**Dorothea Greiling and Eveline Häusler**

# Stakeholder accountability of Austrian and German health insurance funds

*accountability, annual report, case study, comparison; competitive factors, statutory health insurance*

*Over the past two decades Austrian and German statutory health insurances (SHIs) have been through an era of reforms aiming at transforming them into more entrepreneurial public service providers. In this context the issue of stakeholder accountability has been widely ignored. This deficiency is surprising as accountability is one of the cornerstones of New Public Management and an element of good governance. SHIs should report on how efficiently and effectively they have carried out the mandated tasks. The lack of research on accountability practices serves as a motivation to take a closer look at the annual reports of SHIs in Austria and Germany. Our analysis shows that financial accountability has evolved gradually but that stakeholder accountability, especially towards (potential) members and health care providers as contract partners, has not advanced very well yet.*

## I. Introduction and research questions

Statutory health insurances (SHIs) have complex mandates and governance structures in both countries. In Austria and Germany they are financially independent but bound in their activities to legally mandated tasks. With respect to performance accountability, this leads to a high level of complexity as the accountability of SHIs should not be restricted to financial aspects, but should also ask how efficiently, effectively and equitably SHIs have carried out their tasks.

In the past decade Austrian and German SHIs have been through an era of reforms aiming at transforming them, to a varying degree, into entrepreneurial public service providers. Nowadays German SHIs play a more and more active role in managing health care and making full use of the entrepreneurial freedom opened up to them especially within selective contracting programmes (Greiling/Häusler 2011, pp. 174). Regarding Germany, the financial risk for SHIs has increased and they are no longer protected against bankruptcy. In this context financial accountability has evolved gradually (Art. 1 N°7 and Art. 2 N°1 GKV-OrgWG, Art N° 2 GKV-VStG).

The general reform agenda of SHIs is reflected in a substantial body of literature. In the German case, a significant body of economic and legal literature evolved after competition among SHIs was implemented by law in 1993 dealing with the consequences regarding effectiveness and efficiency of the German health care system (Wille 1999, Jacobs/Schultze 2004, Busse et al. 2011, Becker/Schweitzer 2012, SVR 2012). By contrast, the managerial implications for SHIs are discussed in a much smaller body of literature (for an overview Gapp 2009), primarily

focussing on marketing aspects (Haenecke 2001, Scheffold 2008, Scherenberg 2011), strategic management (Meckel 2010) or performance and operations management (Lucht/Amshoff 2012, Matusiewicz/Brüggemann/Wasem 2012).

So far, if one excludes legal commentaries and manuals for practicing experts, the issue of accountability has widely been ignored (e.g. Unterhuber/Demmler/Zacher 2014). This is surprising as accountability is one of the cornerstones of New Public Management (NPM) and an element of good governance. New forms of accountability such as managerial, citizen, member or professional accountability have been established as additional forms without abolishing the more traditional forms of accountability (Greiling/Spraul 2010).

In this paper, the lack of research on accountability practices as a precondition for good governance in statutory health insurance serves as motivation for taking a closer look at the accountability reports of SHIs. In the past decades SHIs have actively pushed for tight monitoring of the performance of health care providers. Therefore, it is now time to examine how SHIs themselves perform with respect to accountability.

Given this status quo, our contribution focuses on the following research questions:

- Whom do Austrian and German statutory health insurances regard as their main addressees with respect to stakeholder accountability?
- How balanced is the stakeholder accountability?
- Are the SHIs on the way towards good governance?

In order to address these research questions section II. focuses on stakeholder accountability as well as the structure and recent reforms in Austrian and German SHIs. Section III. gives an overview of the research methodology. The findings are presented in section IV. which is followed by a discussion of the findings in section V. Conclusions and directions for further research are presented in section VI.

## II. Stakeholder accountability and reform agenda in statutory health insurances

### 1. Stakeholder accountability

NPM reforms have increased the accountability obligations for public service providers in the past decades. As NPM emphasises cost control, transparency and the decentralisation of management authority, enhancing accountability is a crucial element to ensure the quality of public services provided (Power 2001, p. 43) and to increase trust (Greiling 2014).

The many faces of accountability are rooted in the fact accountability in itself is an ambiguous and elusive concept. The Organisation for Economic Co-operation and Development (OECD) regards accountability as one of the key policy levers (OECD 2005, p. 11). A narrow understanding regards accountability as "a relationship between an actor and a forum in which the actor has the 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, p. 450). According to Kearns, accountability can be understood as "a wide spectrum of public expectations

dealing with organisational performance, responsiveness, and even morality (…) [which] often include implicit performance criteria (…) that are subjectively interpreted and sometimes even contradictory. (…).The range of people and institutions to whom public and non-profit organisations must render account includes not only higher authorities in the institutional chain of command but also (…) many other stakeholders" (Kearns 1996, p. 9).

Kearns (1994 and 1996) has developed an accountability framework for nonprofits which is suitable for SHIs, as they are not shareholder value-orientated either. The framework focuses on strategic and tactical implications of accountability. It comprises two dimensions: first, a set of (explicit or implicit) performance standards generated by the NPO's strategic environment and second, a (reactive or proactive) response from inside the organisation. This leads to four dimensions of accountability (Kearns 1994, pp. 188):

- *Compliance accountability*: This is the most narrowly interpreted and reactive form of accountability. This dimension includes the legal compliance as well as the compliance with contractual obligations.
- *Negotiated accountability*: This reactive tactic comprises contexts where standards of accountability are implicit, i.e. its underlying values and beliefs have not yet been codified in law or regulations. It involves some form of negotiation with other stakeholders about performance reporting obligations.
- *Professional/discretionary accountability*: Here an organisation responds with proactive strategies to implicit performance standards. It tries to internalise professional standards to react to shifting societal norms in a discretionary manner. Typical examples are codes of conducts, accreditations or certifications.
- *Anticipatory/positioning accountability*: Here organisations seek to influence their external environment as they can foresee the imposition of explicit performance standards. The executives try to either influence legislation or to anticipate the formulation of standards and position themselves proactively.

In line with stakeholder theory (Freeman 1984), stakeholder accountability focuses on the accountability to an organisation's stakeholders. The most often used classification of stakeholder identification is the one by Mitchell, Agle and Wood who uses power, legitimacy and urgency as criteria (Mitchell/Agle/Wood 1997). It is still an open within stakeholder identification of where to close the system is still open. Other problems such as how to specify the stakeholder-value created and how to balance conflicting stakeholder interests also arise (Wall/Greiling 2011).

In his seminal contributions Kearns (1994 and 1996) had only one crucial stakeholder in mind, namely a standard setting body, mainly the legislator. In line with strategic management concepts it called for a widening this focus by including other stakeholders: In a competitive environment it is necessary that SHIs strategically strengthen their market position with respect to the insured (members and co-insured family members) and other customers, especially members' employers, employees and, in a selective contracting-environment, health care providers including the respective professional bodies which take part in the negotiations with the social security institutions. Recalling that SHIs are membership-based organisations it is obvious that members are the primary principals. As SHIs carry out legally mandated tasks, they are under special legal supervision by various public regulatory bodies. The supervisory board, the management board and the employees are relevant internal stakeholders in SHIs. In general, SHIs

have a more complex stakeholder structure than for-profit-entities of similar size because they have, according to Cormier and Gordon (2001), a contract with society that is crucial for legitimising their actions.

Stakeholder accountability in statutory health insurances is exacerbated because, unlike in for-profit, there is no single bottom line for ascertaining performance. The measurement process is often convoluted due to the need to satisfy different stakeholders.

## 2. Austrian statutory health insurances

In Austria 99.9 % of the population are members of one of the 19 SHIs. The Austrian SHIs system is based on the principles of compulsory insurance, solidarity and self-governing with insurance contributions amounting to 79 % of the SHIs' income (HVB 2014). Another 13 % comes from the Federal government for contingent liabilities and 8 % from other income sources, mainly patients' co-payments. SHI is mandatory in Austria. The contributions to SHIs are lower than in Germany. Unlike in Germany the insured persons cannot elect their representatives in the government bodies of the SHIs directly. Since the early 1930 s there is an indirect representation via persons from representative bodies (e.g. chamber of commerce, chamber of labour, unions) and more recently via patient ombudspersons (Hofmarcher 2013). There is strong opposition in the SHIs against introducing a yardstick competition among each other (Trukeschitz et al. 2013).

Access to health care services is regulated by law with the General Social Insurance Act (ASVG) being the most important one. A standardised minimum benefit package across all SHIs is defined by the ASVG (Hofmarcher 2013). Neither this package nor the level of the monthly contribution can be changed by SHIs. Voluntary services by SHIs are possible but play a negligible role. Divergences between SHIs mainly occur in the percentage of patients' co-payments. Since 1960 there is an interregional health insurance equalisation fund. It has only been accessible to provincial SHIs (so called GKKs) since 2004. 2 % of the GKKs' contributions are earmarked for this fund. Table 1 shows the branches and institutions forming the Austrian social insurance system.

<table>
<tr><th colspan="3">Federation of Austrian social insurance institutions<br>Hauptverband der österreichischen Sozialversicherungsträger (HVB)</th></tr>
<tr><th>Accident insurance</th><th>Health insurance</th><th>Pension Insurance</th></tr>
<tr><td rowspan="3">Accident insurance institution (AUVA)</td><td>9 provincial SHIs (GKKs)</td><td rowspan="2">Pension insurance institution (PVA)</td></tr>
<tr><td>6 company SHIs (BKKs)</td></tr>
<tr><td colspan="2">Insurance institution for the self-employed (SVA)</td></tr>
<tr><td colspan="3">Insurance institution for Austrian railways and mining industries (VAEB)</td></tr>
<tr><td colspan="3">Social Security Insurance institution for farmers (SVB)</td></tr>
<tr><td colspan="2">Insurance institution for public sector employees (BVA)</td><td></td></tr>
<tr><td colspan="2"></td><td>Insurance institutions for Austrian notaries</td></tr>
</table>

*Table 1: Austrian social insurance institutions*
*Source: Feninger (2013, p. 9)*

The nine provincial SHIs are the most important ones as they insure around 76 % of the population. The six BKKs insure only 0.6 % of the population.

Until 2009 the SHIs had accumulated more than EUR 2 billion in debts and were forced by the federal government to reduce structural deficits in the years 2010 to 2013. Federal authorities created a tax-funded Structural Health Fund for SHIs from which SHIs could draw money from, if they reached the annual consolidation targets. With this fund the federal government temporarily gained a strong financial leverage over the SHIs (Hofmarcher 2013). By the end of 2013 the SHIs had outperformed the government imposed deficit-reduction targets and had accumulated a surplus.

The Federation of Austrian social insurance organisations (HVB) is an umbrella organisation with complex governance structures in line with the Austrian corporatist system, the social partnerships. Through model statutes the HVB has been trying to establish an equal application of social insurance regulations in Austria. Nearly all presidents and vice presidents of Austrian social insurances are members of the Conference of the Social Security Institution, which is the supreme body of the HVB. De facto the HBV is kept on a "short leash" by its members (Trukeschitz et al. 2013) which makes its coordinating role difficult. On the federal level, supervision of the SHIs is mainly carried out by the ministry of health. The supervision of the HVB is divided between federal ministries. The monitoring rights of the federal ministries include an examination of the cost-effectiveness and whether these institutions are fit for purpose (Hofmarcher 2013). In the past decades the Austrian federal government has sometimes used its supervisory competencies to overrule decisions by the HVB (Tomandl 2005, pp. 181). Austria has a strong tradition as a corporatist welfare state and in cooperative federalism in health care, too. This brings along a multi-stakeholder orientation with wide power differences between different stakeholder groups.

## 3. Enforcement of an entrepreneurial business model in Germany

In Germany the wave of liberalisation in the 1990 s not only changed the rules of the game for private insurance companies (Koehne 1998, p. 143), but also opened the formerly (almost) competition-free world of SHI to the harsh winds of competition. Subsequently, the number of SHIs dropped from 1,221 in 1993 (Statistisches Bundesamt/Robert-Koch-Institut 2014) to 132 in 2014 (GKV-Spitzenverband 2014). To implement competition within the Social Security framework, financial flows were re-organised. The so-called Health Fund (Gesundheitsfonds) at federal level collects income-related premiums from the insured (level of solidarity) and transforms them into risk-adjusted, standardised payments to SHIs (level of equivalency). If risk-adjusted payments by the Health Fund do not cover the expenses of individual SHIs, they have to charge an additional premium from their members. Or, in the reverse scenario, if risk-adjusted payments exceed expenses a premium payout to members is possible (Haeusler 2014). The implementation of risk adjusted funding increased the financial risk for SHIs. Especially when taking into account that since 2010 all SHIs can become insolvent (Art. 1 no. 7 GKV-OrgWG), albeit insolvency proceedings are somehow specific (§§ 171b-172 SGB V).

In Germany, insurance with one of the self-governing SHIs is mandatory for the majority of the population. On top of the wide-ranging statutory benefit package SHIs can offer optional benefits (Satzungsleistungen/statuatory benefits) und selectable tariffs (Wahltarife) which increase SHIs economic scope of action. Benefits are predominantly provided as benefits in kind. This obliges SHIs to contract service providers on behalf of their members because the SHIs themselves are not allowed to run their own medical facilities. The contracts for the provision of medical services and goods are generally concluded jointly and uniformly by all SHIs. As a consequence, there is only limited, but gradually increasing, space to shape terms and conditions of contracts individually and to select the contractual partners (so-called selective contracting). Since selective contracting was first allowed, back in 1997, these possibilities evolved gradually (Amelung 2008, p. 7). From a health policy perspective selective contracts are intended to enhance efficiency and quality in the German health care system (SVR 2001, pp. 21; SVR 2012, pp. 312). From a business management point of view, selective contracts can help to develop a brand if SHIs successfully incorporate distinguishable services and quality standards (Nebling 2012, p. 272). These contracts are a tool to reorganise and steer the activities of different care providers along the health care value chain and, subsequently, to offer fund-specific care-management products to the customers (Greiling/Haeusler 2011, pp. 164). The more benefits, tariffs and care-management programmes become diverse, the higher is the importance of transparency. For the insured this also increases the value of reliable support in understanding and dealing with different options. Hence, a component of trust is added to the health insurance product (Haller 1988, p. 562; Unterhuber/Weber 2006, pp. 827).

In conclusion, the relevant parameters of competition are (SVR 2012, pp. 394):

- price (especially in the form of an additional premium or a premium payout),
- quality and organisation of care (e.g. care management programmes),
- scope and kind of optional benefits and
- (administrative) services.

The single most important factor is still the price. There is empirical evidence that other factors can hardly compensate for an additional, above average, premium rate (SVR 2012, pp. 401).

## III. Research methodology

In order to get a deeper insight into the accountability practices of Austrian and German SHIs, we chose to apply a qualitative research method, namely a documentary analysis. It focuses on the information provision toward crucial stakeholders (members, health care providers, public authorities etc.) by selected SHIs. Additionally, we looked for new accountability practices beyond the traditional forms. For this we included the Austrian social insurance balanced scorecard (BSC). By presenting these cases we aim to provide some guidance for improving accountability practices as a step towards good governance in the area of SHIs

Our sample includes 17 SHIs. In the case of Germany (table 2) our analysis covers the five biggest SHIs by number of members (at January 1st, 2014) and is based on the latest annual report. Four SHIs out of this sample belong to the top-ten market leaders regarding the number

of new members from January 2013 to January 2014: TK, AOK BW, Barmer GEK and AOK Bayern. The DAK Gesundheit is the SHI which has suffered the highest losses.

| Position | Statutory health insurance | Members Jan. 2014 | Growth 2013-2014 (members/%) | Annual report |
|---|---|---|---|---|
| 1 | Barmer GEK | 6,733,481 | 28,752 / +0.43% | 2012 |
| 2 | Techniker-Krankenkasse (TK) | 6,319,407 | 353,451 / +5.92% | 2012 |
| 3 | DAK-Gesundheit | 4,934,732 | -61,826 / -1.24% | 2012 |
| 4 | AOK Bayern | 3,279,138 | 14,899 / +0.46% | 2012 |
| 5 | AOK Baden-Württemberg (BW) | 2,900,441 | 32,489 / +1.13% | 2012/13 |

*Table 2: Top five statutory health insurance in Germany (by members)*
*Source: Authors' compilation based on MCB-Verlag (2014 a, 2014 b)*

As for Germany, the annual reports of the five biggest SHIs in Austria were analysed. Besides a documented analysis, (annual reports, website information, reports by the audit office, additional BSC-material provided by the SHIs and the HVB) expert interviews were conducted in 2013. The interviews were transcribed, all the material was coded and analysed applying the qualitative content analysis by Gläser and Laudel (2010).

| Position | Statutory health insurance | Members Jan. 2012 | Growth 2011-2012 (members/%) | Annual report |
|---|---|---|---|---|
| 1 | Vienna GKK | 1,165,465 | 14,000/1.20 | 2012 |
| 2 | Lower Austrian GKK | 884,133 | 15,651/1.13 | 2013 |
| 3 | Upper Austrian ÖGKK | 881,167 | 10,854/1.01 | 2012 |
| 4 | Tyrolian GKK | 422,102 | 32,90/1.00 | 2013 |
| 5 | Styrian GKK | 392,669 | 13,626/1.63 | 2012 |

*Table 3: Top five statutory health insurance in Austria (by members)*
*Source: Authors' compilation*

## IV. Analysis of the current level of accountability

### 1. Austria

Our analysis of the five annual reports of the GKKs shows that they differ in the depth of information for stakeholders (table 4). The reports are structured in a very traditional way. They are neither systematic with respect to crucial stakeholders nor do they sufficiently cover the main market parameters. Most of the information provided follows a "one size fits all" approach and therefore it is left to the internal and external stakeholders to filter the relevant information. The financial reporting is the most elaborate and standardised one in all annual reports. Main areas of the financial reporting are the annual financial statement and the development of expenditure in the different health care areas. Client/member-related information, in particular, can be found

under different headings. A report on the value created for the members of the GKKs is not established. To varying degrees, and often only with project descriptions, the GKKs present innovation initiatives and prevention activities. There are three main reporting areas: internal innovation (administration, IT-services, BSC), participation in prevention initiatives and reform pool activities. Reporting on prevention activities is over-represented, when one considers that Austria's prevention activities amount to only two percent of health care expenditure. Reporting on disease management programmes is at the very beginning.

| Topic GKKs | Financial performance | Services | Contract partners | Prevention | Reform initiatives | Employees | Other topics/ remarks |
|---|---|---|---|---|---|---|---|
| Lower Austria | + | incl. disease management programmes (DMP); ombuds activities | | + | Administration | + | special sections on innovation and legal changes |
| Upper Austria | + | + incl. own health care services | + | + | IT innovations | + | customer communication and cooperation with academia |
| Styria | + | + own health care services; DMP; youth services, dental health | | + | | Only on trainees | PR activities legal changes building activities |
| Tyrol | + | + incl. own health care services | + | | reform pool activities CSR activities BSC | + | legal changes; customer information; internal and external communication |
| Vienna | + | DMP ombuds services | | | reform pool activities; BSC; integrated care activities | * | Public relations activities; Realised building investments |

*Table 4: Main topics of the annual reports*
*Source: Authors' compilation*

Compliance accountability is most advanced with respect to financial reporting. This is not surprising because it is a legal requirement. Positioning accountability is at the very beginning. It is mainly used to report on the GKKs activities concerning selected innovation initiatives. The

member focus is at most an indirect one. This is in line with the fact that Austrian health insurances do not have to compete for members.

The social security institutions' balanced scorecard (BSCs) are an accountability and a coordination tool. The HVB developed a model BSC for all social insurance institutions back in 2001. The main aims were to improve cost-efficiency of social insurances and to put the clients in the centre of the social insurances' service culture (Brander/Reiner 2003, p. 383). After a constitutional court ruling the BSC process was reformed giving the social insurance institutions more participation rights. Since 2005 the social insurance BSC architecture is displayed as in figure 1. The overall strategies and the (planned) positioning of social insurances are formulated in guidelines.

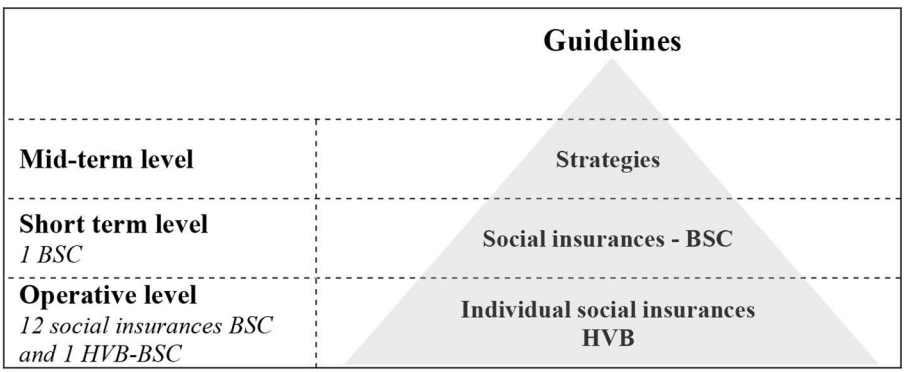


*Figure 1: BSC-Architecture in the social insurance intuitions*
*Source: Feninger (2013, p. 90)*

Mid-term strategic objectives are derived from the guidelines. The most recent strategies are from 2010 (see figure 2).

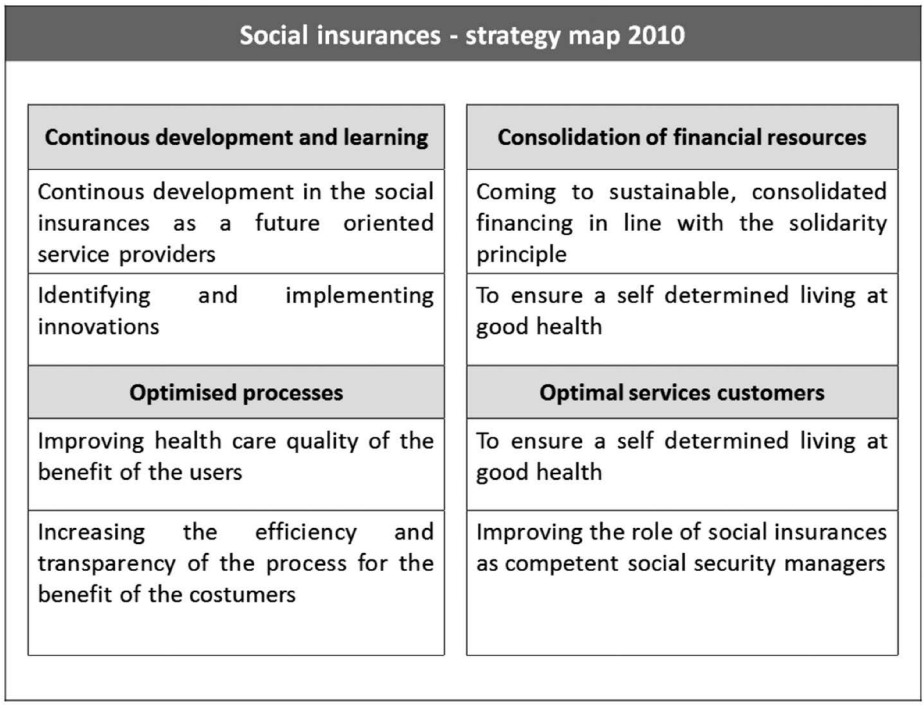


*Figure 2: Joint strategy map of the social insurance institutions in 2010*
*Source: Feninger (2013, p. 91)*

In the strategy map the customer/beneficiary orientation is high. Despite that emphasis the customer perspective is not always at the top of the SHIs BSCs. Only two put customers first, four SHIs have no hierarchy of perspectives. One SHI has the finance perspective at the top-level. Customer orientation is put into perspective as exclusively (six) financial objectives of the GKK-BSCs are incentivised with monetary bonuses. They are granted if an SHI do not exceed the annual financial budget-ceilings for the provision of specified health care services (e.g. physicians, rescue services, physiotherapists).

Strategic objectives are implemented via a social security insurance BSC. The strategic objectives are reviewed annually. The objectives are further cascaded in 13 operative BSCs (12 for SHIs and one for the HVB). The BKKs and the Austrian insurance institution of the notaries do not participate in the BSC process. Seven SHIs do not have additional (internal) objectives in their operative BSCs, another four use a mixed approach. One applies other coordination instruments for internal purposes in addition to the BSC. The main stakeholders addressed in the BSCs are displayed in figure 3.

| **Key stakeholders** |
|---|
| *Customer perspective:* insured persons, patients, customers, co-insured persons, |
| *Contract partners in the finance perspective:* physicians, ambulance services, orthopaedic technicians, pharmacies, hospitals, health service institute |
| *Process perspective:* co-operation with the professional body of physicians |
| *Employee perspective*: employees |
| *Political stakeholders:* self-governing bodies, ministries, provincial and local governments, HVB, social security insurance institutions. |
| *Suppliers:* (mostly indirectly) |
| *Others:* IT outsourcing partners |

*Figure 3: Stakeholders in the BSCs*
*Source: Feninger (2013, p. 111)*

Main strategy areas of the SHIs are presented in figure 4. They have similarities with the topics of the annual reports.

| **Strategy areas** |
|---|
| *Providing top services:* customer satisfaction with service centres and own health care services, employer satisfaction |
| *Health promotion and prevention:* health awareness and prevention |
| *Health service planning and financial planning:* financial objectives |
| *Innovation:* innovative projects |
| *Support processes:* administrative efficiency and employee satisfaction |
| *SHIs as partners:* aiming at being an active and cooperative partner in health care |
| *Processes and Information technology:* process optimising and increase of e-services |
| *Leadership:* systematic leadership process at all management levels |

*Figure 4: Strategy areas of social health insurances*
*Source: Feninger (2013, p. 94)*

The main reasons mentioned by the interviewed experts for implementing the BSC were: possibility of target coordination (nine times), legal obligation (seven times) and strategy implementation (four times) (Feninger 2013, p. 117). Asked for the main benefits, the participating experts put stringent objective orientation first, followed by increase of transparency (nine times) and reducing internal and external principal agent problems (eight times) (Feninger 2013, p. 126).

The overall impression of the BSCs is that the more concrete the BSCs get the less members or contract partners are key stakeholders. The member orientation is at the operative level reduced to member satisfaction with administrative services. Being a strategic player for innovative health care services is put into perspective by the incentives for cost-efficiency objectives and the lack of strategic positioning towards the health care providers. The BSCs are an instrument of coordination between the different organisational levels of SHIs. Therefore, they are a network-internal compliance instrument within complex governance structures. Stakeholder ac-

countability is limited to internal network accountability and the SHIs' management. As only four SHIs have added their own strategies, positioning accountability is not well established.

## 2. Germany

As described above, SHIs in Germany have meanwhile, several parameters of competition on hand. Together with this an increase in the economic scope of action demands came up strengthening accountability requirements in parallel. Currently, detailed reporting obligations to supervisory authorities (Bundesversicherungsamt 2014) are dominating with respect to the financial situation and to membership statistics. To the general public this information is only disclosed in an aggregated way up till now. A new development is that SHIs' financial accounting standards are moving towards those of the German Commercial Code. An audit of financial statements by chartered accountants or sworn-in auditors was recently established (IDW 2012). Experts criticise that the standards of the Commercial Code have not been fully adopted. Influential health care actors have successfully lobbied against a full adoption (Unterhuber/Demmler/Zacher 2014, p. 44). Enforced public disclosure requirements came into force in January 2014 and will be applied for the first time to the full reporting year 2013 (§ 305 b SGB V and § 38 SRVwV). The legal reporting obligations are listed in table 5. The publication has to be made by November 30th of the respective following year. SHIs will have to use a language which is comprehensible for their insured members.

Regarding these modest accountability stipulations with respect to members, public demands to further enhance accountability requirements persist: As a precondition for informed choice between different SHIs, optional tariffs, care management programmes or selected contracting models offered by SHIs, (potential) members need well-structured and meaningful information. The information has to be offered in a way that allows extensive comparison across industry (SVR 2012, p. 105). The Association of German Jurists even goes a step further by extending the call for standardised, transparent and comparable information to the SHIs' quality policy in the area of selective contracts. Furthermore they do not only name members and potential members but also Consumers' Organisations as target groups (Becker/Schweitzer 2012, p. B76 and pp. B78).

The analysis looks at the latest available annual report which is, for all of the funds, the report covering business year 2012. The collection of data was structured along two main analytical strands: *Firstly*, it was checked whether the annual reports already comply with the upcoming legal reporting obligations (table 5). *Secondly*, optional reporting items were screened regarding their relation to the existing parameters of competition for members. To get a comprehensive insight of information offered and groups of stakeholders addressed by annual reports an additional "other" category was added (table 6).

| Legal reporting obligations | Barmer GEK | TK | DAK Gesundheit | AOK Bayern | AOK BW | Addressed key stakeholder |
|---|---|---|---|---|---|---|
| **Number of members/insured** | | | | | | |
| Total number of members and insured | X | X | X | X | X | Insured, health care providers, employees |
| Rate of change | -- | -- | -- | X | -- | |
| **Revenues** | | | | | | |
| Total revenues | X | X | X | X | X | Insured, health care providers, employees |
| Revenues by category of income | X | X | X | X | -- | |
| Revenues per insured | -- | -- | -- | X | only total | |
| Change rate per insured | -- | -- | -- | X | only total | |
| **Expenses** | | | | | | |
| Total expenses | X | X | X | X | X | Insured, health care providers, employees |
| Expenses per category of benefits | X | X | X | X not adm. ex. | X | |
| Expenses per insured | X not adm. ex. | X | X not adm. ex. | X | X not adm. ex. | |
| Change rate per insured | X not adm. ex. | X | X not adm. ex. | -- | X not adm. ex. | |
| **Assets** | | | | | | |
| Total assets | X | X | X | -- | -- | Insured, health care providers, employees |
| Short-term financial assets | X | X | X | -- | -- | |
| Statutory financial reserve | X | X | X | -- | -- | |
| Financial assets | X | X | X | -- | -- | |

adm. ex.: administrative expenses

*Table 5: Compliance accountability in annual reports*
*Source: Authors' compilation*

Only TK's annual report 2012 complies fully with the coming legal reporting obligations already. For all other SHIs some information is missing. The lack of data regarding administrative expenses is particularly remarkable. Moreover, AOK Bayern and AOK Baden-Württemberg do not disclose any information on assets. It will be interesting to get this data for 2013 and to compare them with other SHIs to analyse potential reasons for this reluctance. Such a reason could be given if assets are especially high and "rich SHI" are apprehensive of revealing this or if the statutory financial reserve is lower than average.

| Optional information | Barmer GEK | TK | DAK Gesundheit | AOK Bayern | AOK BW | Addressed key stakeholders |
|---|---|---|---|---|---|---|
| **Price** | | | | | | |
| Prognosis | X | -- | X | -- | -- | Insured |
| Any ind. measuring financial risk | -- | - | age structure | -- | -- | |
| **Optional Benefits** | | | | | | |
| In relation to statutory benefits | health account for benefits of choice 150 € | -- | only bonus programmes | selected benefits only | -- | Insured, health care providers |
| For individual target groups | -- | as brief reports | only welcome baby programme | selected benefits only | -- | |
| **Care management programmes/Disease management programmes (DMP)** | | | | | | |
| Description of fund specific programmes | X | as brief reports | -- | X | X | Insured, health care providers |
| Any ind. measuring acceptance by target groups | -- | -- | no. participants prevention programmes | no. participants in DMP | no. participants | |
| Any ind. regarding programme quality | -- | -- | -- | selected ind. for different programmes | selected ind. for different programmes | |
| Any information on quality policy | fairly general | -- | -- | -- | -- | |
| Any information on included providers | -- | -- | -- | -- | number of care providers | |
| **Service** | | | | | | |
| Service level guarantee | -- | fairly general | -- | -- | -- | Insured, supervising bodies |
| Service quality ind.:<br><br>*Customer satisfaction rates | -- | -- | -- | -- | -- | |
| *Grading external service ratings | -- | -- | -- | X | X | |
| *Other | -- | -- | -- | no. staffed offices | -- | |

| Optional information | Barmer GEK | TK | DAK Gesundheit | AOK Bayern | AOK BW | Addressed key stakeholders |
|---|---|---|---|---|---|---|
| **Other** | | | | | | |
| Statements on health politics | X | X | -- | X | X | Customers, supervisory bodies |
| Services for customers other than insured<br>*Description | corp. health programmes | corp. health pro. | corp. health programmes | corp. health programmes | -- | |
| *Any ind. measuring acceptance of services | no. firms served | -- | no. firms served | no. long-term cooperation, no people reached, structure firms served | -- | |
| *Any ind. regarding quality of services | -- | -- | -- | best practice network, evaluation | -- | |
| Information on innovation projects | internet portal | multiple | -- | -- | -- | Customers, care providers |
| Health fund as employer<br>*No. of employees | -- | X | -- | -- | X | Employees, customers, supervising bodies |
| *Ind. staff qualifycation | -- | X | -- | X | X | |
| *Grading external employer ratings | -- | rated "top employer" | -- | X | rated "top employer" | |
| *Other | -- | several projects mentioned | -- | -- | Career-family policy, leadership principles, regular employee survey | |
| Any information related to corporate social responsibility | -- | X | -- | -- | -- | Employees, customers, supervising bodies |

ind.: indicator(s) corp.: corporate

*Table 6: Positioning accountability in annual reports*
*Source: Authors' compilation*

## V. Discussion

In Germany, the main focus of accountability lies on compliance accountability towards supervisory authorities. This goes far beyond the publicly disclosed information. Legal reporting obligations addressed in annual reports are very limited compared to other industries. Most of the SHIs included in the sample do not meet the upcoming requirements at the moment. Taking into consideration that we analysed the biggest and most dynamic growing SHIs it seems plausible that other SHIs do not do this either. The optional information provided can be classified, according to Kearns' accountability framework (Kearns 1994, pp. 188), as a proactive response to implicit or explicit performance standards. Participation in external ratings (service, quality as employer) or the implementation of regular employee surveys are examples for proactive strategies to internalise professional standards or societal norms (discretionary accountability). Based on the information given in the annual report, the AOKs and the TK seem to be more active in this regard than other SHIs and they clearly address groups of stakeholders of high competitive relevance: employees and customers. Additional price related information is scarce. This might be related to the fact, that the price is the single most important competition factor and therefore handled with extreme care. Annual reports contain benefit related information. This information is often given in form of brief reports and therefore it is neither standardised nor comparable. A proactive strategy which seeks to influence future explicit performance standards (positioning accountability) may be the efforts regarding quality indicators, acceptance indicators for care or disease management programmes and corporate health management programmes. In the past decade, discretionary power was given by the legislator to the SHIs for reorganising and steering the health care value chain. The intention behind this has been establishing structures for increasing the effectiveness and efficiency of medical treatment. At some point in the future SHIs will have to render account on the results achieved.

It is remarkable that service providers are hardly addressed. Information on selective contracts is scarce. SHIs which try to position themselves in the competition by practicing a proactive form of public disclosure of selective contracts use the internet, not annual reports, e.g. AOK Baden-Württemberg (AOK Baden-Württemberg 2014). Public disclosure in this case is the mere publication of contracts, which hardly fulfils the requirements of information-oriented reporting. Nevertheless, the publication of selective contracts is the exception.

Recalling the Austrian results the members of the SHIs are not the key addressees of stakeholder accountability. Participation rights of the insured persons are nearly non-existent with the exception of ombudspersons at the GKKs. The member-orientation in the GKKs' annual report is very low. This is not surprising as no need for competition exists. With respect to non-financial performance data a great need for improvement exists. The health service providers are not well provided with specific information either.

The seemingly innovative approach to introduce a BSC, as a coordination instrument, in the social insurances institutions and a network governance accountability tool had an unsuccessful start. Only financial targets are linked to incentives. With respect to the technical side of the BSC, deficits exist as the majority of SHIs do not have cause-and-effect relationships. A further shortcoming is that the BSCs have far too many objectives across the different levels. Feninger

(2013) counted 74 different objectives, which is well above the recommendations of Kaplan and Norton (2001). More on the political level there are shortcomings which have to do with the difficulties of the HVB to fulfil its coordinating function. The HVB does not have the power to keep its members on a short leash. Therefore, the BSCs are implemented in a network with a weak hierarchy where the SHIs keep an anxious watch that their self-governing autonomy is not reduced. Interference from the political level adds to the problem.

With respect to the issue of compliance versus positioning accountability, the Austrian findings only show compliance in the field of selected financial objectives. As most of the SHIs have not added their own objectives and do not compete for members, the positioning accountability is very low. Despite the NPM-rhetoric, expressed in the strategy map 2010, the SHIs do not use their BSCs to position themselves actively, as a strategic player in health care.

Looking at areas for improvement the following suggestions are backed by our findings: The first step would be that the SHIs ask themselves who are their strategic stakeholder groups. Stakeholder-value accounting needs some clarity about the "give and take" in the relationship to stakeholders. The reports analysed show quite substantial imbalances regarding the quantity of information offered to the different stakeholder groups. Not only for increasing the reputation but also for strengthening the legitimacy, SHIs should start to demonstrate the member value created, not only by storytelling but based on hard, reliable facts. Approaches for member-value accounting in cooperatives could be tested for their transferability to SHIs. As SHIs are an essential part of the social public services regular communication with key stakeholders should be used to position SHIs as a reliable, sustainable provider of the social infrastructure in both countries. Another step to increase stakeholder accountability would be to use modern communication tools to implement stakeholder forums in order to come to a continuous stakeholder dialogue.

When we take into account that German SHIs compete for members, then it is also necessary to think of ways of how to ensure that the information provided by SHIs is trustworthy and comparable. SHIs have at least two options: The first one is that it leaves others (consumer organisations, rating agencies, health ministries' etc.) to define performance standards. The second one is that SHIs themselves engage proactively in standard setting and even developing a rating or labelling which proves beyond any doubt that it is only a public relations instrument. Perhaps SHIs could learn from the efforts hospitals and other care providers had to undertake and still are undertaking to publicly report on financial data, service and quality.

## VI. Conclusion and directions for further research

Recalling our first research question we can conclude that most of the SHIs still pursue a one size fits all-reporting. In both countries the contract partners are scarcely addressed with systematic and targeted information. The legal compliance obligations are met at the moment. It can be safely assumed that German SHIs will comply with the new financial accountability obligations. In contrast to this, SHIs still seem reluctant to intensively exploit the potential for proactive accountability, especially positioning accountability. Regarding the reporting on qual-

ity indicators of care management programmes, the methodological problems involved only partly explain this. In Austria the members' accountability is nearly non-existent.
With respect to the second research question, notable imbalances can be stated, even if, as is the case in Germany, SHIs start to address employees as an additional stakeholder group. The Austrian annual reports only inform on selected human resource activities. Members and contract partners play a negligible role as (strategic) stakeholders. Concerning the issue of whether SHIs are on a way to good governance, we have to conclude that there is much room for improvement. The stakeholder involvement of members in the decision-making process is quite low which is illustrated by the fact, that in Austria the insured cannot even directly elect their representatives. The more SHIs act in line with old corporatist structures, the less transparent they are. Transparency is the very first step towards good governance. For improving stakeholder accountability, SHIs should invest some resources in establishing a more structured and regular stakeholder dialogue, especially with members and health care providers. For this, it would be necessary to be more proactive and go beyond a legally or statutory mandated compliance.
As in all empirical studies there are limitations. Firstly, our sample size could be extended and so far we have only conducted expert interviews in Austria. Secondly, it would be interesting to include other countries. In particular the focus could be extended to countries with a Beveridge system, as Germany and Austria both organise their social security systems according to the Bismarck model. Thirdly, with respect to stakeholder-involvement, best practices from other industries or countries could be value-adding, e.g. the U.S. where specific organisations deal with accreditation and quality measurement of health plans. Another rewarding option would be to start model projects with the more innovative SHIs on how to calculate the value-added for its members.

Zusammenfassung

*Dorothea Greiling und Eveline Häusler; Stakeholderbezogene Rechenschaftspflichten in deutschen und österreichischen gesetzlichen Krankenkassen*

*Fallstudie; Gesetzliche Krankenversicherung; Geschäftsberichte; Rechenschaftslegung; Vergleich; Wettbewerbsfaktoren*

*In den vergangenen zwei Jahrzehnten sind die Gesetzlichen Krankenkassen in Österreich und Deutschland durch eine Ära von Reformen gegangen, die darauf zielten, sie stärker unternehmerisch auszurichten. In diesem Zusammenhang wurde der Aspekt stakeholderorientierter Rechenschaftslegung kaum beachtet. Dieses Defizit erstaunt, da die Pflicht zur Rechenschaftslegung einer der Eckpunkt des New Public Management Ansatzes und ein Element guter Unternehmensführung ist. Gesetzliche Krankenkassen sollten darüber berichten, wie effizient und effektiv sie ihren öffentlichen Auftrag erfüllen. Der Mangel an wissenschaftlichen Untersuchungen zur Praxis der Rechenschaftslegung diente als Anlass für eine Analyse der Geschäftsberichte ausgewählter Gesetzlicher Krankenkassen in Österreich und Deutschland. Die Untersuchung zeigt eine Weiterentwicklung in der Finanzberichterstattung während die Rechenschafts-*

*legung vor allem gegenüber (potentiellen) Mitgliedern und den Leistungserbringern nicht sehr weit entwickelt ist.*

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