life. In the German case, as well as in other countries, the welfare sector including the hospital sector can have notions of complex accountability relations and systems. The paper will study the relationship between, on the one hand, organization of the hospital sector, regulatory framework and funding of hospitals and, on the other hand, the accountability relationships.

The research topic for this paper is to describe the political accountability relationships for publicly owned hospitals in Germany in light of the changes in the hospital sector since 1990.

The aim of the paper is to explore and discuss the mechanisms and structures which produce political accountability relationships in the health care sector, and more specifically the hospitals. The reason for limiting the study to publicly owned hospitals is that it can be assumed that different ownership types, e.g. non-profit/for-profit private hospitals will be subject to other accountability regimes (cf. Pieper and Klenk 2012).

Accountability is a contested and ambiguous concept. But in this paper it is defined as a relationship between an actor and forum, where the forum can pass judgement, which may have consequences
for the actor (Bovens 2007). This study is a qualitative study, and the data primarily comes from written sources (public documents and secondary literature).

The study is organized as follows: (1) A description of accountability as concept. (2) Thereafter comes a short presentation of the reform activity in Germany since the late 1980s. (3) Based on the accountability framework a description of the regulatory framework, the funding of hospitals and organization of hospitals follows. (4) And finally, a presentation of different accountability relationships and how they are manifested.

This paper will argue that the German hospital sector consists of multiple and interrelated accountability relationships, which may have unintended consequences for the governance of hospitals, and in the end, political legitimacy.

**Accountability**

Accountability is an ambiguous and complex concept, and can be described and operationalized in many different ways. It was originally a concept related to bookkeeping, but today accounting is only a weak connotation of accountability (Bovens 2005: 182). Mulgan (2000: 570) claims that the scope and meaning of accountability has been extended in a number of directions well beyond its core sense of being called to account for one’s actions. There are also larger discussions on the concept: what it should include and how it can be defined (cf. Mulgan 2000, Dubnick and Justice 2004, Bovens 2007), the effects of it (cf. Ossege 2012), or if it too little or much of it is bad for democracy (cf. Flinders 2011, Tetlock 2011, Dubnick 2011). To make use of accountability as an analytical concept, some limitations and definitions are needed. This process can be seen as describing the threads of a tangled web.

A distinction between accountability in a *broad* and *narrow* sense, as Bovens (2007) presents it, is useful. In the broad sense it is seen as ambiguous and normative concept because it is often defined close to responsiveness or dialogue (cf. Mulgan 2000). As a narrower concept it becomes more meaningful and useable since it is placed particular emphasis on holding actors to account through formal channels of external scrutiny and sanctions. Bovens (2007: 450) describes accountability as “*a relationship between an actor and a forum, in which the actor has an obligation to explain and to justify his or her conduct, the forum can pose questions and pass judgement, and the actor may face consequences***. This means that the relationship can have a formalized character, and this understanding makes it easier to describe and analyse accountability relationships. Other contributions to the debate on the accountability concept emphasize the effects of informal
mechanisms, such as norms, expectations and behaviour (Romzek et al. 2012). These mechanisms are also important, but will be beyond the scope of this paper.

Bovens (2007) points out that there are four important questions to be asked in accountability relationships: The first question is who is the “accountor” or forum? The second question is who is the “accountee” or the actor? The third question is about what is account to be rendered? The fourth question regards that of why the actor feels compelled to render account. The obligation that lies upon an actor to render account can be formal or informal. Since there are many different actors and forums, and an actor can be accountable to different forums, it is useful to distinguish between several types of accountability. Bovens (2007) elaborates on five types of accountability based on different types of forums an actor must report to: Legal, political, professional, administrative and social accountability. This paper will focus on political accountability.

According to Bovens (2007) political accountability is built on a chain or set of principal-agent relationships (cf. Strøm 2000), i.e. a delegation of sovereignty by voters to elected representatives, and further on to cabinet of ministers and the civil service. Their accountability then moves in the opposite direction, from the civil service to the voters. In addition to this, both political parties and the media can function as informal forums for political accountability (Christensen and Lægreid 2011). Christensen and Lægreid (2011: 6) argue that political accountability can include accountability to the minister, the cabinet, as well as to the parliament and to the public (cf. Mulgan 2003).

There is also the question of the kind of information provided or at least demanded in these relationships. Bovens (2007) distinguish between three types: procedural (legal) information, financial information, and product (functional) information. Organizations in the service delivery end of the welfare state will in most cases be under scrutiny on all of these dimensions in all the forms of accountability.

Bovens (2007) last dimension of accountability relationships is based on the nature of the obligation, where he distinguishes between vertical, diagonal and horizontal accountability: Vertical meaning that the forum formally wields power over the actor as in a hierarchical relationship. Horizontal refers to relationships where formal obligations to render account may be lacking, as with social accountability. On the other hand, organizations may fell or can be pressured to give account for them self, for instance through media. And lastly, diagonal can be described as an intermediary form, i.e. actors that have no direct hierarchical relationship to the forum, but may have some power and influence to enforce their compliance, such as supervisory authorities and audit offices.
The point of departure in this paper is that a public agencies/welfare delivery organization is subject to several types of accountability. The boarders of distinctions between different forms of accountability that are posed by Bovens (2007) can be somewhat unclear since the different types of accountability relationships often can be interrelated, i.e. organizations in the public sector or governments must are subject to several types of accountability. There are several types of accountability, each giving a very different answer to the question of who is accountable for what, to whom and according to which criteria. As mentioned earlier, this paper does acknowledge that there exist different accountability relationships, as posed by Bovens (2007), but here the focus will be directed at political accountability.

When operationalizing political accountability, the point of departure here is the hospitals, but in the end it is elected officials and cabinet who are accountable to (1) other elected representatives and local government (internally) and (2) to citizens, media and parties (externally). The content of the relationship is conformity with goals of public policy, including conformity with laws, finances and function. The main sanctions which the accountor can use within political accountability are voting out of representatives, resignation and dismissal.

This paper argues that the regulatory framework, funding, organization, ownership and management of public hospitals in Germany will affect the political accountability. But before describing these elements, the reform activity will be presented, since it is assumed this also have some implications for accountability changes.

**Reform activity in the German health care sector**

Expenditure, on health care, including public hospitals, has risen severely since the 1970s and has led to federal attempts at cost containment (Dent et al. 2004). Since the late 1980s, there have been at least seven substantial healthcare reforms and many smaller ones. These reforms have also had some impact on hospital governance in Germany. The reforms in the sector have restructured both the funding system and the organization of work with the aim to increase efficiency and cost control (Klenk and Pieper 2012). Also during the 1990s the health care sector was on the German political agenda, with various reform legislation and regulatory interventions addressing different aspects of the statutory health insurance (SHI) (Altensetter and Busse 2005).

According to Gerlinger (2010: 105) German health care policy had a paradigm shift, initiated by the enactment of the Health Care Structure Act in 1992 (Gesundheits-Struktur-Gesetz). The act pursued two different strategies to increase clear-cut cost-containment measures and to introduce more
competition to enhance efficiency, especially between sickness funds and in the hospital sector. But even though there have been reforms in the field of health care since, not many of the reform elements have affected the structure or governance systems of hospitals profoundly, and when they have it have been more indirectly or could be understood as adaption to new conditions, either due to legal or financial mechanisms.

Germany has so far not implemented sweeping structural reforms but has instead opted for a sequence of incremental reforms primarily modifying the financial incentives facing providers and patients (Hommel 2002). To summarize the output of the reforms in the period from 1988 through the 2000s, cost containment has been the major objective. The major change was the introduction of the diagnosis-related groups (DRG) reimbursement system with the Statutory Health Insurance Modernization Act (*Gesundheitsmodernisierungsgesetz*), which came into force in 2004. Busse and Riesberg (2004) show that the main political interventions in health care have primarily occurred when the SHI had financial deficits, resulting in the sickness funds and health care providers to pursue a goal of cost-containment. The overall evidence is that the German sickness funds have not been effective at controlling medical costs.

It can be argued that it is more appropriate to speak of one long incremental reform since 1992, instead of several separate reforms (Gerlinger and Schmucker 2009, Pannowitsch 2009). Pannowitsch (2009) argues that every single reform and act seems to be only one step, which in itself does not end the reform process, but which is another step in the direction of the next reform. In a more general way or at organizational level, it is possible to classify some of the reform elements under a New Public Management (NPM) reform umbrella (cf. Hood 1991).

**The German health care sector**

In this section the regulatory framework, funding, organization/ownership and management related to the hospital sector in Germany will be presented. The reasons for choosing these dimensions are that they are assumed to have consequences for the accountability relations, for instance the different elements can reveal the kind of information provided or at least demanded in these relationships (procedural (legal) information, financial information, and product (functional) information), the nature of the obligation (vertical, diagonal and horizontal) and formal and informal relations.
Regulatory framework

Germany is a federal republic consisting of 16 Länder (states), each of which has a constitution consistent with the republican, democratic and social principles embodied in the national constitution (known as the Basic Law or Grundgesetz). The German constitution requires that living conditions shall be of an equal standard in all Länder. However, health promotion or protection is not specifically mentioned as a goal. Specific topics relevant to health are included in the concurrent legislation, i.e. social benefits, measures against diseases that threaten public safety, certification of physicians and other health professions and the economy of hospitals (Simon 2010).

Health is not an area exclusive to federal legislation, and many aspects of health are the responsibility of Länder. However, federal law takes precedence over Länder law. This sharing of decision-making powers between Länder, the federal government and legitimized civil society organizations is a fundamental facet of the German political system, and the health care system in particular (Spranger 2011: 19). In this paper it has not been examined to which degree the state legislation varies among the 16 Länder.

At the federal level the legislation, namely the Hospital Financing Act (Krankenhausgesetz) of 1972, which was amended through the 2007 Hospital Configuration Act (Krankenhaustzungsgesetz), defines overarching goals of all hospitals included in a regional hospital plan. Beyond this, there appears to be no explicit process of goal setting or determining the future direction of health care organization at federal or state level (Ettelt, Fazekas, Mays, Nolte 2011: 53). The ministry responsible within the federal state has to work out the hospital plan under participation and consultation with the regional associations of the German Hospital Federation (Deutsche Krankenhausgesellschaft, DKG) as well as with the regional health insurance funds. In recent years the federal state administrations have also increasingly involve consulting firms and research institutes in the planning process (Schulten 2006). But in the end decisions are taken at the politico-administrative level.

Further on, the health care sector in Germany features some other interesting characteristics. The health care system is dominated by its statutory health insurance (SHI), making it a Bismarckian system with a compulsory social insurance in which health funds are financed by payroll deductions with mixed public and private providers (Moran 2002). In the German case, the system is also described by the notions on self-governance, self-regulation and self-administration within the legal framework. Physicians and the representatives of both health insurances and hospitals are granted institutional rights and hence they are also greatly involved in health policy. Both Länder and the federal level provide a legislative framework, but the implementation and the negotiations on details of prices and offered services are left to the actors of self-administration (Klenk and Pieper 2012: 5).
The most comprehensive legislation which lays out the stakeholders in the German health care sector is the Fifth Social Code (Sozialgesetzbuch V) (Busse, Nimptsch, Mansky 2009). The regulatory framework provides hospitals with accountability relationships to patients, governments on both state and regional level, the sickness funds and quality assurance agencies.

**Funding of hospitals**

Hospital funding in Germany is based on a two pillar system. The first is consisting of the statutory health insurance funds as well as of the private health insurance companies which are both responsible to cover the costs for the treatment of their patients and operating costs. The second pillar is the Länder which are responsible for the maintaining of hospital infrastructure. This means that they are responsible for investment in the sector, which they do through hospital plans and their funding. Hospitals that are considered to be necessary to provide equal and nationwide access to hospital care are eligible for public funds, as long as they are accredited in the Länder hospital plans. The investments are paid for independently of actual ownership of the hospitals and according to the priorities of the Land government. While the responsibility for major investments, such as buildings and large-scale medical technology, is undisputed, sickness funds are responsible for financing building maintenance and repair (Busse and Riesberg 2000: 41).

But as Klenk and Pieper (2012: 5) points out, the reorganization in the wake of the introduction of DRGs goes far beyond a mere change of payment practices: it has pressed ahead the managerialization of internal hospital governance. This funding system has contributed to an increase in administrative complexity as it requires detailed information on several aspects of diagnosis and treatment of diseases (cf. Mosebach 2009).

After the introduction of DRG reimbursement system there has also been a shift in ownership structures in the German hospital sector. The abolishment of the full cost coverage principle has especially affected public hospitals. Against the backdrop of already limited financial scope of action, many local communities and cities had difficulties to afford to subsidize their hospitals after the shift to the DRG-system (Klenk and Pieper 2012: 5). To sum up this sketch of hospital funding in Germany it can be argued that the cost pressure and funding system would make it favourable for Länder with financial deficits to privatize their hospitals. The change in ownership structure will be presented in the next section.
Organization of German hospitals and ownership

A key feature of the health care delivery system in Germany is the clear institutional separation between (1) the public health services, (2) primary and secondary ambulatory care, and (3) hospital care, which has traditionally been confined to inpatient care. Since 2004, hospitals have been granted additional competencies to provide care to outpatients that require highly specialized care on a regular basis (Busse and Riesberg 2004: 104).

Regarding the ownership of the hospitals Germany has a mix of public (usually meaning ownership by local governments), non-profit and for-profit hospitals. There are three main groups of hospitals: (1) Public hospitals (Öffentliche Krankenhäuser), which are run by the local authorities, the towns and Länder, but are mainly organized as enterprises. (2) Voluntary non-profit hospitals (Frei gemeinnützige Krankenhäuser) operated by the churches or non-profit organizations, e.g. German Red Cross. (3) Private Hospitals (Privatkrankenhäuser) are managed as free commercial enterprises. Non-profit hospitals are also considered to be private, i.e. non-public, but in contrast to private hospitals, they are run by non-profit organizations such as churches (Statistisches Bundesamt 2012: 3). The public hospitals can be organized as entirely public or as enterprises. The enterprise form can be either GmbH (Gesellschaft mit beschränkter Haftung), a company with limited liability) or a gGmbH (Gemeinnützige GmbH), which are companies which because of a non-profit-status get some tax benefits). For a hospital to be considered public 50 % of the nominal share capital or voting rights must belong to some level of government (federal, provincial, districts, counties or municipalities) (ibid).

The proportion of public hospitals is 30.5 %, and the share of non-profit hospitals is 36.6 %. Privatization is another important feature of the German health care system, and the share of private hospitals was 32.9 % in 2011. Even though the majority of hospitals in total are private and non-profit about half of the patients are treated at public hospitals and public hospitals also account for half of all beds (Statistisches Bundesamt 2012). Public hospitals tend to be larger, than non-profit and private hospitals.
Table 1: Ownership of German hospitals in 2011

<table>
<thead>
<tr>
<th>Types</th>
<th>Owners</th>
<th>Percentage of hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public hospitals (Öffentliche Krankenhäuser)</td>
<td>Local authorities, towns and Länder</td>
<td>Public 30.5 %</td>
</tr>
<tr>
<td></td>
<td></td>
<td>GmbH</td>
</tr>
<tr>
<td></td>
<td></td>
<td>gGmbH</td>
</tr>
<tr>
<td>Voluntary non-profit hospitals (Freigemeinnützige Krankenhäuser)</td>
<td>Churches or non-profit organizations</td>
<td>36.6 %</td>
</tr>
<tr>
<td>Private Hospitals (Privatkrankenhäuser)</td>
<td>Free commercial enterprises</td>
<td>32.9 %</td>
</tr>
</tbody>
</table>

Source: Statistisches Bundesamt 2012

Even though the funding and enterprise model is incorporated independently of the ownership of the hospitals it can be argued that the different types of hospitals are subject to different accountability mechanisms and relationships. The regulation of the hospital sector in Germany is the same for public, non-profit and private hospitals since it is the Länder who decide if a hospital should be included in the hospital plan, and thereby enabled for funding. Still from a accountability perspective, there is a difference between being accountable to the public or to shareholders of a private enterprise.

Management of public hospitals

The German health care sector is diversified in terms of the internal organisation of public hospitals and the internal organizational structure of hospitals may vary according to the Länder legislation (Kampe and Kracht 1989). However, it is still possible to identify some fundamental common features of public hospitals in Germany.

German corporations are required to have separate management boards (Vorstand) and supervisory boards (Ausichtsrat), and this is also the case of publicly owned hospitals. This is done to reflect co-determination and the element of representation in the hospital sector. In the hospital system it is primarily based on the participation of elected political appointees in the supervisory boards of public hospitals (Mattei 2007: 380). Some of the Länder have detailed provisions with regard to the composition of management boards for public hospitals, but management and supervisory functions are normally devolved to municipal level authorities.
The public hospitals’ supervisory boards usually consist of representatives for health affairs from the local authorities, local councils, and members of the professional groups of the individual hospitals. In the case of most German public hospitals, elected politicians are members of the supervisory boards. In many cases the director of the board is the Landrat in the Landkreis, which is a level between Länder and counties, or mayors. The Landrat can be directly elected by the county citizens or chosen by the district council. The supervisory boards’ responsibilities included the supervision of the legality of rules and procedures, the cost efficiency of the public enterprise, the attainment of targets by the management board (Mattei 2007: 381). The supervisory board has full discretion over the appointment of the members of the management board, including the approval of the elected medical director. Supervisory boards are responsible for appointment of the members of the hospital management board and approval of the budget. Thus, the supervisory board plays more than a symbolic and advisory role (Mattei 2009). Hence, elected councillors represent an important element of the governance structure of public hospitals.

**What does all this entail?**

The regulatory framework, the funding management and the organization of hospitals has importance for understanding the accountability relationships that can emerge for the German health care sector. Related to the concept of accountability it is possible to identify several actors and forums, which can have both informal and formal relations in the outline of the German hospital sector presented above. The hospitals have clear accountability relationships to sickness funds, patients, owners, associations, local, regional and federal government. Table 1 show some of the main actors relevant for hospitals.

**Table 2: Regulations and actors in the public hospital sector**

<table>
<thead>
<tr>
<th>Regulation (accountable for “what”)</th>
<th>Actors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital planning</td>
<td>Governments of Federal States under participation of regional health insurance funds and hospital providers.</td>
</tr>
<tr>
<td>Hospital financing (Investment costs)</td>
<td>Governments of Federal States in consultation and negotiations with hospital providers.</td>
</tr>
<tr>
<td>Hospital financing (Operational costs)</td>
<td>Health insurance funds in negotiation with hospital providers.</td>
</tr>
<tr>
<td>Ownership</td>
<td>Municipalities, districts, states or regions has majority of shares or board members.</td>
</tr>
<tr>
<td>Management</td>
<td>Combination of professionals and elected representatives in the hospital boards.</td>
</tr>
<tr>
<td>Quality of services</td>
<td>Independent associations and agencies, member associations and patient association.</td>
</tr>
</tbody>
</table>

Actors relevant within political accountability are in bold. Source: Own compilation
Political accountability in the hospital sector

Public institutions are frequently required to account for their conduct to various forums in a variety of ways. The point of departure for this paper is that an actor can be accountable to multiple actors, whom all can pose judgements which may have consequences for the actor. In the following sections I present political accountability relationships in the German hospital sector.

The outline above shows that the hospitals in Germany enjoy a high degree of autonomy within the semi-corporatist system of self-governance. As mentioned, political accountability is built on delegation of sovereignty by voters to elected representatives, and further on to cabinet of ministers and the civil service. In the German case there are direct accountability relations between public hospitals and politicians, and lastly the electorate or citizens, even though the hospital sector has a high level of autonomy.

In the eyes of the citizens it is possible to identify two strong chains of political accountability. Firstly, the Länder level is responsible for the hospital plans which include the investments and changes in the hospital sector, this entail citizens possibility to reward or sanction the political parties in charge through elections or interest groups at Länder level. The legislation states that hospitals need to be included in a regional hospital plan to qualify for SHI reimbursement and to receive financial support for investments from their Länder government. Contents and methods of the hospital plans differ substantially among states. Regulation of capacities is planned according to the principles of need, but the criteria differ considerably (Busse and Riesberg 2004).

Secondly, the hospital boards (both management and supervisory boards) must answer to the local councils. Further on, the local council can change the composition of the boards and politicians often function as chairpersons of the advisory boards. The managers have to account to elected representatives. Also at this level citizens can therefore voice their opinions, as at Länder level. But since the Land often covers many hospitals in many different districts, it is more likely that citizens reward or sanction politicians at local level, because they both appoint boards and are more linked to the daily operations of the hospitals.

This makes a dualism for political accountability as both Länder and local level can be hold accountable. The Land level controls the level of investments, but even though, local politicians in the boards may have to answer to their local communities for a closure of a hospital. Also, in Germany, hospital privatization often faces public protest (Böhlke, Gerlinger, Mosebach, Schmucker and Schulten 2009). This opens for the possibility for conflicts between local/regional and Länder
level. Also, different party or party coalitions at Länder level and local level may influence the level of conflict.

A third chain of political accountability could be included, namely the federal level. But since much of the legislation and regulation on the field is devolved to Länder level, combined with the strong corporatist elements in the sector (cf. the role of the Federal Joint Committee), it can be described as a weak chain of political accountability. This opens for another side of political accountability. Not least for the reason of blame avoidance, major responsibilities for health care administration have been shifted from parliament to semi-public corporatist actors, such as the Federal Joint Committee (Gemeinsamer Bundesausschuss), according to Klenk and Pieper (2012: 14). Instead of parliament, the Federal Joint Committee and other bodies in the system of self-administration can call health care providers to account. There is also another aspect regarding blame avoidance. Responsibility for hospital planning is described in the federal and Länder legislation. Länder governments are legally responsible for planning hospital capacity. However, the federal legislation does not prescribe how and to what extent states have to be involved in planning or how they can be held to account. As shown by Ettelt, Fazekas, Mays and Nolte (2011) the Länder government can delegated the implementation of the hospital plan to lower tier authorities (such as district governments) and, eventually, hospitals and regional associations of sickness funds.

As mentioned earlier, the hospital sector in Germany has a decline of public hospitals and increase in private for-profit hospitals. This privatization process can be interpreted as a political strategy to avoid responsibility for the quantity and quality of hospital services. Especially this may be the case in districts with a strained financial situation, where privatization can be viewed as a way to get rid of the deficits on the budgets, but also the responsibility for the hospitals.

Lastly, Behn (2001) argues that NPM shifts the focus to business efficiency and accountability for performance without paying much attention to political accountability. It is also argued that NSM/NPM reform elements tend to shift the balance away from traditional forms of public accountability (cf. Dent 2005, Mattei 2009, Wollmann 2010). But in the case of public hospitals in Germany the political accountability relationships and mechanisms appear to be strong, even though the system of self-administration moves responsibilities away from political to corporatist forums. These political relationships can be described as horizontal as they are based on hierarchy and/or have principal-agent elements in them.
Conclusion

The aim of this paper has been to describe the political accountability relationships for publicly owned hospitals in Germany. In this paper the reform activity in Germany since the late 1980s has been presented. Based on the accountability framework a description of the regulatory framework, the funding of hospitals and organization of hospitals followed. This paper argues that the regulatory framework, funding, organization, ownership and management of public hospitals in Germany affect political accountability. And finally, different accountability relationships and how they are manifested has been presented. This paper argues that the German hospital sector consists of multiple and interrelated accountability relationships, which may have unintended consequences for the governance of hospitals (and in the end, political legitimacy).

The accountability relations in the German health care sector can be describes as a tangled web, even when just focusing on political accountability. Whether this has positive or negative effect on political legitimacy or is good or bad for democracy can be discussed, but is not within the scope of this paper.
References


---

\(^{i}\) Tangled web is a reference to Romzek (2011)

\(^{ii}\) Even though, for instance, Bode (2010) points out that ownership plays less of a role due to the funding system, cost pressure and increased competition. “Public” is only used on the delivery side, as for instance public hospitals, while public funding through the sickness funds is labelled “statutory”. The sickness funds have been said to transcend public and private categories since they are private in formal ownership, but public in their responsibilities and liabilities (Busse and Riesberg 2004: 54).

\(^{iii}\) Bovens (2007) sees legal accountability as an important to public institutions due to formalization of social relations and because there is great trust in both civil and special administrative courts. Further on, he sees legal accountability as the most unambiguous type of accountability, since it is based on specific formal or legal frameworks. This form is mostly associated with the courts, but other scholars as for instance Romzek and Dubnick (1987) this type can also relate to legislators. Administrative accountability is about making those with delegated authority answerable for carrying out agreed tasks according to agreed performance criteria, according to Bovens (2007, cf. Day and Klein 1987). This can include a wide range of quasi-legal forums, exercising independent and external administrative and financial supervision and control. Professional accountability is, by Bovens (2007), viewed as the mechanism of professional peers or peer review. Public organizations often have a large degree of professionals, and different professions are constrained by professional codes of conduct and scrutinized by professional associations or disciplinary tribunals. This type of accountability is particularly relevant for public managers who work in public organizations concerned with professional service delivery, e.g. hospitals. These relationships can have combination of external and internal elements in connection to organization. Social accountability is a relationship which is more direct and explicit accountability relations between public agencies and clients, citizens and civil society. This kind of accountability place pressure on public organizations because they can feel obliged to account for their activities to the public at large, stakeholders, or interest groups (Christensen and Lægreid 2011). But because the possibility of judgement and sanctioning often are weak or lacking, one can ask the question if this is a full worthy accountability mechanism.
For an overview, see Busse and Riesberg 2004, p. 184.

In Germany this trend can better be described as a variant of NPM, called the New Steering Model (Neues Steuerungsmodell) (NSM). This is based on an approach first introduced into German local administration which differs from NPM in as much as the aim is to defend the fundamental principles of federalism and corporatism rather than replace or undermine them (Pollitt and Bouckaert 2000). According to Wollmann (2010: 161) the NSM was originally intended to achieve two objectives: (1) To reshape the relation between local politics and local administration, and (2) apply concepts and instruments borrowed from private sector managerialism to the public sector.

According to Busse, Nimptsch and Mansky (2009: 295) the seven main actors in this system are: (1) The National Association of Statutory Health Insurance Funds (GKV Spitzenverband) is the central organization to represent all sickness funds. (2) The Federal Chamber of Physicians (Bundesärztekammer) is responsible for the qualification of specialist, and all physicians are members of their respective regional chambers. (3) The Federal Association of SHI Physicians (Kassenärztliche Bundesvereinigung, KBV) represents all physicians who participate in outpatient contracts with the sickness funds. (4) The German Hospital Federation (Deutsche Krankenhausgesellschaft, or DKG) represents all public, not-for-profit, and for-profit hospitals in Germany. (5) The Federal Joint Committee (Gemeinsamer Bundesausschuss, G-BA) is the highest decision-making body in the SHI system and is responsible, among others, for defining quality standards for health care services. Its decisions are published in the form of binding directives. (6) The Institute for Quality and Efficiency in Health Care (Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen, IQWiG) is a foundation which has several tasks, but among others provision of information to patients on quality of health care. (7) The Federal Office for Quality Assurance (Bundesgeschäftsstelle Qualitätssicherung, BQS) concentrates on measuring quality in hospitals. The Federal Office for Quality Assurance has been replaced by the AQUA-Institut in 2010.

This section may contain factual errors due to different Länder regulations.

Excluding the city-states of Berlin, Bremen and Hamburg.