

# Same cheat, different wrapping: DRG scandals and accountability in Germany and Norway

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# Same cheat, different wrapping: DRG scandals and accountability in Germany and Norway

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## Abstract

Across the world, the DRG system is used for administrative and financial purposes in hospitals. Combining statistical registration and aggregation of data on medical activity with activity based financing; DRGs have proven to be a powerful, incentive-based performance management system with large implications for the wider governance of hospitals. Although economic dysfunctions of DRGs are widely reported within health economics, the organizational basis of the system and its implications for governance is less explored. This working paper aims to show how DRGs create negative side effects in both the Norwegian and the German hospital system. It is argued that although the adverse effects of the DRG system are comparable across country, the ways in which such effects are handled differs considerably between the two systems. We investigate a set of eight scandals or cases that have been dealt with quite differently in Norway and Germany, showing how accountability relationships and processes take different shapes and play different roles in the two countries. A lesson to draw is that accountability is not an easy fix or a ready-made solution for handling adverse effects, but that the likely outcome is ambiguity and complexity defined by reform trajectories, institutional dynamics and the contextual factors of any given case.

## Introduction

Hospital systems across the globe have faced an epidemic of reforms (Stambolovic 2003). The application of the DRG system, in tandem with cost containment initiatives and activity based financing (ABF) schemes, are among the common features for many of these reforms. The Diagnosis Related Group (DRG) system is a powerful administrative tool for statistical registration, aggregation and monitoring of activity and performance in healthcare. DRG system practices are coupled to finance, which directly influences the cash flows to hospitals, and the system creates a framework for various legitimate and illegitimate administrative behaviors (Læg Reid and Neby 2012). German and Norwegian experiences with the system are not entirely positive, as both countries have seen cases displaying manipulation and malpractice. These practices may challenge the legitimacy of the system, and arise as important examples of how accountability plays a role in the governance of hospitals and healthcare.

The DRG system and activity based funding schemes are both part of a transparency-based rationalization of hospital governance, where ideas gathered from New Public Management (NPM) are combined with an evidence-oriented medical approach to handle performance (Levay and Waks 2006). From the mid-1980s, the reorganization of welfare bureaucracies at both central and sub-central levels of government have been associated with a shift from bureaucratic to managerial types of public organization (Aucoin 1990; Hood 1991). As organizational legitimacy becomes less dependent on input and due process, output and results are shifted into focus as sources of legitimacy. The suggestion to let politicians deal with principal questions and allow subordinate actors a considerable degree of autonomy creates an organizational distance that requires some form of control. Accountability arrangements are typically introduced as control mechanisms, although with a dual purpose: They are intended to both handle undesirable situations and to help prevent them (Bovens 2007b).

In this paper, we investigate and compare a number of cases of DRG malpractices and downright scandals in order to answer the following questions: When such scandals surface, how are they dealt with through processes of accountability? How does the political-administrative setting influence the handling of such malpractices, comparing across the Beveridgean, NHS-style Norwegian system and the corporatist, Bismarckian German system?

The data for this article was generated by studying a selection of cases that illustrate how the DRG systems in Norway and Germany create undesirable side effects along two main dimensions: the quality of care, and the documentation of service delivery. We rely on media coverage, press releases, public documents and reports of different types, as well as on research literature on the cases and subject at hand. Additionally, we lean on assessments of reform and governance of healthcare in the two countries to provide a context and possible explanations for the phenomena at hand.

We proceed as follows: First, we describe the Norwegian and German health contexts; including the two countries' hospital systems, a few notes on recent reforms and changes, and an account of the introduction of and experiences with DRGs in both countries.

Secondly, we describe our take on the DRG system as such. We assess its basic construction, point to relevant dimensions of its functioning and describe some of the fairly established problems with this system, based on existing research literature. Thirdly, we present our explanatory framework, before; fourthly, we lay out our understanding of accountability, arriving at possible classifications for the cases we investigate. Fifthly, we present our case studies, underlining our findings in terms of accountability. Finally, we discuss our findings and conclude by suggesting a set of possible explanations. A central argument is that whereas both the DRG system and some of its adverse effects are relatively similar across national context, the handling of the cases reveals how different existing institutional arrangements may influence accountability processes in practice.

## The context: Norwegian and German hospital governance and reforms

Norway is often described as having a variant of a Beveridgean, or NHS-style, integrated, tax-financed and single-payer hospital system, placed within a consensus-oriented and unified nation-state. In terms of classification, a Nordic or Scandinavian group of hospital system is a more direct reference than the NHS system, however. In terms of politics, the Norwegian system has been subject to heavy debate and conflicted political battles for decades, and constant re-negotiation and disagreement on policies, structures and interpretations of performance display a tense political climate (Byrkjeflot and Neby 2008). The main topic has perhaps been expenditure, although evidence indicates that themes such as quality of care, access and redistribution are also regularly surfacing in the political agenda. Norway has – comparatively speaking – high healthcare expenditure, particularly if calculated as per capita costs (OECD 2012). Cost containment and efficiency is high on the agenda, although both the public and the political debate reflect a tension between the desire for cost containment on the one hand, and possibilities for spending more (Norway has a large oil-based state revenue) in order to increase coverage, accessibility and quality on the other.

The hospital system has been subject to a series of reforms during the last 15 years or so: From being a county-based, decentralized system with regional democratic governance of single hospitals, the solution after 2002 has been a system with state-owned, corporate-like hospital enterprises (Byrkjeflot and Neby 2008). To mend problems with rising expenditure and concerns for cost containment, efficiency and quality of care, the 2002 hospital reform established a system of five (now four) board-led regional health trusts owned by the Ministry of Health, that in turn own around 30 local health enterprises that organize approximately 250 hospitals, treatment facilities and other units. Operational and managerial tasks are structurally less directly connected to politics than before, but the centralization of ownership implies that involved national-level politicians are now in fact closer to hospitals (Neby 2009). A unitary management scheme was introduced in 2001, requiring that the total responsibility for any performance-reporting unit should rest on one managerial position (Torjesen 2008). This management scheme formally closed the gap between administrative and medical leadership in Norwegian hospitals, although most

managers remain physicians or other healthcare professionals and some departments still practice a two- or three-way division of management responsibilities between doctors, nurses and administrators.

Germany's healthcare system can be described as a corporatist Bismarckian arrangement, different from the traditional NHS model – thus also different from the Norwegian model. It is characterized by a system where several actors have a stake in decision-making processes – the Federal government, the Länder and a variety of other actors and interest groups (including private agencies). The system is insurance-based: Health insurance is mandatory for citizens and permanent residents, and is provided through either the Statutory Health Insurance scheme (SHI – provided by competing non-profit sickness funds) or voluntary Private Health Insurance (PHI). Hospital financing is based on a dual-financing model (in existence since 1972) where initial investments are made by the Länder parliaments and running costs are the responsibility of health insurance providers. Based on the «federal distribution of competencies» (Wismar and Busse 2000:38) in the country, the national Government sets the legislative framework for health services (as well as the broader SHI framework) while the 16 Länder set hospital plans and co-finance health services (together with sickness funds or private insurers). This means that the Länder, sickness funds and insurers have a considerable degree of autonomy: «Approaches to hospital plans, capacities and investments vary widely among Länder» (Busse and Riesberg 2004:166). Further, regulation of service delivery is through self-governing bodies (i.e. physicians» associations, provider associations and sickness funds) that, through joint negotiations, take decisions «...on the actual contents of the uniform benefits package and the delivery of curative health services...at both regional and national levels» (Busse and Riesberg 2004:207).

Cost containment schemes were first introduced in Germany in 1977, and were followed by the idea of health targets a decade later – although these remained largely unsuccessful (Wismar and Busse 2000). Prospectively negotiated (i.e. based on expected rather than incurred costs), *per diem* charges to reimburse hospitals» running costs were first introduced through the 1984 Hospital Restructuring Act. The initial forms of any diagnosis-related payments were, however, introduced only in 1996 as prospective case and procedure fees for a selection of inpatient hospital services (Busse 2000). These fees formed part of every hospital's budget, negotiated as a yearly target between hospitals and sickness funds, with financial adjustments made in case of over- or under-utilization.

The pre-DRG healthcare system in Germany reportedly suffered from three weaknesses: a lack of transparency, a lack of comparability, and an adverse incentive for prolonging hospital stay of patients (Wilke et al. 2001). There was also evidence of generic efficiency problems due to a lack of performance-based incentives for inpatient care (Böcking et al. 2005). The case payment system in place since 1996 was criticised as lacking in risk adjustment and the multiple, coexisting cost reimbursement systems were considered barriers to an efficient health system (Busse and Riesberg 2004).



## The introduction of DRG financing in Norway and Germany

The DRG system was introduced in Norway through several steps: First as small-scale trials in 1991, then as large-scale experiments in 1997, and finally as a mandatory component of all somatic hospital financing in 2001 (Magnussen and Solstad 1994; Pettersen 1999; Byrkjeflot and Torjesen 2010). In Norway, the DRG system is thought to serve three main purposes: To improve efficiency and contain costs (Magnussen 1995), to stimulate and maintain productivity (Helsedirektoratet 2011), and to monitor performance (Løkeland 2013). Moreover, the activity-based component of Norwegian hospital funding has been subject to national-level political negotiations on a semi-annual basis: Funding of hospitals combines block grants and activity based financing. Over the years, the share of ABF/DRG financing has ranged from about 15 % to 60 %. It is generally recognized that the DRG/ABF system has contributed to increased activity and reduced waiting lists (Kjerstad 2003; Kjerstad and Kristiansen 2005), but is also thought to have increased costs (Byrkjeflot and Torjesen 2010). The promised efficiency gain is contested, however (Jakobsen 2009).

The introduction of the DRG/ABF schemes in Norway replaced a system with combinations of block grants and earmarked funding. The formerly county-based system had severe difficulties sustaining the rising hospital expenditure, resulting in national politicians becoming involved in county finances and relatively detailed budgetary matters. Whereas counties were formally unable to levy or adjust taxes adequately to sustain hospitals, national government funds were channeled into hospitals and the regional democratic governance was short-circuited by blame games and scapegoating over hospital matters (Byrkjeflot and Neby 2008). Much political debate continues, however, as the hospital system's performance is questioned and as hospital expenditure is still high on the national political agenda. Among vivid themes, is the question of patient rights and choice, which were amongst the reasons to introduce a more flexible funding system.

Diagnosis Related Groups (DRGs) were introduced in Germany with the passing of the Reform Act of Statutory Health Insurance (SHI) (2000) in the year 1999. The Act stipulated the introduction of uniform case fees across hospitals for inpatient and daycare services across all clinical departments with the exception of psychiatry, psychosomatic medicine and psychotherapy services, taking into account complexities and comorbidities (Busse 2000; Schreyögg et al. 2006). Joint negotiations between the Federal hospital organization, the association of sickness funds and private health insurers resulted in the decision to base German DRGs along the lines of Australian refined DRGs, but with scope for adaptation and modifications with the passage of time. The German DRGs were launched on a voluntary basis in 2003 and rolled out nation-wide in 2004. The G-DRG has been the only system for financing running inpatient hospital expenditure in Germany since then (Busse and Riesberg 2004). The intention behind the introduction of Diagnosis Related Groups (DRGs) was two-fold: improving the *profitability* of the system through cost containment and efficiency gains, and increasing the *quality of healthcare services* through increased transparency, comparability and service success assessment (ibid.; also see Scheller-Kreinsen et al. 2009).

Busse (2011) has divided the 10 years of DRGs in Germany (2000–2010 and onwards) into three distinct developmental phases. The period described previously and up until the launch of the DRGs in 2003 was the «phase of preparation». The period 2003–2004 is termed the «budget neutral phase», and was characterized by a shift in the unit of reimbursement for hospital running costs from *per diem* to DRG. From 2005 to 2009 was what is termed the «phase of convergence» with the move from hospital specific to statewide base rates (i.e. a uniform price system at the Länder level). Since 2010 and up until 2014, the focus is on policy discussions and decision-making that relates to, for instance, the establishment of a nation-wide base rate, the introduction of DRG in psychiatric settings, moves towards quality assurance and the reconsideration of the dual financing model (versus the monistic alternative) for financing recurring expenditures.

The advent of DRGs has led to extensive changes in the functioning of health care services in both Germany and Norway, and resulted in the identification of a number of challenges and adverse effects. These adverse outcomes are, perhaps, a result of the economic pressures generated by the system, evident in anecdotal accounts reported by the media (Bode 2012). Wilke et al. (2001) recognized two significant challenges when DRGs were first introduced in Germany. The first related to the challenge and importance of correct documentation, the absence of which could lead to improper grouping, faulty diagnosis and incorrect reimbursements. The second challenge lay in acknowledging that «every medical relevance relating to illness carries with it an economic relevance» (ibid.:80) and related to the recognition of case complexity and appropriate evaluation by doctors. These observations are also relevant to the Norwegian context.

## The DRG system, its uses and its abuses

Although introduced across the globe, the DRG system is an American invention. Its initial implementation is often connected to rationalization and cost containment efforts of the Reagan administration in the 1980s (Covaleski et al. 1993:69). The DRG system is basically a system to monitor activity in hospitals. Instead of counting the number of stays or individual patient encounters, a classification system aggregates hospital activity into produced DRG points. Patient diagnosis, treatments, procedures, gender, age and status at discharge – among other data – are coded and aggregated into groups, which in turn are assigned DRG points (Fetter 1991). The coding takes place in accordance with a standardized classification scheme (ICD – International Statistical Classification of Diseases and Related Health Problems), that is typically modified to fit national contexts. This creates a basis for activity measurement that makes comparisons across hospitals possible, even though they may treat patients that are hard to compare in medical terms. Productivity thus becomes the general performance measurement provided by DRG systems. In terms of financing, the DRG system is coupled with a scheme that assigns pre-calculated treatment costs to the diagnoses related groups; each group has a standard cost. This coupling includes all costs that any given hospital has, meaning that medical costs are only one of several included types of cost. Although employed differently in different countries, DRG financing generally refers to this coupling between hospital activity and finance.

The DRG system is one marked by complexity. As the ICD standards are modified to fit national standards, the German and the Norwegian systems are not identical – neither in terms of registration, coding and aggregation of medical activity or in terms of financing. For example, German DRGs (G-DRG) are based on a version of a refined Australian variant, whereas the Norwegian system relies on a common Nordic development of the system called NordDRG – which in turn is based on the American variant. Another example of dissimilarity is the variation in the proportion of funds allocated through DRGs – while some systems, e.g. Germany, rely almost entirely on DRG-weighted prospective cost calculations for covering running costs, others e.g. the Norwegian funding scheme combine block grants and earmarked funds with DRG funding on the basis of political budget negotiations.

A wide range of Norwegian, German and international literature reflects the fact that the DRG system is characterized by some flaws (both intentional and unintentional) as well as adverse incentives (see e.g. Donaldson and Magnusson 1992; Ellis 1998; Mikkola et al. 2002; Morriem 1991; Silverman and Skinner 2003; Hafsteinsdottir and Siciliani 2009; Martinussen and Hagen 2009; Cots et al. 2011). According to Scheller-Kreinsen et al. (2009), there are two broad dimensions along which unintended or adverse consequences may be observed – first, with relation to *the quality of care*, and second, the *documentation of service delivery*.

Adverse strategies that focus on reducing costs and increasing profitability, and negatively influence the quality of care include, e.g., increasing the number of cases treated but decreasing the quality of care to individuals, or engaging in patient selection and «*dumping*» (e.g. selecting low complexity, high reimbursement cases versus high-risk, high cost cases) (Ellis 1998; Böcking et al. 2005; Busse et al. 2006; Bode 2012). Other strategies include «*creaming*» (over-provision of services to low severity patients), «*skimming*», (under-provision of services to high severity patients) and «*skimming*» whereby high profit/low cost patients will be selected over patient groups yielding a lower profit per treatment. In Norway, activities that do not yield a net income tend to be given lower priority (NOU 2003:1). Another situation may be the under-treatment of patients motivated by potential savings on certain tests or procedures normally performed (Kastberg and Siverbo 2007). The introduction of DRGs has been known to impact quality indicators such as the average length of stay in hospitals (Schlingensiepen 2003 and Wöhrmann 2003, for instance, indicate that the average length has decreased in case of Germany). This might be a positive effect but might also create the «*revolving-door effect*» (Wöhrmann 2003) where shorter hospital stays are accompanied by a higher number of hospitalizations. In Germany, examples of «*still bleeding patient*» discharges have also been widely reported (Scheller-Kreinsen et al. 2009, Bode 2012) as have instances where outpatient doctors have been bribed for referring patients to specific hospitals in a bid to increase their volumes (Bode 2012).

Wrongful documentation of services may be reflected in cases of «*upcoding*», «*overcoding*», and «*case-splitting*» (billing individual diagnoses for the same patient separately) (Böcking et al. 2005; Busse et al. 2006; Bode 2012). A number of empirical studies indicate an increase in health costs post-DRG introduction, when compared with the pre-DRG era (e.g. Jaklin 2003; Wittman 2003). Recent figures from the Federal Statistical Office in Germany reflect that the average number of procedures and operations

for each case have steadily increased from 2.2 in 2005 to 2.8 in 2011, while the average number of secondary diagnoses per case reflect an even greater increase from 3.9 in 2005 to 4.8 in 2011 (Statistisches Bundesamt, 2011:11). Hospitals have even been accused of conducting surgeries that were avoidable and not required (Bode 2012, Læg Reid and Neby 2012). Upcoding between 2004 and 2009 led to an estimated additional expenditure of between 1.9 to 3.24 billion Euros for the German healthcare system (Schönfelder et al. 2009).

Such gaming practices and illegitimate behavior indicates that quality assurance is rapidly becoming a central concern of the healthcare system. In Germany, mechanisms already in place include a mandatory quality reporting system for approximately 2000 acute-care hospitals, and the requirement for all hospitals to publish results based on 27 quality indicators defined by the Federal Office for Quality Assurance (Thomson et al. 2012). Regional medical review boards conduct random case reviews, with unintentional coding requiring reimbursement of funds received by hospitals and an added penalty charge in case of intentional upcoding (Schreyögg et al. 2006). Nevertheless, a national level safety agency for ensuring quality of care and patient safety does not exist (Thomson et al. 2012). Similar arrangements are also in place in Norway, with a national quality indicator scheme (in which the production of DRG points is an indicator). The Board of Health Supervision has a nationwide responsibility for auditing medical quality (in contrast to the lack of such an agency in Germany), and the state county representative (the Fylkesmann) conducts audits and scrutiny as well.

The alteration of medical and administrative behavior within hospitals was always within the aims of the DRG system (Hsiao et al. 1986). On the one hand, the reimbursement system creates external incentives and constraints for hospitals, while on the other, internal effects include changes in the utilization of information about price patterns registered through the system by administrators and physicians. Covaleski et al. (1993) show how these effects influence both the instrumental and the normative nature of relationships between actors in the hospital system, and thus argue that DRG systems are examples of institutionalization processes as much as instrumental implementations: The uses and abuses of the DRG system – in various national contexts – reflect that the introduction of DRG systems are institutionalization processes that are «...profoundly political and reflects the relative power of the organized interests and actors (...)» (Ibid:66).

## Political, administrative, legal, professional and social accountability

Robert B. Fetter – one of the original developers of the DRG system – argued early on that accountability is among the central features of this system. He describes the system as one of accounting and control: «(...) the DRGs provide hospital administrators and physicians with a mechanism to control costs (...)» (Fetter and Freeman 1986:51). This understanding of accountability is wholly managerial and economic, however, he describes physicians as accountable for any significant variance in the use of resources for their defined groups of patients (DRGs) and administrators as accountable to their superiors, something that «(...)

allows the organization to assign specific organizational authority and responsibility» (Ibid:49). However, as health expenditure and hospital performance – in terms of both output and outcome – are also central topics for policymakers and the society at large, it can be argued that an applicable notion of accountability must extend beyond the somewhat technocratic descriptions that Fetter employed.

From a broader point of view, accountability in healthcare systems such as the Norwegian and German involve a large number of varying actors and relationships, subjects and processes. These range from the physicians and administrators that Fetter includes to politicians at different levels, as well as the general citizen. Accountability relationships and processes generally serve two main objectives: Preventing illegal, inappropriate behavior and abuse of power, and handling tensions from any behavior that has already taken place (Bovens 2007a). Operationalizing accountability in a somewhat narrow sense, Bovens (2007b:45) (a) defines accountability as a relationship between an actor and a forum, where there is (b) an obligation for the actor to explain and justify her conduct, where (c) the forum may pose questions and pass judgments, and, lastly, where (d) the actor may face consequences. Such arrangements may on the one hand be formal and hierarchic, but they could also be informal and more loosely organized.

Accountability arrangements are intended to aid public systems in resolving two principal problems: These are the so-called «*problem of many eyes*» and «*problem of many hands*» (Romzek and Dubnick 1987; Bovens 2007b; Byrkjeflot et al. 2012). On the one hand, public organizations – the actors – are accountable to a number of different forums that apply different criteria for assessing an actor's conduct. On the other, forums face a similar challenge when deciding who to hold accountable, and who has contributed in what way to specific cases or processes. This suggests that a classification of accountability arrangements need to deal with at least two dimensions: The first concerns the nature of the forum (i.e. to whom the actor is accountable), and the second concerns the actors themselves (i.e. who the forum may hold accountable). A third question is deciding what the substance of the conduct is: In our study this is a given, as the common denominator is improper application and practice of the DRG system.

Bovens (2007b) describes five basic types of accountability based on the nature of the forums an actor reports to: *Political accountability* is the external control of an actor by different forums such as voters, members of parliament, ministers and the cabinet (Mulgan 2003). The idea is that voters delegate their democratic sovereignty to representatives in elected bodies, in turn delegating authority to the cabinet and related institutions. These are considered vertical accountability relationships, as the forums' power is based on superior democratic authority.

*Administrative accountability* also relates to an actor's location within a hierarchy. Here, a superior calls a subordinate to account for delegated duties and agreed tasks according to specified performance criteria (Day and Klein 1987), reflecting the administrative chain of command. The relationship does not necessarily have to be internal to the organizations in question, as authorities of different kinds may have superior jurisdiction over units in terms of accountability but less so in terms of regular and ordinary day-to-day business. A range of scrutiny bodies, such as inspectors, controllers, regulatory agencies, ombudsmen or audit offices, perform supervision and control. Managerial

systems also fall within this category. Although they have been granted extended autonomy, they are held directly accountable for performance. It is pertinent to note here that administrative accountability presupposes a system of clear separation of policymaking and policy implementation (Wallis and Gregory 2009).

*Legal accountability* implies that actors within public systems are accountable to judicial authorities, such as courts or tribunals. With increasing formalization of social relations and because of greater trust in courts than the government, legal accountability becomes more important for public institutions. Legal accountability is considered the most unambiguous type of accountability, since it is based on specific, formalized definitions of responsibility, accountability and procedure. This, however, does not suggest that the application of law takes place without discretionary practices, e.g. as courts or juries deliberate and lawyers argue.

*Professional accountability* revolves around professional standards and expertise, e.g. compliance to normative professional standards or peer review. In typical professional public organizations actors are constrained by professional codes of conduct and scrutinized by professional organizations or disciplinary bodies. Such systems rely on normative standards of expertise, where one relies on the technical knowledge of experts in deciding what appropriate conduct is (Romzek and Dubnick 1987). This type of accountability is particularly relevant for managers who work in public organizations concerned with professional service delivery, such as hospitals.

*Social accountability* arises from existence of stakeholders across areas of society that fall outside the formal apparatus of accountability arrangements in the public sector. Such stakeholders have various ways of producing pressure on public organizations and individuals to account for their activities, whether to the public at large, the media, particular stakeholders, or (civil) interest groups, users» and patients» organizations. Such accountability is typically exercised via public reporting, public panels, media coverage or information on the internet (Malena et al. 2004). Giving account to various stakeholders in society normally occurs on a voluntary basis and has been labeled as a form of horizontal accountability (Schillemans 2008), since there is no notion of hierarchic organization to the pressures created and relationships are largely external.

Following this relatively standardized scheme for classifying accountability arrangements leaves us with the following structure:

Table 1: Accountability classification by forum and actor

«The problem of many eyes» – accountability to whom?					«The problem of many hands» – who is accountable?
<i>political</i>	<i>legal</i>	<i>administrative</i>	<i>professional</i>	<i>social</i>	
External control, democratic authority. (On behalf of) voters, MPs, ministers, cabinet and such.	Judicial authority, based on legislation. Specific and formalized. Courts.	Hierarchical authority, internal or external. Scrutiny bodies, regulatory agencies, audit offices, ombudsmen, superior managers, boards.	Professional authority. Codes of conduct, professional standards, or peer reviews. Professional organizations, disciplinary bodies.	Stakeholder authority, producing pressures to account. The general public, media, user organizations, public panels.	Distinctions: Individual or collective/organizational; location in governance system.

### Converging or diverging patterns? An institutional explanatory framework

Lessons from the literature on organizational design and policy implementation is that the practicality and complexity of achieving systemic change to a large extent relies on the context reforms are introduced to, their timing and sequence (Pierson 2000a, 2000b) and the broader developmental trajectories of the institutions in question – not least in hospital systems (see e.g. Byrkjeflot and Neby 2008). On the one hand, the realities of introducing organizational designs such as the DRG system may depend on previous choices and solutions, and the (combined) effect of these. Thus, changes in governance systems do not necessarily replace each other as time goes by: There are mechanisms of translation (Czarniawska and Sevon 1996), whereby standard solutions are interpreted and modified to fit new institutional frameworks; there are mechanisms of drift, layering and replacement at work as well, where the introduction of new measures to a large extent may be seen as both part of and influenced by the larger institutional environment and choices made over time (Thelen 2004; Streeck and Thelen 2005; Beland 2007; Mahoney and Thelen 2010). From such a perspective, there are two expectations relevant for our study. Firstly, that the characteristics of local variants of DRG systems to a large extent will depend on the institutional context they are introduced to – including possible dysfunctions (which we are primarily interested in here). Secondly, one may expect that the handling of undesirable side effects will depend on the larger development dynamics and patterns identifiable in each system. In other words, there may be variations in both the DRG systems and the way dysfunctions are handled in terms of accountability that stem from nation-specific institutional traits.

On the other hand, there are limitations to rational organizational design that may yield an insight as to why the DRG system has such adverse effects and that may suggest a take on the role of accountability systems in our study. In an assessment of approaches to institutional designs, Pierson (2000b) argues that there are in particular three limitations or sources of influence that restrict the possibility of «rational designs»: Firstly, there is the insight that those involved in institutional design may not act instrumentally, as gathered from theorists such as March and Olsen (1989) and Powell and Dimaggio (1991). The point

is that what is deemed rational may just as well be a matter of doing what is deemed appropriate; that cultural–normative pressures are as important for design choices as instrumental consideration is. Secondly, there is the matter of time horizons in institutional planning: Long-term effects may be by-products of actions taken for short-term reasons, whether intentional or not. Combined with the observation that institutional choices depend on contexts that may be marked by processes of layering, drift or conversion (Beland 2007), the promise for organizational systems such as DRGs is less certain than suggested by model designers. The third limitation proposed by Pierson (2000b: 483) is that institutional effects may be unanticipated, notwithstanding that designers may act instrumentally and do consider long-term effects. For our study, the proposition would be that the DRG system experiences we study may be the result of «appropriate planning», short-term considerations or just unanticipated consequences.

## Two countries, eight cases, similar cheats?

In the following sections, we provide descriptions of eight different cases, all of which revolve around various DRG-related malpractices. The cases display gaming of varying severity taking place in different settings and resulting in a range of effects varying from patient death to illegitimate hospital revenue. In our assessment of the cases we emphasize the type of gaming that has taken place and how it has been dealt with in terms of accountability. For structuring purposes, we start with the Norwegian cases (N1 through N4) before moving on to the German (G1 through G4).

**N1: The Arendal Hospital coding scandal:** In 2003, a leading newspaper reported what was labeled a «coding scandal» in the Helse Sør regional health enterprise (Aftenposten 12.3.03). A certain clinic had registered around 50 % of *all* patients having undergone or being in need of tonsillectomies to treat snoring.

A physician acting as an external consultant proposed a new «creative» way of coding to the regional health enterprise, primarily by adding a secondary diagnosis to the primary. He asked for a commission – 10 per cent of the extra funding yielded by this practice. The managing director of the regional health enterprise and some of the local enterprises agreed, thus bringing each hospital extra funding to the tune of several million Norwegian kroner. When the scam was revealed, the minister set up an investigation and the board of the regional health trust was instructed to report back. An external auditing firm was hired to investigate the case, which found that 48 per cent of the investigated coding was false. As soon as the case gained momentum, a formal investigation was set in motion. In gathering information about the conduct, the minister relied on two separate processes: The hierarchical instruction of the regional trust's board within the governance chain, but also the engagement of an external accounting firm (Christensen, Læg Reid and Stigen 2006).

The case attracted national attention and a thorough administrative and political debate on the matter arose, indicating that central actors took the potential undermining of the delegation of authority seriously. The standing committee on scrutiny and control in



the Storting asked for an evaluation of the activity-based funding system, and the Auditor General conducted a performance audit of the DRG/ABF system, focusing on the coding of patient diagnoses.

The manager of the local health enterprise and the clinic manager involved resigned, and illegal surplus had to be paid back. The director of the regional health enterprise was at first severely criticized and stripped of many of his board chairmanships, later he resigned from his position. The minister eventually also replaced the executive board of the regional health enterprise. The consequences were formal and followed the hierarchical chain from minister to regional board to local director and hospital manager. Another consequence of the coding case was that the Ministry of Health for the first time conducted a thorough evaluation of the activity-based funding system for Norwegian hospitals. Upcoding of treatment was revealed to be a widespread practice; three out of five hospitals practiced some kind of creative coding to increase funding.

**N2: The Asker and Bærum Hospital manipulating of patients» records:** In late 2009 and early 2010, the national newspaper VG ran a series on the problem of long waiting lists in the Norwegian hospital system. The newspaper revealed that Asker and Bærum hospital in the local health enterprise Vestre Viken had not followed up on patients as it was supposed to, because of a semi-systematic alteration of patients» records. Patients had not received proper information about waiting times for hospital treatment, about opportunities to complain about hospital decisions, about their right to treatment, nor about the possibility to choose between providers. Patient records were accessed and changed, particularly information relevant for making follow-up appointments and records of examinations performed before discharge.

This caused more manageable and favorable-looking waiting lists for the hospital, as fewer patients were added to them. Length of waiting lists and time spent waiting by patients are among the parameters for measurement of hospital performance. The problem persisted for six years before being uncovered, and as a consequence several lives were lost. Possible gains for the hospital included a smaller likelihood for becoming a subject to cost containment measures and an improvement in its reputation, but also an alteration of the financial basis for the hospital as a result of actual diagnoses not being recorded, reported and coded appropriately.

The investigations by the newspaper VG triggered direct formal scrutiny of the journal practices in Asker and Bærum hospital. The Board of Health Supervision – the national audit agency for healthcare – immediately became involved in the case. Moreover, because the case involved illegal conduct, the Board of Health Supervision reported the health enterprise to the police, who made their own investigation. The board of the Vestre Viken enterprise also acted as a forum towards the hospital management, a particular issue being that the hospital had initially denied its own board access to internal reports on the matter.

The case triggered a prolonged public debate establishing a picture of a hospital system in crisis. With the national attention one could perhaps expect the involvement of central actors, but in this particular case the problem was considered local and confined; leading public officials were only marginally affected. The discussion pointed at specific practices in particular organizational locations and the case was considered a direct

violation of regulations more than a systemic flaw. The focus was on malpractice rather than system failure.

In terms of sanctions, all board members (except one) of the Vestre Viken health enterprise were replaced, and at least three managers were removed from their positions. The police investigation ended with the health enterprise being fined 5 million NOK. Sanctions were issued as a consequence of a direct breach of standard codes of conduct and regulations for hospitals. The role of the police also signals that a hospital administration is not exempt from legal investigation, reflecting the severity of loss of life. The sanctions issued by the police were directed towards the hospital and not towards individual managers or medical professionals.

**N3: The code cheating in Lillehammer Hospital:** In June 2011, a standing committee acting as advisor to the Ministry of Health on issues of activity-based financing, uncovered a systematic wrongful coding practice at Lillehammer hospital, part of the enterprise Sykehuset Innlandet: Minor injuries had been coded as multiple traumas. The committee stated that the code manipulation could only be motivated by an increase in hospital revenues (VG June 24, 2011).

In contrast to the first two cases, the media did not play a role in uncovering this case. The committee had been working with statistics concerning hospital activity, and Lillehammer hospital displayed an incredible success rate in the treatment of multiple traumas; so successful, in fact, that the number of treated traumas exceeded the likely number of such injuries in the hospital's catchment area. Upon closer inspection, it became clear that the hospital had employed a different coding practice than other Norwegian hospitals.

The local health enterprise stated that it would refund the extra revenue, but added that the guidelines and regulations concerning coding and financing were unclear, and that this contributed to the practice at Lillehammer hospital. The managing director of the unit involved resigned immediately. Interestingly, both the local medical professionals at the hospital and the enterprise board supported the department manager, notwithstanding that the code cheating had been going on for several years. In the rather sparse media coverage of the case, the manager is by supportive actors described as something of a coding authority. The manager remained an employee of the unit, but was stripped of managerial responsibilities. The discussion phase seemed to revolve around whether the committee's criticism was just, around possible sanctions and around the severity of the problem. No patients were harmed, reducing damage to breaches of appropriate practice and unlawful economic gain.

The case shows that the perceived severity of inappropriate coding practices seems to depend on the possible consequences for patients and on whether the malpractice is seen as a systemic problem. In this case, formal sanctions were not issued – in part because the individual in question resigned from his managerial position and in part because the hospital management immediately acknowledged the wrongdoing and decided to reimburse the state. This means that the size and scope of the case matters when it comes to activating accountability mechanisms. More importantly, the hospital's statement

regarding unclear regulation shows how loopholes may exist within performance measurement systems such as the DRG/ABF system.

**N4: The code cheating in Drammen Hospital:** In late 2011, the national broadcasting corporation NRK revealed that patients with same-day appointments in Drammen Hospital, a subdivision of the Vestre Viken enterprise, were being registered as overnight patients – even though they had not spent the night at the hospital. This time, the coding practice did not have direct medical consequences, but brought substantial financial gains to Drammen hospital. In effect, the false coding practices led to increased expenditure for the state and increased revenue for the hospital.

An interesting facet to this case is that the unit manager was notified about the code cheating but did not take action for six weeks. Finally, an employee blew the whistle about the practice to the regional health trust, which demanded a full investigation. The case was filed with the police. The media served as the initial investigator. The reluctance of the department manager to deal with the case seems to have jeopardized the internal investigation of the case, leaving it for the police to investigate.

In terms of debate and consequences, Vestre Viken health enterprise openly admitted that Drammen hospital had wrongfully coded at least 1500 patients over an extended period of time, which meant that the fundamental facts of the case had been established. The enterprise board accepted a fine issued by the police; a formal judicial sanction was issued. What the case shows, however, is that the coupling of coding responsibilities with financial incentives creates room for inappropriate maneuvering. In terms of accountability, we again observe the combination of informal external attention with more formal action – in this case by the police. As with the 2011 Lillehammer case, this case shows how internal, trust-based accountability mechanisms do not seem to hinder code cheating, but also that internal reactions are rather soft. This could perhaps indicate a strong loyalty among professionals, where external control and «bureaucratic excess» are seen as part of the problem rather than as a solution to malpractice.

**G1: The creaming in Altmark-Klinikum Gardelegen:** In September 2011 six doctors, five consultant doctors and the head doctor, informed the managing director and the medical director of the Altmark-Klinik in Gardelegen (state of Saxony-Anhalt) about unacceptable conditions in the neuro-surgical ward. An increasing amount of surgeries was being performed without medical indication and the doctors were worried about the standing and reputation of the clinic. Several such letters were written and a list comprising 62 names of patients emerged. At least one person had died of several unnecessary surgeries.

The clinic's management, however, did not react by holding the neuro-surgeon accountable, but undertook several attempts to fire the whistle-blowing doctors. The head doctor, a surgeon himself, was denied renewal of his contract and received altogether four dismissal letters, which he legally challenged. The head doctor won the legal case, and has to be re-hired. The management of the clinic, the executive director, the medical director as well as the head of the supervisory board who is also the head of the administrative district in which the hospital is located, remained reluctant to comment on the case for a long time – but in late February 2013 clinic's management admitted that in 15 cases the

medical indications had not been sufficient to warrant surgery. The clinic's executive director has since been fired.

Seven health insurers as well as the union of health insurers Saxony-Anhalt activated their Task Forces to investigate the books of the hospital. Prompted by several media reports, the legal prosecutor of Stendal began investigating. The investigations are led against the head of the neuro-surgical ward for grievous bodily harm. Whilst the medical association (Ärzttekammer) has also been alerted, this professional body currently awaits the legal investigations to come to a judgment. The Federal State's Administrative Office is also doing an investigation.

**G2: The organ transplants in Göttingen, Regensburg, Munich and Leipzig:** Since 2011 there has been a series of scandals relating to organ transplants in Germany. Here, data were manipulated in order to make transplant organs available for patients who otherwise would have had to wait much longer, especially for livers. Four instances together comprise our case:

- In Leipzig (Universitätsklinikum), between 2010 and 2012, the data of 38 patients (as of Jan. 2013) were manipulated.
- In Göttingen (Universitätsklinikum), the data of 25 patients were manipulated.
- Munich (Klinikum Rechts der Isar) reported more than 20 cases.
- Regensburg (Universitätsklinikum) reported about 40 cases

A range of incentives seems to have facilitated this behavior. Firstly, some doctors genuinely wanted to help their patients. For example, recovered alcoholics need to prove a 6-month dry period to be eligible for a transplant, but some would have died in this period. Secondly, surgeons received bonuses for each transplanted liver. For example, the surgeon in Göttingen received 1500 Euros per liver. Around 50% of all working contracts with doctors now include bonuses for treatments and services that are lucrative for the clinics. Thirdly, target agreements (Zielvereinbarungen) as part of the clinics' policy also played a role in a number of cases: The hospitals earn up to 200.000 EUR per liver transplant, a high reward compared to e.g. a kidney transplant that yields 50.000–65.000 EUR or a bypass-surgery yielding 18.000 EUR. Since having a transplant center is very lucrative for hospitals, there has been a rise in the number of such centers (currently 41). There is significant competition amongst them, as they are legally required to perform a minimum of 20 liver transplants and 25 kidney transplants per year. Fourthly, bribery may also have been involved. In Göttingen, a Russian patient received a liver, even though he would not have been eligible for it. A company that had advertised treatments on the internet and which was in touch with the clinic is under investigation.

The clinics reacted to these scandals by suspending the doctors in question for the time that legal investigations were under way. In July 2012 the Universitätsklinik Göttingen abolished both target agreements and bonuses for transplant medics. As regards the bonuses, in January 2013 governmental fractions have issued a legal proposal to order the German Association of Hospitals «to review their counseling and formulation advice for

contracts with leading doctors». Also, bonus payments are to be transparent by becoming part of hospitals regular Quality Reports.

Legally, some differences are notable: The Saxonian Ministry for Science, responsible for Leipzig, saw no further need to act, whereas the Permanent Commission Organ Transplants, which is part of the Federal Medical Chamber, now shuts down all doctors involved in such manipulations. The clinic in Leipzig introduced a «several eyes-principle,» so that single doctors cannot single-handedly decide whom to put on the Eurotransplant waiting list. However, these self-control mechanisms internal to the clinics have in other areas proven to be ineffective, as the Minister of Science in Bavaria insists. In Munich, the transplant center underwent a re-structuring. In this the Bavarian Minister of Science, who is also the head of the hospital's supervisory board was involved.

The legal prosecution, taking place at a local or regional level, has taken different approaches. The prosecutor in Braunschweig (responsible for Göttingen) charged the doctor in question with attempted manslaughter, since patients entitled to a liver transplant may have died as a result of being moved down on the waiting list. Another possibilities include filing the manipulations as law infringements, violations of the Transplant Law (in Regensburg), and for the clinics to get away with penalty fines. Investigations are still ongoing.

On the federal political level, the Marburg Association (Marburger Bund), the Federal Medical Chamber and the Association of Leading Hospital Doctors have been lobbying the government to ban bonuses in doctors» contracts, fearing that these are contrary to the doctors» ethos and dangerous for medical quality. However, after being reduced to «making the bonuses transparent», this suggestion was declined. The federal health minister Daniel Bahr, who had previously portrayed the health care system as a «growing economic sector» is blocking any legislation that would reduce economic incentives for doctors to cheat. However, he wanted to install further control mechanisms, involving the district administrative authorities. Legal expertise has been commissioned to change the measures of punishment, norms for legal fines as well as changes in professional law. There has also been talk about reducing the number of transplant centers; the one in Munich will in all likelihood be shut down.

**G3: The DRK-clinics upcoding:** The investigations against the DRK (Deutsches Rotes Kreuz) hospitals in Berlin began with an anonymous report to the police. Presumably the report was submitted by a member of staff, which had been striking repeatedly against bad working conditions and low pay. In June 2010, the police raided three hospitals in Berlin (Westend, Wedding, Köpenick). The «Medical Care Centres» (Medizinische Versorgungszentren, MVZ) had fraudulently been charging health insurers for specialist treatments. In order to make this possible, the hospitals» managements and medical heads had searched for specialist doctors who wanted to give up their practices. Then they pretended to hire them, including their insurance approbations (Kassenärztliche Zulassung) – but the specialists never actually worked in the clinics. Instead, twelve assistant doctors were performing the treatments, which subsequently were coded as specialist services. Between 2004 and 2010, an estimated financial damage of around 11 million Euros was caused. The income of the polyclinics rose, as did the incomes of the head doctors.

The consequences, firstly, took place on a legal level. In February 2012 the former head doctor and two managing directors were charged with fraud; an additional four members of staff were charged with aiding and abetting fraud. The charges include wrongful medical treatments, 128 manipulated bills/accounts (DRG-related) and 56 cases of bodily harm. The legal prosecutor classified the case as «organized and professional medical accounting fraud». Altogether 90 persons were investigated. Notably, though, these investigations do not necessarily lead to professional disadvantages. Secondly, in relation to the health insurers, the DRK-clinics came to an agreement with the Insurance Doctors» Association (Kassenärztliche Vereinigung, KV) to close down the Medical Care Centres in Mitte, Westend and Köpenick. Moreover, the public association of hospitals paid back 11 million EUR in fees to the KV, so that protracted legal proceedings were avoided. Thirdly, the DRK-clinics fired several members of administrative staff. Structurally, the new manager aimed at a strict separation of in-patient and ambulant administration.<sup>4</sup>

**G4: The Helios-clinics upcoding:** The case of the Helios-clinics in Berlin resembles that of the DRK-clinics. Here, between 2008 and 2011, medical services provided by assistant doctors were coded and billed as specialist treatments. The focus was specifically on the radiological and cardiological wards in Berlin-Buch. After a police-raid, 14 people were investigated, including doctors, head doctors and managers. In 2012, prompted by the prosecutors in Berlin, the prosecutors in Thuringia started investigating the Helios-clinic in Erfurt. Eight cases are currently under investigation.

Notably, the public prosecutor's office in Meiningen, which is now investigating the charges against Helios in Erfurt, has a «Special Department for the Combat of Accounting Manipulations in the Health Care Sector». Again, the political reaction here has been slow to non-existent. The Berlin Senator for Health, Katrin Lompscher (Left Party) said she was «expecting more such cases». However, just like the Gardelegen supervisory board is staffed with political/ state's administrators, so is Lompscher also on the supervisory board of the Vivantes hospital corporation, owned by the state of Berlin. There, she said «she found no evidence» of any account fraud. As regards private clinics she sees her task in «demanding a full investigation of what happened» and in «helping the clinics in their efforts» to investigate.

## Discussion

In both Germany and Norway, the DRG systems allow behavior that by different standards is deemed inappropriate. Whether described as upcoding, creep, skimming or just fraud, such practices challenge both formal regulation and informal sets of norms and values – sometimes both, always the latter. This is a common point of reference in all cases: The three common denominators are, firstly, that the cases revolve around coding, financing or DRGs in one way or another; secondly, that there is evidence of an ethos being challenged

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<sup>4</sup> [http://www.kma-online.de/nachrichten/management/id\\_\\_23643\\_\\_\\_view.html](http://www.kma-online.de/nachrichten/management/id__23643___view.html)

by practice; and, thirdly, that accountability arrangements of various kinds were set in motion to deal with them.

*Table 2: Case summary by type of forum and actor, (x) indicates category is less characteristic*

Case	To whom is the actor accountable?					Who is being held accountable?	
	political	legal	administrative	professional	social	individual	collective
N1	x		x		x	x	x
N2	(x)	x	x		x	x	x
N3	(x)		x	x	(x)	x	(x)
N4	(x)	x	x	x	x	undecided	
G1		x	(x)	x	x	x	x
G2	(x)	x	(x)	x		x	
G3		x	(x)	x	(x)	x	
G4		x	(x)	x	(x)	x	x

A summary of our findings may be in order (see Table 2). If we compare the cases across both countries in terms of the type of forum, a few patterns emerge. Firstly, the cases clearly display complexity in terms of accountability arrangements at play. In all cases, three or more different forms of accountability are identifiable. Although the significance or centrality of a forum's role varies considerably, accountability arrangements never exclusively revolve around a single forum's scrutiny, judgment or sanctioning.

This entails an elaboration: A second characteristic emerging from our comparisons is that administrative accountability assumes a role in all cases investigated. In Norway, there is in general a combination of internal and external administrative accountability – whether individual actors are held accountable to boards and directors, or if entire organizations are held accountable to external agencies or scrutinizing bodies. In the German system, however, external administrative accountability is scarce. Here, internal mechanisms play a more distinct role, although efforts to introduce «more eyes» within the hospital organizations are criticized for being ineffective and biased. German hospitals are more independent or autonomous from the general politico-administrative system than Norwegian hospitals, it seems, as is also evident in the fact that health services in the country are largely decentralized at the Länder level, with regulation of service delivery organized through self-governing bodies. Whereas administrative accountability is among the hierarchic characteristics of the Norwegian governance system as such, the German relationship between e.g. task forces from the health insurers and the hospitals are less hierarchical and more loosely connected. On the individual level, likely sanctions in both countries are loss of positions or the firing of officials – but more so in Norway, as

illustrated by the replacement of enterprise boards and directors or even by the stripping of a doctor's managerial responsibilities in the Lillehammer case.

Thirdly, legal accountability – mostly towards individuals – is a characteristic of the four cases reported from Germany. It is both the most visible, and in some cases, the only concrete form of accountability being exercised. It is, however, important to note a disjunction: Whereas individuals are investigated and checked for illegitimate practices, organizational and economic entities such as hospitals are largely left unchecked for malpractice. In Norway, it seems that where legal accountability plays a role, it is mainly towards collective entities such as local health enterprises. Fines or formal charges towards individuals are not common here, and it seems that accountability in legal terms is mostly connected to the public organizations' responsibilities to provide services that meet standards in terms of both quality and code of conduct. In Germany, it seems that corporate entities are out of the reach of legal forums handling malpractice within the economic incentive system. In Norway, on the other hand, legal sanctions have a systemic outlook.

Fourthly, different forms of social accountability seem to be important in the handling of DRG scandals in both countries. Notably, the media is pivotal in raising awareness and setting the agenda, and in quite a few of the cases in both countries the media served as the initial investigator. Other forums then act on the provided information. In Germany, the media attention is largely focused on individual actors, but it has at times focused on flawed incentive systems such as bonus payments or target agreements in hospitals. The Federal Chamber of Doctors here has an ambiguous reputation. On the one hand it tends to come under negative scrutiny, as it is seen as merely protecting doctors' privileges. On the other hand, the Chamber's commissions and audits are playing a pivotal role in uncovering the scandals, especially as regards manipulations in the context of organ transplants. At the national level media reports focus on singular, large scandals or a series of scandals, following up also on federal legislative responses. However, since organizational, supervisory and political decision-making relating to individual hospitals is the prerogative of the State, it is the State and local media who follow up on the hospitals' responses (if at all): This happened in the case of the Berlin clinics, but also in the case of Gardelegen. In the Norwegian setting, national media quickly pay attention to healthcare-related cases, also the cases we have investigated. Political debate is carried out relatively openly, typically engaging both politicians and practitioners. The professional associations play a lesser role, however, as regulation and decision-making to a larger extent rests within state apparatus.

Fifthly, professional accountability plays a more prominent role in Germany than in Norway: This is where ethical debates are conducted, and all the German cases show how scandals are uncovered and publicized amongst peers and hospital staff. Moreover, German professional bodies are semi-independent legal bodies that issue guidelines for hospitals and for professional sanctions: The Medical Chamber shuts down practices and issues revised guidelines, and they have a supervisory role in feeding information to legal processes. However, in itself a body of «self-administration», its regulation of the transplant system has come under critical fire from constitutional lawyers and state lawyers, who have called it downright unconstitutional. At the same time, the Federal Medical Chamber is keen to uphold hospitals' self-administration through trust in the self-



regulating, self-controlling capacities of doctors and the hospital system as a whole. In the Norwegian cases doctor's associations have not played any role. However, in the Lillehammer case, local professionals (and the hospital management) rushed to the support of the accused physician, and in the Drammen case whistle blowing by peers based on professional opinions played an important role for the case to surface.

Sixthly, the engagement of national level politicians is more upfront in Norway than in Germany. In effect, this engagement does not necessarily revolve around the formalities of single cases (hence the (x)'s in Table 1), but comes to show in media coverage, through vivid debates and not least through broader assessments and reports to parliament and cabinet. The less court-oriented Norwegian system tends to lend its attention to collective action problems, in the sense of a broad consensus around the belief that issues like these are everybody's problems and that they must be «fixed» as such. An important note to make, is that the Norwegian cases display how political accountability arrangements connect to social forms of accountability: A broad media coverage of Norwegian hospitals has in general created a picture of system failure (Neby 2012), and large-scale assessments of the DRGs and connected coding practices have been set in motion by both the Auditor General (which acts on behalf of parliament), the Health Directorate and the regional health enterprises (Lægneid and Neby 2012).

## Closing arguments

Summing up, there is a difference in how «the problem of many eyes and hands» (Bovens 2007b) is resolved in the two hospital systems, despite the fact that the nature of the investigated scandals are remarkably similar: They all concern illegitimate practices reflecting the room for strategic maneuvering created by the application of DRGs, whether these concern a lesser quality of care, improper coding practices, or both. The differences in accountability arrangements that deal with these scandals show how policy initiatives – such as DRGs – are not independent from the settings they aim to change, and how new solutions build on previous policy choices. For example, although Norway was slightly earlier in its implementation of DRGs than Germany, the old system of block grants was in practice never left behind. As Germany introduced DRGs, the choice of a reference baseline fell on an Australian variant of the system – one did not start from scratch.

The German corporatist system differs distinctly from the Norwegian state-owned solution, in terms of how political influence is channeled into the system, the structuring of finance (insurance providers versus state grants), the role of the professions and not least the role of the legal system in resolving conflict and tension. The DRG system is embedded in these two differing contexts, although the incentives created by it are largely the same. This suggests that it is important to keep in mind that although new measures – such as DRGs – may influence accountability arrangements, such effects depend on the larger institutional framework that they are located in. For example, Norwegian DRG practices cannot be properly understood without taking into account the state-owned enterprise structure, whereas the German court system ensures a more discretionary and profession-oriented system. The direct opening for ministerial intervention that the Norwegian system

allows through the ownership of hospitals is not possible in Germany, where the trust in the system rests with decisions of legality weighted to performance. The common choice made in Germany and Norway to apply DRGs in performance management and financing of hospitals rests on the same logic and creates similar opportunities for adverse gaming practices, but how the larger systems handle and resolve the scandals studied, varies considerably.

From historical institutionalism, we know the arguments that historical trajectories and contexts matter (Thelen and Steinmo 1992). Or as March and Olsen (1995:4) claim, «The democracies of today are the products of yesterday». Institutional changes are layered onto each other, developments drift in particular directions, and institutional arrangements are supplemented with new, translated components from other settings – not least in healthcare (Byrkjeflot and Neby 2008). Both the G-DRGs and the NordDRGs are in this sense translations of a particular scheme for influencing institutional behavior. The accountability arrangements that follow the scandals we have studied, suggest that the larger institutional frameworks surrounding the DRG systems change less than the practices dealt with. While the gaming practices seem relatively similar across country, the resolving of the cases differs markedly between the German and the Norwegian setting.

Whereas the Norwegian and German DRG systems arguably are translated versions of a particular organizational tool, the translation in either country has not excluded the possibility for undesired adverse effects. These effects resemble each other, notwithstanding the institutional differences between the two hospital systems. The interesting facet, related to our analytical expectations, is that whereas the DRG gaming is comparable, the handling of adverse effects in terms of accountability differ markedly. Moreover, the introduction of DRGs seems to be a case of what is often labeled as isomorphism (Powell and DiMaggio 1991): In spite of large variation in the institutional environment, both the DRG system and its effects are comparable across national context.

Revisiting Pierson's arguments (2000b) about limitations to institutional designs, the DRG dysfunctions could perhaps be interpreted as unanticipated consequences, where the contextual framework, the pressures for cost containment and availability of a particular solution may have played a role. The handling of the discussed cases in terms of accountability, however, differs more than the DRG solution itself: The German and Norwegian systems provide different opportunities for resolving arising issues of accountability, which the cases clearly show. In the German context, resolving issues through legal procedures is much more characteristic than in Norway, where administrative, political and social forms of accountability play a larger role. In Beland's (2007) terms, it seems that the DRG system in both countries has been layered on top of existing frameworks, where traditional institutional arrangements are left to resolve issues of accountability. As to the causes of the malpractices discussed in this paper, one may argue that there has been a policy drift (*ibid.*), where the existing institutional framework has been unable to adapt to the new organizational tool that the DRG system arguably is.

This leaves us with a situation where, one may argue, pressures towards isomorphism across international borders are strong enough to allow the introduction of relatively similar institutional arrangements, but where the interaction between the existing institutional framework and the DRG system creates different practices of accountability in

the two countries. Our main finding, thus, is that whereas the gaming and misconduct that stems from an isomorphic adaption of the DRG system is relatively similar across the Beveridgian–Bismarckian divide between Norway and Germany, the accountability arrangements and processes involved in resolving the cases to a much larger extent reflects this divide. Neither hospital system has proven to prevent gaming, perhaps reflecting that both the introduction of and the handling of adverse practices rest on a logic of appropriateness that highlights normative pressures.

## Literature

- Aucoin, P. (1990) Administrative Reform in Public Management: Paradigms, Principles, Paradoxes and Pendulums. *Governance*, 3(2):115–137.
- Beland, D. (2007) «Ideas and institutional change in social security: Conversion, layering and policy drift». *Social Science Quarterly*, 88(1):20–38.
- Bode, I. (2012) Processing institutional change in public service provision: The case of the German hospital sector. *Public Organization Review*, published online October 23 2012, DOI 10.1007/s11115-012-0201-z.
- Bovens, M. (2007a) «Public accountability». In E. Ferlie, L.E. Lynn and C. Pollitt (eds.), *Oxford Handbook of Public Management*. Oxford: Oxford University Press.
- Bovens, M. (2007b) «Analyzing and assessing public accountability. A conceptual framework». *European Law Journal*, 13 (4): 837–868.
- Busse, R. (2000) Germany opts for Australian Diagnosis-Related Groups. *Euro Observer*, 2(3):1–3.
- Busse, R. (2011) *The German healthcare system: An introduction*. LIF Seminar, 12 April 2011, Stockholm, Sweden.
- Busse, R. and A. Riesberg (2004) *Health care systems in transition: Germany*. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2004.
- Busse, R., J. Schreyögg and P.C. Smith (2006) Editorial: Hospital case payment systems in Europe. *Health Care Management Science*, 9(3):211–3.
- Byrkjeflot, H., T. Christensen and P. Læg Reid (2012) «The many faces of accountability comparing reforms in welfare, hospitals and migration». Paper presented at the ASPA Conference, Las Vegas 2–6 March.
- Byrkjeflot, H. and S. Neby (2008) «The End of the Decentralized Model of Healthcare Governance? Comparing Developments in the Scandinavian Hospital Systems». *Journal of Health Organization and Management*, 22(4):331–349.
- Byrkjeflot, H. and D.O. Torjesen (2010) «Managerial Innovation in Health Care. The Introduction, Translation and Use of American DRG System in the Hospital Sectors in Norway and Denmark». In M.F. Knudsen, ed. *Mysterion strategike og kaintotomia*. Oslo: Novus Forlag; pp. 130–48.
- Böcking, W., U. Ahrens, W. Kirch and M. Milakovic, (2005) First results of the introduction of DRGs in Germany and overview of experience from other DRG countries. *Journal of Public Health*, 13:128–137.

- Christensen, T., P. Læg Reid and I. Stigen (2006) «Performance Management and Public Sector Reform: The Norwegian Hospital Reform». *International Public Management Journal*, 9(2): 1–27.
- Cots, F. et al. (2011) «DRG-based hospital payment: Intended and unintended consequences». In R. Busse et al., eds. *Diagnosis-Related Groups in Europe*. Mc Graw Hill: Open University.
- Covaleski, M.A., M.W. Dirsmith and J.E. Michelman (1993) «An Institutional Theory Perspective on the DRG Framework, Case-mix Accounting and Health-care Organizations». *Accounting, Organizations and Society*, 18/1, pp. 65–80.
- Czarniawska, B. and G. Sevón. (eds.) (1996) *Translating Organizational Change*. Berlin, De Gruyter.
- Day, P. and R. Klein (1987) *Accountability. Five Public Services*. London: Tavistock Publishers.
- Donaldson, C. and J. Magnussen (1992) «DRG: the road to hospital efficiency». *Health Policy*, 21: 47–64.
- Ellis, R. (1998) «Creaming, skimping and dumping: Provider competition on the intensive and extensive margins». *Journal of Health Economics*, 17:537–555.
- Fetter, R.B. (ed.) (1991) *DRGs*. Ann Arbor: Health Administration Press.
- Fetter, R.B. and J.L. Freeman (1986) «Diagnosis Related Groups: Product Line Management within Hospitals». *Academy of Management Review*, 11/1, pp. 41–54.
- Hafsteinsdóttir, E.J.G. and L. Siciliani (2009) DRG prospective payment systems: refine or not refine? *Health Economics*, 19 (10): 122–139.
- Helsedirektoratet (2011) *DRG systemet*. Oslo: Helsedirektoratet.  
<http://www.helsedirektoratet.no/finansiering/drg/Sider/default.aspx>
- Hood, C. (1991) A Public Management for all Seasons? *Public Administration*, 69(1):3–19.
- Hsiao, W.C., H.M. Sapolsky, D.L. Dunn and S.L. Weiner (1986) «Lessons of the New Jersey DRG payment system». *Health Affairs*, 5/2, pp. 32–45.
- Jaklin, P. (2003) Neues Preissystem treibt Klinikkosten hoch. *Financial Times Dtsch*, April 29, 2003
- Jakobsen, M.L.F. (2009) «The Effects of New Public Management: Activity-based Reimbursement and Efficiency in the Scandinavian Hospital Sector». *Scandinavian Political Studies*, 33 (2): 113–134.
- Kastberg, G. and S. Siverbo (2007) «Activity-based financing of health care – experiences from Sweden». *International Journal of Health Planning and Management*, 22:25–44.
- Kjerstad, E. (2003) «Prospective Funding of General Hospital in Norway – Incentives for Higher Productions?» *International Journal of Health Care Finance and Economics*, 3(4):231–251.
- Kjerstad, E. and F. Kristiansen (2005) «Free choice, waiting times and length of stay in Norwegian hospitals». Health Economics Bergen Working Paper No. 21/05. Bergen: Institute for Research in Economics and Business Administration.
- Levay, C. and C. Waks (eds.) (2006) *Strävan efter transparens. Granskning, styrning och organisering i sjukvårdens nätverk*. Stockholm: SNS, Förlag.
- Læg Reid, P. and S. Neby (2012) *Gaming the system and accountability relations: Negative side-effects of activity based financing in the Norwegian hospital system*. Working paper 10-2012. Bergen, Uni Rokkan Centre.

- Løkeland, T. (2013) *Prestasjonsmåling på en kreftavdeling. Ikke alt som teller kan telles, og ikke alt som kan telles teller*. Master thesis, Department of Global Public Health and Primary Care, University of Bergen.
- Mahoney, J. and K. Thelen (2010). *Explaining Institutional Change: Ambiguity, Agency, and Power*. Cambridge: Cambridge University Press.
- Malena, C., R. Forster and J. Singh (2004) *Social Accountability: An Introduction to the Concept and Emerging Practice*, Social Development Paper 76, Washington DC: World Bank.
- Magnussen, J. (1995) «Efficiency measurement and hospital financing: the Diagnosis Related Groups in Norway». In A. Alban and T. Christiansen (eds.), *The Nordic Lights. New Initiatives in Health Care Systems*. Odense: Odense University Press.
- Magnussen, J. and K. Solstad (1994) *Case-based hospital financing: the case of Norway*. *Health Policy*, 28:23–36.
- March, J.G. and J.P. Olsen (1989) *Reidscovering Institutions*. New York The Free Press.
- March, J.G. and J.P. Olsen (1995) *Democratic Governance*. New York: The Free Press.
- Martinussen, P.E. and T.P. Hagen (2009) «Reimbursement systems, organizational forms and patient selection: Evidence from day surgery in Norway». *Health Economics, Policy and Law*, 4 (2): 139–158.
- Mikkola, H., I. Keskimäki and U. Häkkinen (2002) «DRG-related prices applied in a public health care system – can Finland learn from Norway and Sweden?» *Health Policy*, 59 (1):37–51.
- Morriem, E.H. (1991) «Gaming the System». *Arch Intern Med*, 151:443–447.
- Mulgan, R. (2003) *Holding Power to Account. Accountability in Modern Democracies*. London: Palgrave.
- Neby, S. (2009) «Institutional Reform and Governance in the Scandinavian Hospital Fields. The dynamics of and between change and control». PhD dissertation, University of Bergen.
- Neby, S. (2012) «Accountability and the media: Single-case lessons and patterns from Norwegian health care». Draft paper.
- NOU (2003:1) Behovsbasert finansiering av spesialisthelsetjenesten (Need-based financing of specialist health care). Oslo: Ministry of Health.
- OECD (2012) *How Does Norway Compare?* OECD: Health Data 2012.
- Pierson, P. (2000a) «Increasing Returns, Path Dependence, and the Study of Politics.» *American Political Science Review*, 94(2):251–267.
- Pierson, P. (2000b) «The Limits of Design: Explaining Institutional Origins and Change». *Governance*, 13(4): 475–499.
- Powell, W.W. and P.J. DiMaggio (1991) *The New Institutionalism in Organizational Analysis*. Chicago: University of Chicago Press.
- Romzek, B. and M. Dubnick (1987) «Accountability in the Public Sector: Lessons from the Challenger Tragedy». *Public Administration Review*, 47 (May/June):227–238.
- Scheller-Kreinsen, D., A. Geissler and R. Busse (2009) The ABC of DRGs. *Euro Observer*, 11(4):1–5.

- Schillemans, T. (2008) «Accountability in the Shadow of Hierarchy: The Horizontal Accountability of Agencies». *Public Organization Review*, 8 (2): 175–194.
- Schlingensiepen, I. (2003) Erste Abrechnungsdaten nach DRG schüren Misstrauen der Kassen—werden Klinik-Budgets nachverhandelt? *Ärzte Zeitung*, May 02, 2003.
- Schönfelder, T., S. Balazs and J. Klewer (2009) Kosten aufgrund von DRG-Upcoding durch die Einführung der Diagnosis Related Groups in Deutschland. *HeilberufeSCIENCE*, 2(3):77–81.
- Schreyögg, J., O. Tiemann and R. Busse (2006) Cost accounting to determine prices: How well do prices reflect costs in the German DRG-system? *Health Care Manage Sci*, 9:269–79.
- Silverman, E. and J. Skinner (2003) «Medicare uploading and hospital ownership». *Journal of Health Economics*, 23: 369–389.
- Stambolovic, V. (2003) «Epidemic of Health Care Reforms». *European Journal of Public Health*, 13:77–79.
- Statistisches Bundesamt (2011) *Gesundheit – Fallpauschalenbezogene Krankenhausstatistik (DRG-Statistik): Diagnosen, Prozeduren, Fallpauschalen und Case Mix der vollstationären Patientinnen und Patienten in Krankenhäusern – Fachserie 12, Reihe 6.4.*
- Streeck, W. and K.A. Thelen (2005) «Introduction: Institutional Change in Advanced Political Economies». In W. Streeck and K.A. Thelen (eds.) *Beyond Continuity: Institutional Change in Advanced Political Economies*. Oxford: Oxford University Press.
- Thelen, K.A. (2004) *How Institutions Evolve: The Political Economy of Skills in Germany, Britain, the United States and Japan*. Cambridge: Cambridge University Press.
- Thelen, K.A. and S. Steinmo (1992) *Structuring politics*. New York, Cambridge University Press.
- Thomson, S., R. Osborn, D. Squires and M. Jun (2012) *International Profiles of Health Care Systems, 2012*. The Commonwealth Fund, November 2012.
- Torjesen, D.O. (2008) *Foretak, management og medikrati – en sektorstudie av helseforetaksreform og ledelse i spesialisthelsetjenesten*. PhD-dissertation, University of Bergen.
- Wallis, J. and B. Gregory (2009) «Leadership, Accountability and Public Value: Resolving a Problem in «New Governance»». *International Journal of Public Administration*, 32: 250–273.
- Wilke, M.H., E.F.J. Hoherl, J. Scherer and L. Janke (2001) Introducing the new DRG-based payment system in German hospitals – a difficult operation? *HEPAC*, 2:79–85
- Wismar M. and Busse, R. (2000) «Targets for health in Germany». *European Journal of Public Health*, 10(supplement 4):38–42.
- Wittmann, D. (2003) Fallpauschalen ein Fall für die Gesundheitspolitik? *Nürnberger Zeitung*, May 20, 2003.
- Wöhrmann, S. (2003) Wundersame Vermehrung. *FOCUS* 29:11.