Accountability and recent reforms of the Danish health system

Karsten Vrangbæk, draft paper for ECPR, Reykjavik 2011

Introduction

The Danish health system has previously been characterized as relatively path dependent in its development (Vrangbaek and Christiansen 2005). Yet, the past decades have seen a remarkable number of minor and major adjustments culminating with the “structural reform” of 2007. The sum of these changes may lead to a revision of the path dependency perspective, particularly when considering issues of accountability. Accountability can be analyzed from a formal perspective 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” (Bovens 2007).

Developments in the Danish health care system have been analyzed from a number of health economic and organizational perspectives. The system is often characterized as a belonging to the group of NHS or Beveridge type systems financed by taxation and providing universal coverage for all citizens (Strandberg-Larsen et al 2007). The decentralized governance of the system has been emphasized as Denmark, like the other Nordic countries relies on regional or municipal (Finland) authorities for delivering hospital care.

Such broad descriptions of the Danish health system have usually not emphasized the accountability relations within the system. This is remarkable, as the system is strongly embedded in a political-bureaucratic steering context facing general issues of legitimacy and subjected to ongoing changes in the configuration of steering relations between politicians and bureaucrats, state and decentralized authorities, delivery organizations, professionals and the political-bureaucratic chain of control. The claim of the paper is that an accountability perspective can provide important insights into recent developments in the Danish health system and supplement health economic and health system perspectives with more explicit knowledge about the steering mechanisms within the broad structural design.

The paper presents an initial mapping of changes in accountability relations in the Danish health system based on an assessment of reforms and gradual changes in the system over the past two decades. The first research question for the paper is thus: How have accountability relations changed as a consequence of recent reforms and major policy adjustments in the Danish health system?

Mapping accountability changes is an interesting and challenging task in itself. Yet, the emerging picture of accountability relations becomes even more interesting when evaluated against a set of general goals and aspirations for the health system. The perspective then becomes: to which extent do the changing
accountability structures support the general goals of the health system? Are changing accountability structures a result of conscious shifts in objectives, or are they likely to undermine basic goals? The second research question for the paper is thus: do the emerging accountability structures support the general objectives of the Danish health care system?

This paper will focus on objectives related to the democratic governance structure, and will use ideas from the literature on decentralized democratic governance as a focus point for this assessment. Answering the two questions will allow us to assess the more general issue of whether the Danish health system can still be characterized as path dependent in nature, when focusing explicitly on accountability and democratic governance perspectives.

The analysis will be based on secondary sources and particularly the “Health Care Systems in Transition” reports for Denmark from 2007 (Strandberg-Larsen et al 2007) and 2011(forthcoming), supplemented by descriptive analyses presented at the website of the Danish Ministry for the Interior and Health.

A framework for analyzing accountability

Accountability is a fundamental principle in the organization of democratic governance systems. Ideal typical presentations of the parliamentarian steering model present concepts of accountability relations between key actors as an underlying idea (Olsen 1978, Antonsen et al 1992). Citizens/voters are supposed to hold politicians accountable for their decisions through their voting behavior (Ott and Dicke 2000, Harmon 1995). Politicians are in charge of the bureaucracy, and there are both formal and informal rules for the interaction (accountability relations) between politicians and bureaucrats. The Bureaucracy is organized on hierarchical principles and based on formal legal rules specifying responsibilities and tasks. Bureaucrats can be held accountable within the hierarchical system and through the legal system in more severe cases.

Administrative reforms in the past decades have led to important modifications to this ideal typical picture (Mattei 2010, Pollitt and Boukaert 2000). The idea of detailed rules and hierarchical control has to some extent been replaced by NPM based ideas of decentralization and more managerial (and flexible) accountability relations within the bureaucracy in order to promote entrepreneurship (Osborne and Gabler 1989). At the same time markets, contracting and the use of partnerships with private actors have gained importance for delivery of public services, and there is greater emphasis on horizontal and network based policy and delivery structures including both public and private actors (Torfing og Sørensen etc). many of these international trends have been introduced with at specific Nordic flavor building on the existing traditions for decentralized steering and negotiated multi level policy formation (Magnussen, Vrangbæk and Saltman eds 2009).
In spite of many similarities it is also clear that the instruments for securing accountability between the different levels vary between the Nordic countries. One can distinguish between the situation where decentralized levels are governed by their own political assemblies (regional and municipal councils) as in Denmark, Sweden and Finland, and situations, where they are either part of a bureaucratic hierarchy, or semi-independent agencies run by professional managers or politically appointed boards (as in Norway). The fist situation creates complex accountability situations as citizens in principle can hold both national and regional/local politicians accountable for given service delivery decisions. The situation with semi-independent professionally managed entities creates similar issues of ambiguous accountability but between public and private decision makers. – This will be discussed in more detail below.

The many reform efforts in Nordic public sectors over the past three decades have thus created new challenges for the ideal typical perceptions of accountability relations in the parliamentarian chain of command. Catchwords like ”New Public Management”, ”from government to governance” and ”network steering” capture different aspects of this development (Hood 1991, Hjelmar 1998, Pollitt og Bouckaert 2000, Vrangbæk og Jørgensen 2004, Greve 2009, Sørensen et al 2011). Increasingly complex vertical and horizontal interactions challenge the traditional perceptions of accountability practices and create a demand for new accountability forms. The Dutch researcher Mark Bovens discusses different dimensions of ”accountability”, which may be used to analyze the new accountability demands and instruments in the public sector. The starting point is the following definition of accountability:

”Accountability is 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” (Bovens 2007).

A number of sub-dimensions are derived from this general definition. First Bovens distinguishes between political, legal, administrative, professional and social accountability forms depending on the type of forum that is involved ( see also Romzek and Dubnick 1994, and Jabra and Dwivedi 1998 regarding social responsibility). Political accountability is found when the forum is a political entity such as a national parliament, regional or local councils. Legal accountability is related to the judicial system, administrative accountability to the hierarchical, bureaucratic chain of command. Professional accountability is linked to professionally based structures of assessment and peer review. Finally social accountability refers to formal structures where user groups, interest organizations etc. are involved in assessments, user satisfaction surveys etc. It should be noted that the different accountability forms are often combined or overlapping. An example is accountability for medical professionals in public health care systems, which is typically a
combination of internal professional accountability, accountability to hospital management, legal accountability in cases of misconduct, and political accountability for hospital management.

The next question is "who is held accountable" (the subject)? In some situations the answer will be entire organizations in other cases it is individual persons. Individuals may be in positions, where they are held accountable for organizational performance. This will typically be the case in hierarchical structures, where the ultimate responsibility rests with the top management, while lower level actors are held accountable through the hierarchical chain of command.

A third dimension deals with the substance of the accountability relationship. It is useful to distinguish between economic, procedural and output/outcome accountability.

A final dimension from Bovens framework distinguishes between vertical accountability relations where the "forum" has formal power to hold someone accountable and to issue sanctions, and horizontal accountability, where power is more informal, normative and morally based. An example would be accountability to inform the general public through media, and the accountability relations in (voluntary) network governance structures. A third form is labeled "diagonal" accountability and refers to oversight institutions like ombudsmen etc., which do not hold formal hierarchical power, but may be able to activate a formal hierarchical power by referring to relevant ministries or legal institutions. The following table summarizes the key dimensions:

<table>
<thead>
<tr>
<th>Forum</th>
<th>Who can hold someone else accountable?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subject</td>
<td>Who is being held accountable (individuals or organizations)?</td>
</tr>
<tr>
<td>Substance</td>
<td>What is the substance of the accountability relation (economy, process or output/outcome)?</td>
</tr>
<tr>
<td>Direction</td>
<td>Vertical, horizontal or diagonal?</td>
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</table>

The next important question is how to assess such accountability structures? When are particular accountability forms appropriate? Since public health care systems are embedded in democratic decision structures it seems appropriate to judge the accountability structures by their ability to support such democratic decision-making and the legitimate and efficient functioning of the public decision and implementation structure. Based on a democratic governance perspective, one may take general elements from theories of decentralized democracy as a starting point for the discussion. The following table provides an overview of dimensions that are typically mentioned, when discussion prerequisites for well-functioning democratic governance:
I: Democratic participation and efficiency

Well-functioning democratic decision structures which are able to elicit participation and to transform citizen interests into decisions while balancing conflicting interests and long and short term perspectives. Access and transparency are important for citizen participation, while the structural and procedural setup of the democratic decision body is important for the ability to make decisions that balance conflicting interests and take both short term and long term perspectives into account.

II: Steering and governance capacity

Democratic structures that make it possible to steer and control public service delivery according to collectively decided goals and aspirations.

III: Fiscal governance and accountability

An appropriate degree of power to balance income and expenditure (service level). Accountability to the voting population for both income and expenditure levels. Appropriate mechanisms for controlling expenditures and budget keeping.

IV: Functional dimension

A good match between the size of the political/administrative unit and the responsibility for tasks. Finding a size of the political-administrative unit that allows optimal delivery (through benefits of scale and specialization), while at the same time promoting legitimacy (fairness, equity, participation etc)

V: Relational interaction

Ability to interact with other relevant network actors in a mutually accountable fashion

An appropriate degree of autonomy and distribution of decision scope and power across governance levels

Well-functioning mechanisms for coordinating national, regional and local goals and activities.

The dimensions can be formulated and weighted in different ways, but for the present purpose it is sufficient to establish that the first four constitute key elements in traditional accounts of decentralized democracy, while the fifth contains a more explicit presentation of relational dimensions than usually seen in writings on decentralized democracy. A key point in regards to this paper is that at least four of the five dimensions can be linked to accountability mechanisms that can be used to support the dimensions, and thus in a broader sense contribute to the efficiency and legitimacy of the governance structure. The following table illustrates a set of possible linkages between the different dimensions of democratic objectives and accountability forms:

<table>
<thead>
<tr>
<th>Democratic governance dimensions</th>
<th>Forum, form and subject of accountability relation</th>
</tr>
</thead>
<tbody>
<tr>
<td>I: Democratic</td>
<td>Political accountability: Mechanisms for citizens to hold politicians accountable for decisions.</td>
</tr>
</tbody>
</table>
participation and decision making efficiency

II: Steering and governance capacity

III: Fiscal governance (macro level)

V: Relational interaction

| participation and decision making efficiency | Voting and transparency.  
Political and hierarchical accountability: Internal accountability for good procedural practices.  
Adhering to procedural rules, allowing access at appropriate times |
|---------------------------------------------|
| II: Steering and governance capacity | Political accountability between politicians and bureaucrats. Hierarchical accountability within the bureaucracy and of service delivery organizations.  
Legal accountability in regards to contracted service partners.  
Professional accountability to ensure quality levels |
| III: Fiscal governance (macro level) | Accountability to voters for decisions on income (taxation) and expenditure (service delivery) and/or hierarchical accountability to national authorities for income and spending levels |
| V: Relational interaction | Accountability mechanisms to support horizontal relationships (with other public entities), and vertical relationships (with the state level) to ensure an appropriate degree of coordination and monitoring of compliance with national guidelines and agreements. |

It is an important point that pursuing the different dimensions of democratic governance at the same time may create conflicting pressures. For instance to encourage democratic participation may take more time and thus affect the efficiency of governance. Detailed accountability requirements for hierarchical control may weaken professional accountability etc.

The empirical issue now is the degree to which recent reforms in Denmark have challenged accountability mechanisms or established new accountability mechanisms to support the democratic governance dimensions presented in the previous table. In other words what are the implications in terms of accountability of recent governance reforms in Danish health care, and is there a good match between the development in governance objectives and the dominant accountability structures?

**Major health policy initiatives from 2001 to 2010 and their implications for accountability relations**

**A brief overview of the general accountability structure**

The Danish health care system can be characterized as a universal, public integrated system with a relatively high degree of decentralization (OECD 1992, European Observatory on Health Systems 2007). This means that political accountability is a dominant part of the system with a national parliamentary forum holding the Minister of the Interior and Health accountable for the overall health policy and system performance. Yet, the decentralized setup with both regions and municipalities as the managers
of service delivery complicates the political accountability as there are political forums at both of these
d levels. The Regional Councils (County councils prior to 2007) are the formal owners of the hospital systems
and act as the forum for ongoing accountability relations between delivery organizations and democratically
elected representatives. Likewise the municipal councils act as forums for holding municipal health service
delivery actors responsible for rehabilitation, prevention and long term care outside of hospitals. Danish
citizens thus have three political forums that are involved in health care, and which can be held accountable
for different aspects of health care planning and delivery. While the division of labor between the three
forums is relatively clear in principle, many ambiguities remain for citizens at the practical level. If a citizen
is dissatisfied with the service level in a particular region, he or she should in principle address the regional
council either directly, through interest group representation or by expressing dissatisfaction at the next
election. But the regional council operates within a national legislative framework, and economic conditions
for the regions that are largely determined by the state after annual budget negotiations between state and
regions/municipalities. This means that accountability relations between citizens and politicians at the
national level are also highly relevant for health care. Furthermore, many citizens experience issues related to
the coordination of services between municipalities, regional hospitals and (private) general practitioners
(financed by the regions). The key issue for citizens is who to hold accountable for coordination, information
exchange etc.

Administrative accountability is an integrated part of the organization of the political steering at both the
national, regional and municipal levels. At the national level the Minister for the Interior and Health is
appointed by the government, and is accountable to the parliament. The minister is also the head of the
ministry and the bureaucratic staff within the ministry, which is organized according to hierarchical
principles and subject to general legislation regarding administrative conduct, for which it can be held
accountable in both administrative forums and ultimately in the legal system. In this sense there is an overlap
between the political-administrative accountability structures and the legal accountability which serves a
back up for citizens in regards to the system, although this is activated much less frequently than for instance
in the US or Germany.

Another area with overlapping, and somewhat ambiguous accountability relations is in the control of health
professionals (Burau et al 200x). More than 95% of all hospital beds are within regional (public) hospitals.
Regional hospital doctors (and nurses) are salaried employees and thus part of the bureaucratic chain of
command running from regional councils through hospital and department management. However, hospital
staff is also part of a professional community with informal and formal accountability structures. The formal
professional accountability structures are linked to the administrative chain, as they are subject to the
obligation of the National Board of Health to license and control professional conduct. The NBoH relies
heavily on professional forums when developing assessment standards and when holding professionals
accountable in cases of complaints. It is noteworthy that professional accountability mostly takes the form of individual accountability, while the more administrative quality assurance schemes within the Danish health system relies more on systemic perspectives, holding hospitals or departments accountable for living up to procedural and output standards. This is done through clinical databases, patient satisfaction surveys and collection of other quality data through DDKM (the National Danish System for quality improvement). Enforcement is mostly through administrative channels, and to some extent social accountability forms of “naming and shaming”. Hospital and department managers are typically held accountable for quality failures, while explicit individual misconduct is a more personal matter, and may trigger administrative sanctions and ultimately redrawing of license to practice or judicial sanctions.

Social accountability in the form of user satisfaction surveys etc. have been an integrated part of the system for the past three decades. These mechanisms are less direct and formal than the previously mentioned forms, but nevertheless plays a role as parts of “benchmarking “ and “naming and shaming” exercises.

In terms of the substance of accountability relations it is obvious that economic accountability is a key dimension in the relation between state and regions/municipalities, and within the regional steering of hospitals and hospital departments. Historically the steering of hospitals has been based on global budget frames where hospital management, and in turn department management is held accountable for staying within the budget when delivering services. This has increasingly been supplemented by the use of targets for activity levels, service and quality levels. This means that output and procedural accountability forms have become more important within the political-administrative accountability sphere.

The general accountability regime that emerges is thus characterized by a combination of political accountability at several different levels and administrative accountability within the bureaucratic structures related to each level and extending down to the publicly owned and managed delivery organizations. In a sense health care professionals within hospitals are the last part of the political-administrative accountability chain due to their status as publicly employed staff. The situation for practicing doctors and specialists is somewhat different, although their close integration into the regional planning system in reality creates many parallels. Both hospital and privately practicing professionals are also subject to more professional accountability forms both formal and institutionalized through the surveillance of the National Board of Health and more informal through peer review and professional control. The substance of accountability relations in the public health care system is a combination of economic, procedural and output/outcome dimensions. Both procedural and output/outcome dimensions have gained importance over time, as measuring methods have become more sophisticated.
Recent reforms and their implications for accountability structures

The political context for recent reforms in Danish health care is a parliamentarian situation with a liberal/conservative minority coalition government since 2001. The government has been supported by DPP, and the collaboration has been sufficiently tight to create a de facto majority situation for most policy issues.

Health care has been relatively high on the political agenda since the 1990s, and the liberal/conservative government has deliberately continued the policy of “controlled increases in expenditure levels. At the same time, the government has pursued an agenda of reforming the governance structures within health care to allow for more choice, and the development of more private sector involvement in delivery. The government has also focused on using stronger economic incentives for steering within the public health sector. It has therefore pushed for greater use of activity based funding at all levels.

The government, and particularly the Conservative Party and the Danish Peoples party have frequently expressed frustration over the continued dependency on decentralized authorities to implement policies. This has led to demands for changing the governance structure and to a series of gradual adjustments in power, culminating in the structural reform of 2007.

The current PM is the former minister of health, and the main policy entrepreneur behind the structural reform in Denmark.

The general steering structure has been adjusted over the past two decades. The following section presents recent reform initiatives in more detail along with discussions of related accountability issues.

One of the first major policy initiatives from the incoming Conservative/Liberal government was the *Waiting time guarantee* of one month linked to extended free choice of provider. The general waiting time guarantee of one month was introduced as a national policy initiative in 2002. The
guarantee sets the target of maximum one month waiting time for all types of procedures upon referral. If the public hospitals in the patient’s home region are unable to provide treatment within one month then the patient can go to private providers at the expense of the home region. In accountability terms this represents a more explicit right to service than previously, where the public counties/regions could specify their service level independently (although from 1992 with the risk that patients could use “free choice of hospital” to move to another public hospital in the country). Regions are thus “sanctioned” by the economic mechanism of having to pay for treatment in other regions or at private hospitals. Equally important as the economic sanction is probably the more informal (social) accountability mechanism in publishing figures for average waiting times and utilization of the waiting time guarantee. These figures create pressure on hospital management and regional governance structures to adjust to acceptable levels.

Compared to the general accountability regime this opens up a new type of accountability relations b/n voters/citizens and the public system, as they are now able to express their dissatisfaction through voting with their feet in addition to the more traditional channels for political voice.

The waiting time guarantee was linked to another general policy aim namely to promote private provider alternatives. The other main instrument was the introduction of a tax exemption for employer offered health insurance offered as a fringe benefit. Both of these initiatives are national level attempts to strengthen private market alternatives to the regional health systems.

In accountability terms this extended use of private providers creates issues of quality control and coordination of services. While health professionals working at private facilities are subject to the same general, individual licensing and control regime as publicly employed professionals, matters become more complex when looking at the organizational level accountability. While public hospitals are directly subjected to the bureaucratic chain of control, and thus can be held directly accountable for quality and service performance, this is more difficult with private hospitals. Private hospitals are a diversified group ranging from small specialized hospitals to large clinics. It has proven difficult to get uniform and reliable measures of quality to use for accountability relations from all. Since regions deal with several different private hospitals it has also been difficult to follow up and take action against each on an ongoing basis. The general point is a transformation from political-administrative accountability to market based accountability, which is ultimately
backed up by judicial accountability relations, as regions can take private providers to court, although this tends to be a costly and protracted option. Patients/citizens on the other hand may see the schemes as ways of introducing private alternatives, which can serve as a possibility for “sanctioning” the public system, by de-selecting the public hospitals. The social accountability function of this should probably not be underestimated.

Another general policy orientation since 2001 has been to introduce *stronger economic incentives for regions, hospitals and municipalities*. Compared to e.g. Norway the introduction of activity based payment schemes have been more hesitant in Denmark. The general approach has been to facilitate experimentation with activity based schemes within the regions and to use it for “free choice” patients crossing regional borders. A Danish DRG system was developed from 1990 and onwards in order to facilitate this, and to enable more accurate benchmarking across hospitals and regions. Yet, contrary to the Norwegian case the Danish counties were able to hinder a more radical, mandatory introduction of activity based funding until 2001. In 2001 the incoming government introduced a pool of funding of 1.5 billion to increase treatment capacity and reduce waiting lists. This funding was to be distributed to the counties based on documented activity increases. Payments started when a “baseline” activity level was reached, and were reduced to 70% when reaching a given threshold level and to zero after a specified maximum level was reached. This scheme continued the following years with a built in expectation of a 2% productivity increase was expected every year (implemented by raising the threshold level). At the same time the government and the counties entered an agreement in 2004, that set a target of 20% activity based funding for the following years. Although the activity based funding only amounts to a minor part of the total funding it has spurred important changes in the internal management of the health system. While health professionals 20 years ago were largely ignorant (and disinterested) in economic implications of their actions they are now very much involved in DRG coding, and much more aware of the economic implications of the coding. Similarly at department and hospital management levels there seems to be much more emphasis on registration and more concerns with linking costs and benefits of particular procedures in order to assess the economic viability given the level of the DRG rates. The activity based funding pool was continued after the Structural Reform of 2007 (see below) and was supplemented by a financing scheme whereby municipalities pay a fee for hospitalization of
their citizens. The idea was to create incentives for municipalities to undertake more prevention activities.

In accountability terms the most important implication of the increased reliance on economic incentives is probably that economic accountability has become much more central both within hospitals, between hospitals and regions and between regions and the other levels of the political-administrative system. The block grant/global budgeting system established an overall economic accountability while the activity based system makes it much more important for actors at all levels to implement and use economic accountability systems.

“The Structural Reform” of the governance system in 2007 introduced far reaching and radical change of size, tasks and financing of health care and thus established the new administrative framework to support previous reforms. The Structural Reform changed the governance structure for the Danish health care system. Fourteen counties were amalgamated into five new regions and 98 new municipalities were created instead of the previous 279. The municipalities assumed a larger portfolio of tasks including a stronger role for rehabilitation and health promotion. The regions on the other hand were stripped of many activities, and were left with health care as the dominant task, and minor responsibilities for regional planning and social care. The reform also meant a change in the financing system for health care. The regions were denied the right to finance their activities by regional taxation, and a new municipal co-financing scheme for hospital treatment was introduced. The regional activities are now financed by state block grants combined with activity based funding from state and municipal levels.

The accountability implications of the reform are manifold. It is obvious that the reform implies changes in the construction and functioning of the political forums at both regional and municipal levels. The entities became larger and the each regional council became responsible for more organizational units. At the same time the distance between citizens and politicians increases as each politician represents more citizens spread across a wider geographical area. This may negatively affect the more direct (social) accountability forms within the political systems. The accountability form of voting was maintained at all levels (contrary to the Norwegian reform of 2002), but the larger entities reduce the potential influence of each individual vote, and may also make decision structures more opaque. Voter interest in the old counties was not impressive, but has become even lower with the larger regions, which are only just in the process of forming their identities as democratic entities.

Another important accountability issue relates to the relationship between governmental levels. Several analyses have interpreted the reform as a conscious weakening of the regional level by the state (Christiansen and Klitgaard 2010). This was in response to frustration at the national level about being held accountable.
for health care delivery at the decentralized level, but without strong means to control the counties. The reform stripped the regions of their right to issue taxes. This was a strong move towards creating stronger accountability in the sense that regions are now fully dependent upon the state for their income. The reform also strengthened the role of the National Board of Health in terms of setting standards and guidelines, and in terms of evaluating and interfering in regional level practices. The political-administrative accountability between regions and state is thus strengthened both in terms of economic accountability and in terms of procedural and output accountability. But the reform also introduced another interesting set of accountability relations between regions and municipalities in order to encourage municipal health activities and to improve coordination between the two levels. The primary instrument for pushing municipalities to take a stronger role in prevention etc was the introduction of a municipal co-financing scheme covering up to 20% of the total health expenditures at the regional level. The municipalities pay a fee of 34% of the national DRG rates each time a citizen is admitted to a regional hospital. This is supposed to create a stronger awareness of economic implications in the municipalities and to encourage them to develop preventive measures. The idea is also to strengthen the voice of the municipalities towards the regions.

At the same time the state introduced mandatory health agreements between the municipalities and regions to facilitate coordination. The agreements must be entered once in each four year election period, and are supposed to specify collaboration and communication standards for municipal and regional health actors. There is political-administrative accountability built into the system in the sense that the agreements must be approved by the National Board of Health on behalf of the state. The agreements must also include procedural targets and monitoring systems for the joint municipal-regional evaluation of progress.

How did the reform affect the general accountability regime? The overall structure with democratic accountability was maintained, although with significant changes in the political accountability structures within the three levels (state, regions and municipalities) and not least between the levels. The reform aimed to create more transparent accountability structures for voters, but many ambiguities remain. The reform introduced new forms of economic steering and a tightening of the regions’ accountability for delivering service given the more dynamic (and insecure) financing scheme with activity based payments from both the state and the municipal level.

The Structural Reform was followed by a so-called “Quality Reform” from 2007 and onwards. The term “Quality reform” is a political misnomer as it comprises a range of very different initiatives and only a minority dealing with quality per se. One of the initiatives in the reform was the decision to allocate 40 billion d.kr. for new hospital infrastructure. This is the largest single investment in hospital infrastructure in the past decades, and implies that each region must establish a new regional structure with updated hospital facilities. The funding will be used to establish new
hospital buildings, or reconfigure existing structures by closing down or amalgamating regional hospitals. The underlying principle is to harvest benefits of scale and specialization by creating larger entities that can support more specialized functions. The money was allocated to the regions through an interesting process where the regions were to compete for funding by developing new hospital plans, which were subsequently evaluated by a national panel of experts established by the government. Access to investment money was thus contingent upon approval from the government (represented by the expert committee). This represents another illustration of the changing accountability relations between regional councils and the state level. It also introduces an interesting relation where politically elected officials are accountable to appointed experts in their decision-making.

Another major policy initiative, which has affected accountability relations, is the introduction of a comprehensive systemic model for quality monitoring and enhancement. (Vrangbaek 2007, Knudsen et al (ed.) 2008). The model builds on regional and local quality initiatives dating back to the early 1990s, but was amalgamated and expanded into a comprehensive model covering all parts of the health care system during the 2000s. The scheme combines accreditation by external reviewers, clinical databases and user satisfaction data. General results are published on the Internet, and used as a basis for both external benchmarking and internal organizational development.

The system has been supplemented by a number of other initiatives that illustrate the same basic approach to quality enhancement. The first is an emphasis on life threatening diseases based on the realization that Danish patients experienced poorer treatment results than in comparable countries. This has led to the introduction of several cancer and heart “packages” that combine increased funding with development of detailed patient pathway descriptions and waiting time limits. The regions and their hospitals are monitored and benchmarked on their performance in regards to both the procedural and outcome dimensions of these packages. A similar line of thinking has been applied in developing and implementing patient pathways for chronic care patients. Again there is a focus on procedural and outcome standards e.g. for diabetes patients, and regions are monitored and benchmarked according to these standards.
The following table provides an overview of the initiatives and related accountability issues

**Summary table of reforms and accountability issues**

<table>
<thead>
<tr>
<th>Reform initiative</th>
<th>Accountability issues</th>
</tr>
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<tbody>
<tr>
<td><strong>Waiting time guarantee</strong></td>
<td>Voters get clear targets for holding regional politicians responsible for waiting times. New accountability relations in contract relationships between regions and private providers. Choice and &quot;Waiting Time Guarantee&quot; attempt to create alternative accountability outlets, by giving explicit rights and allowing patients/citizens to &quot;exit&quot;.</td>
</tr>
<tr>
<td><em>(Promoting private provider alternatives)</em></td>
<td></td>
</tr>
<tr>
<td><strong>Stronger economic incentives for regions and hospitals</strong></td>
<td>Hospital managers, department managers and professionals become more responsible for economic performance.</td>
</tr>
<tr>
<td><strong>Structural reform 2007:</strong></td>
<td>New political accountability structures within larger regions and municipalities. More explicit accountability relations between regions/municipalities and state. Municipalities gain economic power in regards to regions. This can be used to strengthen accountability relations. Mandatory health agreements b/n regions and municipalities, subject to approval by the National Board of Health illustrate stronger accountability links b/n state and decentralized authorities as well as more focus on procedural accountability.</td>
</tr>
<tr>
<td>-Establishing new regions and municipalities</td>
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<tr>
<td>-Changing tasks and responsibilities</td>
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<tr>
<td>-Changing financing</td>
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<tr>
<td>-Strengthening national level steering</td>
<td></td>
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<tr>
<td><strong>Quality reform 2007</strong></td>
<td>Accountability relations between state and regions and between regional politicians and expert committee at the national level.</td>
</tr>
<tr>
<td>-Hospital infrastructure investments</td>
<td></td>
</tr>
<tr>
<td><strong>Quality monitoring and enhancement</strong></td>
<td>Professional accountability forms are embedded in more systemic administrative accountability systems combining procedural and output/outcome dimensions. Social accountability through publication of accreditation results and quality data to the public in general and benchmarking with similar organizations</td>
</tr>
<tr>
<td>-Patient pathways and &quot;cancer packages&quot;</td>
<td></td>
</tr>
<tr>
<td>-Accreditation and standards</td>
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**Discussion**

Summing up we see a number of reform initiatives that have implied changes in accountability mechanisms. Although many elements of the political and administrative accountability structures have been maintained, many elements have changed within this structure. In addition a number of general development trends can be identified. Firstly a move towards greater reliance on economic incentives and a combination of market accountability (through choice) and more flexible administrative steering systems where formal hierarchical accountability is replaced by procedural and output/outcome related accountability. Secondly a shift towards stronger emphasis on procedural and output/outcome related accountability in the public system.

Thirdly a layering of accountability principles for health care professionals which means that traditional professional accountability is combined with systemic administrative accountability.
relations manifested through accreditation and quality control systems. Fourthly a development, where professionals are no longer just held accountable for the clinical substance, but are increasingly engaged in economic and output based accountability forms. Fifthly, a gradual reconfiguration of the balance of power between the different levels in the multilevel governance system. This implies the introduction of more strict accountability relations between state and decentralized authorities. The reconfiguration also implies new types of second order accountability, where the state holds both regions and municipalities accountable for establishing mutual coordination and adequate horizontal accountability relations to support this e.g. via the mandatory health agreements.

Taken together these six changes constitute the contours of an emerging new accountability regime with more complex and layered accountability forms, and where political-administrative accountability changes and interacts in new ways with professional and market based accountability. Judicial accountability is not yet as prominent, as e.g. in the US health system, but the introduction of more explicit rights, may be a first step in this direction. It can also be argued that the increased use of market based steering has judicial accountability systems as a necessary precondition in order to secure contracts and rights between more independent actors.

How can we assess these changes in regards to the overall objectives of the public health system? Returning to the dimensions listed previously we can argue that democratic participation and efficiency is influenced by the creation of larger political entities, which creates greater distance between the voting population and the decision makers at municipal and regional levels. The intention with the Structural reform was to counterbalance such potential problems by introducing a more transparent division of labor and a better functional relationship between size (geography and population) and the delivery structures, thus contributing to greater output legitimacy by enhancing efficiency through benefits of scale and specialization. So far it is somewhat unclear if that has been the case. Output legitimacy may have improved somewhat as waiting times have gone down, but there are continuous issues of quality and service levels in general. – There are also persistant issues of unclear accountability relations for the voters in terms of service level decisions. While regions are responsible for the specific planning and delivery, they operate within stricter accountability structures vis a vis the state both in terms of financing and organizational dimensions. The steering capacity of the state is therefore arguably enhanced, although there are still examples of (implementation) gaps between national steering ambitions and regional service delivery. The final dimension deals with relational dimensions in the system. The Structural Reform was supposed to reduce coordination problems and facilitate smooth patient pathways. Yet, it is clear that such issues remain important, in spite of the second order accountability steering with mandatory health agreements and various other coordination efforts.

Do the changes mean that the Danish health care system has embarked on a new development path? This is not yet clear, although obviously there is a significant adjustment of some elements of the previous steering structure and related accountability forms.
References:


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