

CORRUPTION IN HEALTHCARE:
ANALYZING THE IMPACT OF GOVERNANCE ON MEDICAL CORRUPTION IN
THE UNITED STATES AND GERMANY

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ABSTRACT

MEGAN ELISE LEAHY: Corruption in Healthcare: Analyzing the Impact of
Governance on Medical Corruption in the United States and Germany
(Under the direction of John D. Stephens)

This thesis contributes to the literature on corruption in healthcare systems by comparing the effectiveness of governance in two wealthy, stable democracies: the United States and Germany. Supported by evidence from an assessment of four dimensions of governance in healthcare systems, including accountability, transparency, monitoring and regulation and trust, it is argued that systems with less regulatory control and intervention from the state are more susceptible to higher rates of corruption. Implications from this research and evaluation may aid public officials around the world in designing more effective modes of healthcare governance, and eventually improving the overall access to and quality of healthcare provision.

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Chapter One

Introduction

Corruption has a negative impact on the delivery of healthcare services around the world. It comes in many forms and occurs at every level of the system. Researchers, policymakers and healthcare workers worldwide are increasingly focused on exposing its damaging consequences and examining different possibilities for reform and regulation. However, there is currently no consensus as to how the problem can be reduced or eliminated. The complex nature of the healthcare system makes this task exceedingly difficult to overcome, yet performing studies on the sources and impact of corruption may aid nations in reforming or designing their healthcare systems to reduce wasteful spending and maximize quality and efficiency of care.

This thesis intends to contribute to the existing literature on corruption in healthcare systems by concentrating on an area that has received insufficient attention until recent years – the impact of governance in healthcare institutions. Although there has been a recent surge in attention to the effects of governance on control of corruption, the focus has been overwhelmingly directed toward healthcare systems in developing nations. Thus, this thesis attempts to add to the scarce empirical literature by comparing governance in healthcare institutions of two wealthy democratic nations with long histories of social programs: the United States of America (US) and the Federal Republic of Germany (Germany).

Following a brief definition of corruption, the body of this thesis will be divided into two main sections: first, a general analysis of features of healthcare systems that relate governance to systemic openness to corruption; and second, a comparative evaluation of effective governance in the US and German healthcare systems.

Four dimensions will be examined in relation to governance in healthcare systems. These dimensions include *accountability*, *transparency*, *monitoring and regulation* and *trust*. Through a comparative evaluation of systematic vulnerabilities to corruption due to governance, with the presence of five groups of actors in the system, this thesis will argue that systems based on less state intervention experience higher exposure to possibilities of corruption. Due to the difficulty in measuring corruption and finding reliable data, this thesis does not extend itself to reveal *actual* variations in corruption for these two systems, but rather focuses on *vulnerabilities* to corruption due to ineffective healthcare governance.

Chapter Two

Corruption and Governance in Healthcare Systems

As a result of inherent challenges in measuring and predicting corruption, the quality and quantity of available research has been inadequate as of yet. The current theories are not sufficient for designing concrete generalizations or hypotheses on the issue of corruption in health systems. Thus, this section of the thesis attempts to elucidate existing theoretical models by discussing different features of the system as they relate to corruption.

This thesis claims that both a high level of governance capacities, such as accountability, transparency and regulation, as well as positive social perceptions involving citizen trust, are necessary to reduce the impact of vulnerabilities of the healthcare system to corruption. To support this argument, this section will be divided into three parts: first, a description of the actors involved in the system; second, a breakdown of the features of healthcare that make the system prone to corruption; and finally, an analysis of four dimensions of governance that impact the level of corruption in healthcare.

What is corruption?

Before carrying out this analysis, it is necessary to have a clear definition of corruption as it relates to the healthcare system. Throughout the literature on the topic, there seems to be general agreement on the definition of corruption as “the misuse or

abuse of office for personal gain (Brinkerhoff, 2004; Lewis, 2006; Transparency International 2006; Vian, 2008). The office is a position of trust, where one receives authority in order to act on behalf of an institution, be it private, public or nonprofit.

Five Actors and their Opportunities for Corruption

The functioning of the public system is determined by the incentives facing the actors in the system, the manner in which inputs are managed and the accountability imbedded in the incentive structure. (Lewis, 2006, p.5)

One of the common arguments as to why the healthcare system is frequently abused is that the complex design and high number of actors create several points where corruption could occur and reduce transparency in communication between actors. Recommendations for addressing this complexity often suggest establishing clear responsibilities and competencies for each actor, in order to better detect misuse and design appropriate responses for regulation. This section outlines the five groups of actors in healthcare systems and describes their roles and opportunities to abuse their authority or position for personal gain.

Regulators

Regulators include not only governmental institutions and organizations such as health ministries and parliaments, but also commissions, non-governmental and third-party organizations created or appointed to carry out duties of regulation and control. Examples of regulators in Germany and the United States include health ministries (*Bundesministerium für Gesundheit* or U.S. Department of Health and Human Services), regulatory agencies (U.S. Food and Drug Administration), state-level agencies (*Bundesrat* or state health departments), police and several international and domestic

non-governmental organizations with specific regulatory interests (World Health Organization, citizens' rights organizations, etc.). As the number of existing regulatory organizations is constantly growing, competencies are often overlapping or blurred.

Actors in this category have a range of responsibilities, including designing policies for allocation of public funds, regulating approved drugs and procedures and assuring that healthcare facilities and workers are licensed, appropriately staffed and effective. Regulators are responsible for ensuring that the citizens have access to sufficient care and prescriptions; however, these duties also involve many opportunities and pressures for regulators to abuse authority or power. Furthermore, the number of actors involved creates an environment with minimal transparency and accountability. Thus, corrupt regulators are prone to fraudulent activities involving accepting bribes for approving medical practitioner licenses or new pharmaceuticals, overlooking illegal or illegitimate practices and drawing up false reports on providers or facilities (Vian, 2008).

Suggestions for how to reduce corruption within this group include increasing transparency through making regulatory assessments available as well as conversations between regulatory agents and their clients, increasing accountability externally by opening up citizen participation in health regulation and increasing accountability internally by dividing roles and competencies more clearly for better detection of corruption.

Payers

In health insurance systems, many possibilities exist for allocation of payments. Public insurance agencies include federally funded programs, such as Medicare/Medicaid and Children's Health Insurance Program (CHIP) in the United States, and the public

‘sickness funds’ (*Krankenkassen*) in Germany. Non-profit organizations that receive public funding exist to fill gaps in care for those who cannot afford it. Examples of such organizations include Red Cross, Save the Children and Planned Parenthood. These organizations also frequently rely on fundraising projects in order to provide services for the uninsured. Other actors in the payers category include private insurance companies, which do generate revenue, but offer competitive insurance plans to citizens who can afford them both in Germany and the United States. Private insurers have much more autonomy in deciding whom they will insure based on health history and income.

Additional and often informal payer organizations and structures have developed to provide patients without health insurance with access to affordable healthcare. These can come in the form of individual patient-provider agreements, or ‘concierge’ medicine, where individuals can pay a fixed price per year for either basic services or supplementary services to their insurance plans. These types of structures are especially vulnerable to corruption, as they are mostly undocumented and informal.

Both public and private payers are prone to corruption such as creating fraudulent claims, excessive billing, inappropriate allocation of public or private funds and embezzlement. Furthermore, the allocation of public funds for health insurance, when it is not universal, is a controversial issue ridden with opportunities for political interests and bribes to impact how the funds are distributed. Increased governmental transparency and accountability are necessary, but very tough to carry out.

Providers

Healthcare providers, as the main decision makers of the health system, have the highest number of opportunities for corruption. This group includes actors such as

physicians, dentists, nurses, pharmacists and other hospital staff. Healthcare providers are in a position to tell their consumers and payers which services are necessary and have control over the availability of certain drugs and procedures. Consumers rely on providers to offer appropriate services to improve their health conditions and are sometimes put in a position where they must offer extra monetary or other bribes to providers for certain procedures, organ transplants or prescriptions. Physicians often make decisions that are not in the best interest of their patients, for their own personal gain. This may include requiring monetary or other bribes for certain procedures or prescriptions, ordering unnecessary procedures to increase financial revenue or not providing necessary or optimal care due to the lack of benefits for the provider (Vian, 2008).

There is evidence that the manner in which providers are remunerated has a fundamental impact on the way in which they carry out their responsibilities for patients (Lewis, 2006; Savedoff & Hussmann, 2006; Vian, 2008). According to the research, providers who are paid on a fee-for-service basis, meaning they bill their patients for each service that was rendered, have a financial incentive to increase the amount of medical services, regardless of their necessity. Alternatively, ‘capitated’ payment programs, where providers are paid a fixed amount, regardless of how many services are provided, create incentives for providers to offer fewer services and procedures. It is in their financial interest to perform the least amount of work, which sometimes results in situations where doctors do not provide necessary services to the patients. A third method of compensation is ‘salaried’ payments. Here, the providers are not motivated either way

in the amount of services performed, but are often less productive overall (Transparency International, 2006).

Doctors, hospital staff and pharmacists also have access to expensive drugs and medical supplies, which they may steal for their own private gain. They can report services that were not rendered on their reports to the insurers, or create fake patients to receive more payments from payers. They are also susceptible to accepting bribes from pharmaceutical companies who would like providers to prescribe their expensive drugs to the patients. Finally, in systems with mixed public-private funding, public providers have been found to refer their patients to their private practices for extra services that can be charged at higher prices than in public institutions, or to receive kickbacks from referrals to other private physicians. This type of corruption was heavily documented in the publically funded US Medicare program (Gewande, 2009).

Detection and regulation of corruption by providers is very difficult to control, but possibilities for improvement exist. Medical regulatory boards, licenses and codes of ethics for providers are required for doctors to practice. Hospital reports and inventories could be made public to increase transparency and accountability in the system. Patients can protect themselves against corruption by using available resources to inform themselves of treatments for their illnesses, reducing the ability of providers to suggest unnecessary treatments. This principle, however, has caused many problems in the health sector with the patient-provider relationship (Tuohy, 2003).

Consumers

Patients, or consumers, of the healthcare sector are certainly not immune to committing fraudulent acts. Patients are usually in a vulnerable position, being reliant on

the honesty and competency of providers and payers. This vulnerability often creates a pressure for patients who cannot afford healthcare, or who would like better or faster service. These patients may find it beneficial or necessary to bribe providers or suppliers to offer services that are either illegal or unethical. Frequently, it is difficult to differentiate between gifts and bribes; therefore, this form of corruption is challenging to detect or measure. Furthermore, Lewis (2006) notes that in some nations, the practice of bribing providers or suppliers has become acceptable or customary. This is not true for Germany or the United States; thus offering bribes to providers is viewed as a corrupt behavior.

Another form of corruption committed by consumers is the act of giving false information to payers or regulators. In nations where healthcare is not universally required, consumers may abuse the system by attempting to use their own insurance plan to cover family or friends without insurance. This is more common in the United States, where insurance cards and forms are not well managed, and detection and controls are weak (Transparency International, 2006). Consumers may also bribe physicians to approve their medical health statuses in order to obtain licenses for activities such as driving or flying airplanes. Conversely, consumers may also bribe doctors to report poor health, so as to obtain disability benefits. This practice is quite common in nations with high social benefits for disability.

Methods for reducing these forms of corruption include increasing visibility of patient health through electronic databases that gather medical history information (e.g. German electronic health card, *electronische Gesundheitskarte*), standardizing medical report documents to increase transparency and accountability of providers and ensuring

that all citizens have access to health insurance to eliminate the need for fraudulent insurance plans.

Suppliers

In the healthcare system, suppliers control access to the drugs and medical supplies used by the providers for the consumers. The actors include pharmaceutical companies (both domestic and international), medical equipment suppliers and biotechnology companies. Pharmaceutical companies are widely known for their corrupt activities in controlling the access and costs of drugs. They also control the quality and availability of the products and supplies, creating an opportunity for charging full prices to providers for products that are not of top quality, repackaging outdated equipment or expired drugs or setting excessive prices (Lewis, 2006).

Suppliers also bribe regulators to change policies so they favor the supply companies. This is frequently manifested through agencies like the Food and Drug Administration (FDA), a government agency that controls which drugs and supplies are approved for medical providers to use under insured policies. Another opportunity for fraudulent behavior by suppliers is withholding information about negative side effects or reactions to new drugs.

Many controversies have arisen around pharmaceutical companies in the past few decades, increasing the attention to regulation of such actors. This style of corruption is especially challenging to detect and prove, due to the fact that most of the meetings between suppliers and providers or regulators are carried out privately, and information about the impact of new drugs is often not made public. However, efforts should be made

to increase the transparency of drug-testing and alternative methods of treatment, so patients are not forced to accept only one possible treatment when others exist.

Vulnerabilities of Healthcare Systems to Corruption

Although the amount of research and literature focused on corruption in developed healthcare systems is rather minimal, there does seem to be a consensus on three features common to all health systems, which make them more susceptible to abuse and corruption: *uncertainty*, *asymmetric information*, and a *large number of actors* (Lewis, 2006; Savedoff & Hussmann, 2006). Furthermore, Lewis (2006) suggests two additional features of health systems that also appear to be correlated to corruption: *adverse selection* and *moral hazard*. However, these last two characteristics are specific to nations with some degree of welfare.

Together, these five features point not only to weaknesses in the system in regards to opportunities for corruption, but also to weaknesses in the ability to detect and control corruption. Detection and regulation are very important for policymakers in combatting corruption. Below is an in-depth outline of how each feature opens up the system to possible fraud and misuse.

Uncertainty

The level of uncertainty in the field of medicine makes preventing illnesses, providing treatment and paying for services inherently difficult tasks. According to a contribution to Transparency International's 2006 Global Report on Corruption in Healthcare, it is "due to uncertainty, [that] medical care service markets and health insurance markets are both likely to be inefficient" (Savedoff & Hussmann, 2006, p. 5).

Illnesses can go undetected for long periods of time, creating more serious conditions that require costly treatments. Patients without extensive medical knowledge are uncertain about how to best care for themselves or how to best treat their conditions. Providers, despite the depth of their knowledge and experience in medicine, are also never certain about their patients' health conditions, the effects of treatment and the possibilities of alternative treatments.

This feature of healthcare makes it very vulnerable to corruption by actors who know how to manipulate the system and take advantage of patients or providers in uncomfortable positions. There are several examples of situations where patients or providers may be manipulated by corrupt behaviors. On one side, patients may feel forced to accept costly and/or ineffective treatments that might not be in their best interest; they may take unnecessary prescriptions or tests because their providers called for it; they may undergo medical treatment for illnesses that do not require treatment; or, they may forgo medical treatment or neglect illnesses that must be treated by licensed providers.

On the other hand, providers can offer care and services to the best of their abilities and knowledge, but can never be certain about the outcome of treatment or the future health of their patients (Lewis, 2006). They may prescribe incorrect drugs or order unnecessary tests for tricky illnesses that are difficult to detect or treat; they make their treatment plans based on symptoms reported by patients, who sometimes withhold or give false information to obtain certain medications; or, they may feel pressured by patients to carry out unnecessary tests or services in order to avoid potential exacerbation of conditions.

Health insurance is meant to be a solution to the uncertainties of medicine and healthcare, but in systems where insurance is not universal, the uncertainty makes the health insurance system more complex. For those without insurance, the issue is not resolved, but for those with insurance, there is the motivation to accept more treatment as a response to the fear of uncertainty. This issue manifests itself as a so-called *moral hazard*, which will be discussed in detail further on in this thesis. Universally required health insurance programs can protect healthcare systems from the vulnerabilities to corruption, but also generally create additional system inefficiencies (Savedoff & Hussmann, 2006).

Asymmetric information

The level of uncertainty is usually disproportional between different actors in the health sector. When this asymmetry in information occurs, it can manifest itself in *principal-agent* problems, where the *principal*, holding the information, may not act in the best interest of the *agent*, who does not possess the information or ability to make decisions (Tuohy, 2003).

In healthcare systems, where asymmetric information is an inescapable issue, there are several possibilities for relationships between the different actors to take on principal-agent characteristics. This is most obvious in the patient-provider relationship. Providers have extensive knowledge of illnesses, treatments and health implications, which is acquired through a very specific style of education and training. They are in the unique position of telling their patients what services are necessary and beneficial. Without the same level of information and knowledge, the patients are in a vulnerable position, forced to trust that the providers will perform their duties in the best interest of

the patients (Tuohy, 2003). However, this is not always the case. Providers are often found performing extra or fewer services in order to reap personal benefits from the imbalance of information. Patients also do not hold the authority to write prescriptions or order laboratory tests, and are therefore dependent on the providers to use their authority to provide the best services for the patients (Vian, 2008).

Another *principal-agent* relationship in healthcare systems where the information is asymmetric is between pharmaceutical companies and the providers and patients. Pharmaceutical companies hold very sensitive and restricted information about the positive and negative effects of their drugs. The companies who want to sell their products without any public awareness of alarming side effects or cheaper alternatives often conceal this information, which should be shared with providers and the public (Lewis, 2006).

Large number of actors

The healthcare sector involves a great number of actors with various roles and responsibilities. Often, these roles are not clearly defined, overlap or are informal, which creates a very difficult environment for regulation and control. Without very clearly defined and measurable responsibilities, it becomes challenging to hold actors accountable for misuse and corruption. Furthermore, the interactions between actors and groups of actors are tough to manage due to the fact that each actor has a number of different interactions with other actors, sharing different or restricted information. The frequent exchanges between different levels of actors can make analyzing information an ambiguous and tedious task.

Monitoring the allocation of funds becomes increasingly vulnerable to corruption when the money is required to pass through several levels or change hands multiple times. It is often difficult to discern whether missing funds are due to misappropriation, miscalculations or miscommunication.

Adverse selection

In healthcare systems that do not require or provide insurance for the entire population, *adverse selection* can become a big issue. In this situation, private health insurers select their customers based on their pre-evaluated risk-assessments, leaving the unhealthiest or the poorest citizens without insurance, or with expensive alternatives. Therefore, those who have the highest need for insurance- those with chronic illnesses or insufficient financial means- are left in more vulnerable positions without health insurance. If they experience injuries or serious illnesses, they must pay for services out-of-pocket, and can usually not afford this. Government-mandated insurance plans can be used to avoid this situation and protect the poor and ill citizens (Lewis, 2006).

Moral hazard

The converse of *adverse selection* is the problem of overconsumption, referred to as *moral hazard*. For those citizens who can afford insurance or are covered under public insurance programs, there is a risk of excessive use of healthcare services. In cases where out-of-pocket fees are very low or non-existent, the system's ability to control for overconsumption is reduced. Due to third party payment, patients are not bothered with high bill payments, and thus do not feel the financial demands of treatment (Lewis, 2006). This leads to situations where the patients accept treatments regardless of

necessity, and doctors might order additional tests or treatments either due to overly cautious care, or due to the financial incentives of over-testing.

This issue can be controlled through increasing the education of patients about the dangers of over-testing, or by employing a “capitated” remuneration system to remove financial incentives for providers. Additionally, payers and regulators can increase transparency through using electronic databases that track trends in medical treatments and testing.

Governance in Healthcare Systems

The impact of governance on effective and efficient performance in healthcare systems is a prominent topic among researchers around the world. Although the literature is overwhelmingly focused on developing nations, the role of governance in stable and developed nations is equally important and relevant. However, the availability of measurable data and cross-country comparisons in relation to corruption in developed healthcare systems is minimal, making generalizations difficult to produce. The ambiguous nature of corruption limits the ability of researchers to generate convincing theories about its connection to the quality and capacity of government; yet, some researchers have succeeded. This section of the thesis will consolidate some of the existing theories of the role of governance in the healthcare institutions and attempt to connect it to the prevalence of corruption in developed healthcare systems.

The term governance is generally associated with concepts such as accountability, transparency, regulation and citizenship participation. It is widely accepted that systems with stable and effective institutions also have a high level of “good governance,” defined

by Kaufmann and Kraay (2003) as the traditions and institutions by which authority in a country is exercised. What good governance actually implies is still not clearly outlined, but commonly accepted characteristics include:

Capacity of government to formulate and implement sound policies, manage resources and provide services efficiently; the process that allows citizens to select, hold accountable, monitor and replace government; and, the respect of government and citizens for the institutions that govern economic and social interaction. (Lewis, 2006, p. 6)

In the Worldwide Governance Indicator report from the *World Bank*, Kaufmann, Kraay and Mastruzzi (2011), examine a set of six dimensions of governance in each country. These six indicators include *voice and accountability*, *political stability and absence of violence*, *government effectiveness*, *regulatory quality*, *rule of law* and *control of corruption*. While these indicators are all very important to the general measurement of governance, they do not all apply when measuring governance in the healthcare sector. For this reason, this thesis draws from these definitions, and those of other governance experts (Lewis, 2006; Tuohy, 2003; Wendt, Kohl & Thompson, 2006) to compile a new set of governance indicators in the healthcare sector that best apply to the measurement of governance in the German and US healthcare systems.

Two features of governance that are most commonly attributed to the level of corruption are *accountability* and *transparency*. The Quality of Governance theory, developed by Bo Rothstein and Sören Holmberg at the University of Gothenburg, connects corruption to the level of institutional governance capacity, and postulates that, in countries where the level of governance is low, incidences of corruption will be higher due to the lack of *accountability* and *transparency* (Rothstein & Holmberg, 2011). There is much evidence that these two features can impact the quality of governance at every

level of the healthcare system, and improvements in these areas are crucial to successfully functioning systems. Two additional features that are frequently associated with healthcare governance are *monitoring and regulation* and *trust* (Brinkerhoff, 2004; Lewis, 2006; Tuohy, 2003)

Together, these four features can be measured through various approaches in order to determine the quality of governance in healthcare systems. With this information, governments and healthcare workers can reform their systems and habits so as to minimize the possibility for and impact of corruption. However, measuring these features of governance is not always an easy task. The indices are often unclear, and data collection methods are difficult to design for abstract measurements. Existing methods include perception indices, cross-country data analysis, standard health indicators (e.g. mortality and morbidity rates) and surveys of public and private actors.

Below is a detailed outline of how each of these four features relates to governance in the healthcare sector, and how they impact susceptibility to corruption.

Accountability

When discussing quality of governance, accountability is almost always the first feature that is mentioned. In democratic institutions, accountability refers to the government's responsibility to demonstrate to the citizens that it carries out the goals and provides services that are aligned with the interests and needs of the public (Vian, 2008). In terms of healthcare institutions, accountability applies not only to the government, but also to the actors every level. Each actor has a duty to carry out a certain task, and the effectiveness of the system depends on the integrity of all actors to stick to their responsibility. In order to have an efficiently functioning system, different methods are

used to hold these actors accountable for their actions, but when these methods fail, corruption may occur.

In the healthcare system, accountability is important at every level. Applied to the system as a whole, a sufficient level of accountability requires that the citizens have a voice and ability to influence the system to reflect the needs and wants of the public. A healthy system will include features such as effective checks and balances; civil society boards; democratically elected or appointed officials; and accurately collected and reported data. Due to the size of the healthcare system, and the large number of actors, it is very important that the public and private sectors communicate well and share full data and information to avoid leaving gaps for corruption or overlapping duties and wasting public funds on unnecessary tasks.

At the micro-level, each actor in the system must be held accountable to their other actors and the citizens. In order to achieve this, frequent dialogue should occur, goals and expectations should be clearly defined and information must not be withheld. Additionally, the numerous financial exchanges and transactions, including the allocation of public funds, must be accurately reported to avoid vulnerabilities to misappropriation or embezzlement. Furthermore, Brinkerhoff (2004) suggests that the transactions and services must not only be accurately reported, but also justified. It must be clear to the public and to the individual that services were necessary, or that allocation of funds was applied in the most appropriate manner to maximize the benefits for the citizens.

With a higher level of accountability in the healthcare system, actors will feel pressured to carry out their duties in an ethical manner, and will not feel the opportunity

for corruption. A better design of accountability in the healthcare institutions will reduce corruption and lead to higher performance (Brinkerhoff, 2004).

Transparency

Transparency is very closely related to accountability in terms of governance. In order to hold actors and officials accountable, it is crucial that their decisions, activities and performance data be available to the public. Without open access to this information, citizens and policymakers cannot be aware of the problems that need to be addressed. Healthcare system policies must include government-mandated disclosure of this information (Vian, 2008). There are many ways in which this can be transmitted to the public, including open access through websites, publishing data in regular reports, releases from the healthcare officials, publishing financial reports and holding regular local and national public meetings.

In many healthcare systems, patients are put on waiting lists for procedures, drugs or organ transplants that are scarce in availability. When the lists are not made publically available, they may be tampered with to favor patients who offer bribes for a higher spot on the list (Lewis, 2006). This form of corruption has been quite common even in developed nations, including in the US and Germany. Publishing these lists and making other reports about medical supplies and services public can significantly reduce the possibility for abuse by medical professionals.

Monitoring and Regulation

Ensuring quality governance in public institutions requires regular monitoring and effective implementation of regulation policies. Both features are necessary and dependent on each other. On the one hand, the evidence of fraud or corruption collected

from monitoring the system must be accurate in order to justify the application of sanctions. Conversely, sanctions must be deemed appropriate and warranted for the dishonest actions or behaviors.

Within the complex structures of the healthcare institutions, achieving both accurate monitoring and effective control of corruption is a challenge for policymakers and regulatory actors. Due to the large number of actors and the high level of uncertainty in healthcare, the ability to track all activities and transactions becomes an increasingly difficult chore. Furthermore, when accurate and full monitoring of the system is not accomplished, regulation policies and control of corruption cannot be effectively implemented.

Monitoring of the health system can be carried out through various procedures, including requiring licensing and accreditation of providers, regular recertification processes, publishing provider and payer “report cards” that display information about quality of services, establishing a system of quality standards through guidelines, benchmarking, patient reviews of the physicians or facilities, or linking payments to the quality and availability of services (Lewis, 2006; Brinkerhoff, 2004). All of these methods can increase the ability and accuracy of detecting corruption in order for regulators to respond with appropriate sanctions.

In terms of regulation capacity, the application of legal sanctions is essential in shaping incentives for corruption, but social sanctions also play a very important role in the informal regulation of behaviors. Social sanctions refers to normative practices, such as shaming, blacklisting or rewarding good behaviors, and can sometimes be more important in controlling corruption than legal regulation (Vian, 2008).

Effective monitoring and regulation capacities also impact the level of accountability in the healthcare sector. Through the successful application of legal and informal standards and procedures, actors feel more pressure to comply with the actions and behaviors that are expected of their role (Brinkerhoff, 2004).

Trust

“Corruption eats away at the public’s trust in the medical community. People have a right to expect that the drugs they depend on are real. They have a right to think that doctors place a patient’s interests above profits. And most of all, they have a right to believe that the health care industry is there to cure, not to kill,”
David Nussbaum, Chief Executive of Transparency International (Transparency International, 2006)

Often times, the issue of trust is not addressed when discussing features of good governance. This thesis argues that trust is, however, one of the essential features of governance in relation to the occurrence of corruption. Systems that lack a sufficient level of trust are more prone to abuse by the actors involved. Perceptions also play a powerful role in shaping behavior. Investors and patients who perceive corruption or poor quality may be deterred from investing in or using the services (Lewis, 2006).

On the macro-level, trust is generally discussed in terms of citizen confidence and dependence on the honesty, effectiveness and accountability of their public officials and institutions. In systems that involve a high level of public funding drawn heavily from taxes, trust is necessary to motivate citizens to pay taxes and not abuse the system. Evidence has shown that when the citizens trust their social institutions (i.e. welfare programs), the systems perform better and experience a significantly lower level of corruption and abuse. According to the OECD Social Indicators (2011), trust in social institutions is higher in wealthier countries where income is more evenly distributed. Both Germany and the US are considered wealthy nations, but income is much more

evenly distributed among the German citizens than it is among the American citizens. Thus, where larger gaps in social classes exist, citizen trust in social institutions is lower and corruption is more likely.

On the micro-level of healthcare systems, trust is critical in keeping good relations between the actors. If citizens feel that their payers and physicians are held accountable, there will be an increased level of trust not only in their treatments, but also in the system as a whole. When trust is low due to perceptions of high corruption, citizens may be less likely to visit their physicians when they fall ill, or to take preventative care. Furthermore, in systems where insurance is not mandatory, lack of trust in the insurance organizations may deter some people from purchasing insurance, leading to an increased social risk.

Strategies to increase trust and improve perceptions of healthcare systems include improving open and regular dialogue at every level of the system; increasing transparency and improving measures for accountability. Tuohy (2003) suggests that accountability in the healthcare systems is no longer based on the standard “principal-agent” trust-based structure, but has rather evolved into a system requiring formal accountability mechanisms that are designed to punish violators. Whether or not these formalized mechanisms have increased effectiveness of governance in healthcare will be discussed further on in this thesis.

Chapter Three

Healthcare Governance in the US and Germany

At this point, the general features related to governance and vulnerabilities of healthcare systems have already been examined. Thus, this section of the thesis shifts to an empirical perspective, comparing the dimensions of governance in two systems based on different principals of coverage, financing and regulation: a *market-based* system in the United States and a *social health insurance* (SHI) system in Germany. It first draws attention to the historical development and central features of each system in order to demonstrate where they differ. Next, it evaluates the capacities for governance in the US and German healthcare sector, dividing the analysis along the four dimensions of governance discussed in the previous section.

According to the OECD Social Indicators (2011), both systems have generally high levels of governance capacity and experience a low rate of corruption relative to global standards. These statistics do not, however, imply that these systems are immune to abuse and fraudulent activities. For both of these nations, healthcare costs are deemed to be excessive, and much of the wasteful spending occurs due to corrupt or fraudulent activities. Examining governance capacities may highlight areas that are particularly vulnerable to corruption and allow these nations to design reforms that will improve the efficiency and effectiveness of healthcare systems (Lewis, 2006; Rothstein & Holmberg; Vian, 2008).

Historical Development of Healthcare in the US and Germany

United States

Franklin Delano Roosevelt's decision in 1934 to remove public health from the New Deal agenda led the US to develop a private insurance system through employer benefits. This structure placed private insurance companies in a powerful position from the start, working only under the control of market mechanisms, with minimal interference from state-level regulatory agencies (Wendt et al., 2006). Only minor reforms were made to extend coverage to certain risk groups, such as the passing of Medicare and Medicaid in 1965. At that time, the healthcare system in the US had already been tightly bound to the original design of privatized insurance; thus, expanses in public coverage were very difficult to achieve (Hacker, 1998). Until the passing of the Patient Protection and Affordable Care Act (PPACA) in March 2010, no major reforms had passed through Congress.

Throughout the 1960s and 1970s, when the labor market experienced significant changes in both numbers and types of employees, employers altered their benefit plans. The existing health insurance system was not set up to protect the citizens who were no longer covered and/or could not afford private insurance. Large populations of Americans were left uninsured during a time when healthcare expenses were increasing at rapid rates (Haeder, 2012).

As a result of the lack of universal coverage, a wide range of alternatives to public or formal private insurance have developed in the United States. Furthermore, the decentralization of authority in the US to the state-level has led to fragmentation within the health insurance policies (Haeder, 2012). Today, the payers include a very complex

mix of federal public insurance programs, private insurance, employer insurance programs, federally-funded non-profit organizations (e.g. Planned Parenthood), cash-based payments from patients without health insurance and several other alternative programs for insuring citizens for healthcare (Haeder, 2012). For those US citizens without formal or alternative insurance plans, cash payments and non-profit clinics are the only option.

As for the standard employer-sponsored health insurance plans, the traditional forms of remuneration were administered through Preferred Provider Organizations (PPOs) or Medical Savings Accounts (MSAs). However, in the early 2000s, Health Savings Accounts (HSAs) replaced MSAs. Conditions for coverage in these types of plans are decided between individual and employer negotiations with the insurance companies. Negotiations are carried out without interference from national regulations.

Recently, there has been a trend in the US toward more state control. This can be observed through the introduction of Health Maintenance Organizations (HMOs) and Managed Care plans, both of which increase the regulatory capacities of the state (Wendt, Frisina & Rothgang, 2009). Additionally, with the passing of the PPACA in 2010, the role of the state has been strengthened through the forms of mandated coverage, federal subsidies and tax credits (Haeder, 2012).

Critics of the Affordable Care Act point to its failure in performing a complete overhaul the US healthcare system. It was intended to create a universal and more coherent system, but as Tuohy (2011) notes:

The final result was a complex and entirely Democratic partisan mosaic formally comprising the ACA with more than four hundred sections, a budget reconciliation act with thirty-eight sections relating to health care reform, and a four-section executive order. (p. 574)

Still, others, such as Haeder (2012), consider the PPACA to contain some successes for reform, considering the system's history of extreme reluctance to introduce or amend even minor federal policies.

Germany

The framework for Germany's current healthcare system dates back to 1883, when the nation introduced the first mandatory national social health insurance (SHI) system under the leadership of Otto von Bismarck. At this time, the system required only workers with lower incomes to partake in the social health plans, which were distributed through workers guilds and unions (Immergut, 2009; Porter & Guth, 2012). The system was designed to give administrative responsibilities to local structures, but retained a strong supervisory role for the central state structures (Altenstetter & Busse, 2010). This design has proven very stable, yet very difficult to reform to new social risks and cost containment strategies. Still, the German healthcare system was able to gradually extend its programs by the end of the 1980s to provide virtually universal coverage (Bump, 2009).

Following the successful reunification of West and East Germany and an impressive economic and political recovery, the German citizens have given significantly more trust to centralized state authority. This trust in the state institutions has allowed for Germany to make reforms in some areas of health insurance policy without much contention. However, the capabilities of governmental institutions are still quite limited by the decentralized structure, requiring several levels of approval before any reforms can pass into law (Porter & Guth, 2012).

Today, Germany has a mixed public-private health system. Since 1996, citizens have been given the freedom to choose from among the legally accepted statutory health plans, which are administered from the public “sickness funds” (*Krankenkassen*). These organizations, collectively referred to as the *Verbände der gesetzlichen Krankenkassen* (GKV), are independent from the government and are required only to work within a framework designed and decided by the state (Wendt et al., 2006). The premiums are fixed by the state according to income, and some state subsidies are offered for certain risk populations, such as low-income workers (Porter & Guth, 2012).

Toward the end of the 20th century, a private insurance system began developing as an option for certain groups of the population. By this time, the state was focused more on cost containment strategies, which led it to introduce this private option for workers who earned above a certain salary. Self-employed workers, government employees and those who earn above 4,125€ per month (as of 2010) were offered the opportunity to opt out of the public sickness funds (Porter & Guth, 2012). These groups have the option to design personal insurance plans with private insurers. However, for various reasons, only a small percentage of the population chose to take private insurance. Statistics vary, but the percentage of the population insured under the private plans teeters around 10% today. Still, the number of citizens opting for private insurance plans is growing (Porter & Guth, 2012).

Comparative Evaluation of Governance in US and German Healthcare

In the OECD cross-country comparisons, the US healthcare system has been reported to have a higher rate of corruption than the German system (OECD, 2012). This

section intends to reveal the inconsistencies in US and German healthcare governance capacities, which relate to the variances in rates of corruption. The development and design of these two healthcare systems has been shown in several publications (Lewis, 2006; Tuohy, 2003; Wendt et al., 2006; Wendt et al., 2009) to fundamentally impact their capacities for performance in four essential dimensions of governance: *accountability*, *transparency*, *monitoring and regulation* and *trust*. While these dimensions are very tightly intertwined and frequently overlap in terms of increasing their effectiveness, it is beneficial to analyze them separately in order to discover shortcomings in the governance capacities of their systems.

Accountability

All healthcare systems must develop a scheme for maintaining accountability. Different approaches have been used to ensure effective control, oversight, cooperation and accurate reporting of the activities that occur within healthcare systems around the world, yet there is no agreement as to which approach is most effective. Each group of actors in the US and German health systems are confronted with highly asymmetrical relationships in terms of expertise, information, access to services and personal incentives. Furthermore, due to the fact that providers control the relevant information, central supervisory bodies have weak capacities for monitoring performance of providers and facilities, reducing accountability (Brinkerhoff, 2004).

In terms of controlling transfers of funds and billing reports, systems that use public agencies for funding services have been shown to more effectively regulate financial exchanges than those based on market control (Wendt et al., 2006). Thus, the German SHI system, which is mostly (approximately 90% in 2010) administered through

the public sickness funds, should have a higher capacity for maintaining accountability (Porter & Guth, 2012). However, with the rise of private health insurance in Germany, and the growing fragmentation of the system, opportunities for corruption are growing.

In the US system, the market-driven approach has integrated methods for holding actors accountable. The natural influences from the market force actors to provide the best quality and value of service if they want to remain competitive (Wendt et al., 2009). Though, this is not always the case, especially when transparency is weak and providers and payers offer false information. In this case, regulatory agencies must protect the consumers by ensuring that the actors are providing correct information (Tuohy, 2003).

On the other hand, this market-based approach has left gaps in coverage and led to the creation of numerous *ad hoc* health insurance programs. The system has become highly fragmented. In addition to public programs (e.g. Medicare and Medicaid) and standard private insurance plans (e.g. HMOs, PPOs, and managed care), providers might accept informal forms of payment through various private negotiations. Furthermore, the controls and regulations are designed by agencies at the state-level, further complicating the fragmented system (Tuohy et al., 2004).

Though, both systems face challenges in terms of maintaining accountability, the US system must overcome much larger structural deficits. The rapidly growing number of actors, as well as the *ad hoc* creation of regulatory agencies, creates massive inefficiencies in oversight, monitoring performance and improving cooperation. Despite the intention to yield regulatory control to the market mechanisms, the US system has created an incredibly complex healthcare structure, making it intrinsically difficult to employ effective accountability mechanisms.

Transparency

Transparency is a crucial aspect in measuring the effectiveness of governance in healthcare systems. Measures for increasing transparency are typically conducted through issuing public reports on quality of performance and exchanges of services, supplies and finances. Both the US and German healthcare systems have strong policies aimed at increasing transparency, yet they face weaknesses in certain areas of the healthcare system, including procurement of pharmaceuticals, misallocation of supplies and transfers of informal payments.

In terms of drug procurement, both systems lack effective mechanisms for revealing corruption. Pharmaceutical companies are known to offer bribes for providers to prescribe their drugs and withhold information about negative effects (Leiws, 2006). As for the allocation of supplies, both the US and Germany have discovered long-term abuse of the organ transplant waiting lists. For years, hospitals and medical professionals had manipulated transplant waiting lists for private gains. This abuse of the system went undetected, due to the lack of sufficient measures for monitoring and providing reports on the activities within the system. Neither type of system has inherent abilities to overcome insufficient transparency; thus, they must address it within their mechanisms for monitoring and regulation.

Monitoring and Regulation

Governance in the healthcare sector relies on a competent design and implementation of mechanisms for monitoring and regulating activity within the system. Although the specific configuration of regulatory models can vary widely, each framework requires not only effective monitoring and oversight, but also the ability to

apply formalized sanctions for noncompliance. Although several articles have attempted to create typologies for healthcare regulatory systems, Wendt et al. (2006) focus on three types of regulatory structures: hierarchical (state-led), self-regulation through non-governmental organizations (seen in SHI systems) and market regulation.

With regard to the US and German healthcare systems, the basic structures of their systems have led to two fundamentally diverging modes of regulation. In the mostly private system in the US, the market has been the primary source for regulating activities, controlled only when necessary by state-level regulatory agencies. However, the medical care system cannot function purely on market influences. Over time, the increasing fragmentation of the system, as well as the gradual addition of public programs, have required national-level and third-party oversight agencies (Wendt et al., 2009). Wendt et al. (2006) mention that recently, there has been more convergence in the US system toward hierarchical regulation through the Managed Care and HMO plans.

In the SHI system of Germany, regulatory mechanisms are carried out through self-regulation by the sickness funds, which are non-governmental organizations. Still, the state plays a significant role in setting the framework within which the sickness funds and providers negotiate their schemes. The German system has introduced policies that intend to incorporate some level of market-driven influence. For example, since 1996 all members of public sickness funds have been given the freedom of choice between different funds. This policy encourages competition among the sickness funds in order to increase their quality of services for consumers (Porter & Guth, 2012). Though much of the daily regulatory control comes from the non-governmental sickness funds, the state's

influence is decidedly higher in SHI than in market-driven healthcare systems (Wendt et al., 2009).

Trust

Aside from the traditional formal dimensions of governance previously discussed, trust is an essential aspect of the healthcare system. Due to the inherent information gaps in healthcare, actors within the system are frequently left to make decisions based on trust that the other actors will perform tasks in the best interest of both parties. Tuohy (2003) stresses that, over time, systems have designed various solutions aimed at reducing the vulnerabilities caused by these asymmetric “principal-agent” relationships. Solutions have included establishing contractual relationships and, more recently, creating accountability mechanisms. While these structural solutions may increase accountability by applying formalized sanctions, trust still plays a very significant role in daily healthcare governance.

Logically, a well-performing healthcare system should foster trust in the relationships between different actors, which would lead to more efficient provision of services. The presence of insecurities among the actors may lead them to focus on maximizing personal benefits, rather than acting in the best interest for the general good and for the system. Thus, higher levels of trust should indicate a lower incidence of corruption. However, the OECD Social Indicators (2011) show that, while the perception of corruption in social institutions is higher in the US (67%) than in Germany (61%), the percentage of US citizens (58%) who trust their social institution is higher than in Germany (53%). These numbers are inconsistent with what would be expected in these two types of healthcare systems.

The German SHI system functions mostly by self-regulation, which features more integrated mechanisms for accountability. On the other hand, the market-based system in the US relies on natural mechanisms of the market, such as competition, to regulate the healthcare system. Yet, this type of system can lead to high fragmentation and low capacity for accountability, which eventually results in the need for additional ad hoc state regulatory agencies and mechanisms (Wendt et al, 2006). One would expect that the clearly defined roles of the German system would lead to greater trust in the public than in the exceedingly complex structure of the US market-driven system. Nevertheless, the OECD statistics indicate otherwise.

Chapter Four

Conclusion and Discussion

Through this cross-country comparison of four dimensions of governance in the US and German healthcare systems, it has been shown that the model of healthcare does impact the governance capacities. As previously discussed, these discrepancies in governance can lead to variances in susceptibility to corruption. Numerous publications have indicated that low levels of governance are strongly correlated to higher incidences of corruption (Lewis, 2006; Vian, 2008; Rothstein & Holmberg, 2011). This thesis does not analyze the data on corruption, but rather suggests that more effective governance can better control the areas of healthcare that are most vulnerable to corruption.

In regards to the US and German systems, this analysis has shown that SHI systems have higher capacities for monitoring and regulating healthcare, which support stronger mechanisms for accountability and transparency. In terms of the level of trust in the system, it has been shown that higher capacities for regulation do not necessarily indicate more trust from the citizens. The OECD Social Indicators (2011) report demonstrates that citizens in the US, who live under a highly complex and fragmented system, have more trust for their social institutions. Overall, these four dimensions of governance can be deemed more effective in healthcare models that rely on more intervention from the state, and less on the natural mechanisms of the market.

The overarching goal of evaluating systems and policies according is to improve performance and effectiveness by highlighting not only the weaknesses that need reform, but also the strengths that can be used as exemplary models. The fact that health systems in advanced welfare nations such as the US and Germany are converging on certain policy areas implies that lessons have been learned from comparing systems. Thus, despite its inherent weaknesses and assumptions, this thesis can contribute something to the steadily growing collection of literature on corruption in healthcare.

Existing research on the topic of corruption in healthcare systems has attempted to link the occurrence of corruption to variances in governance capabilities; however, empirical research on this claim is mostly performed in reference to developing nations. It is the recommendation of this thesis that researchers in this field extend their focus to include nations with advanced healthcare systems that have developed over a longer period of history. These systems face common challenges in overcoming excessive healthcare spending. Establishing better governance for regulating these systems could lower rates of corruption and significantly reduce wasteful spending.

The interest for this thesis stems from reading Atul Gewande's June 2009 article in the New Yorker Magazine entitled "The Cost Conundrum: What a Texas town can teach us about healthcare." In this article, Gewande discusses the causes for such a large discrepancy in Medicare usage in two different counties of the United States. In Hidalgo County, Texas, the average Medicare spending per capita, at \$12,000, was the highest in the US. The neighboring county, El Paso, spent nearly half as much as McAllen, \$7,504 per Medicare enrollee (Gewande, 2009).

When reports on the quality of health services in these two counties did not connect higher costs to better quality, investigations into the discrepancies were carried

out. The results of the investigation show that medical professionals in Hidalgo County were abusing their roles in both the patient-provider and the payer-provider relationships in order to maximize personal benefits. Corrupt activities, such as over-testing, providing false claims to insurers, accepting bribes and kickbacks and referring patients to their parallel private practices, were frequently exercised in Hidalgo County (Gewande, 2009). Questions as to the sources for the variation in corruption in these two counties led to the development of this thesis.

The main challenge of healthcare systems is to make effective use of available resources while meeting the medical and social needs of the citizens. Regular analyses of healthcare governance and policies aid decision makers in designing more efficient systems for administering health services.

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