

3 Corruption in hospitals



A run-down hospital ward in Tamale, Ghana, March 2004. (Che Chapman)

As the loci of a large proportion of health spending – and given their size and complexity – hospitals provide many opportunities for corruption, as Taryn Vian describes. Money leaks from hospitals through opaque procurement of equipment and supplies, ghost employees, exaggerated construction costs and inflated hospital price tags. In developing countries the result is a depleted budget for other necessary health care services such as primary health care programmes.

Ultimately it is patients that suffer, either because they are asked to pay bribes for treatment that should be free, or because treatment decisions are based on financial motivation rather than medical need. Effects are felt in both the developed and the developing world. Case studies from around the world provide a glimmer of hope by

showing how low-cost efforts to increase transparency – of hospital procurement in Kenya and waiting lists in Croatia – can help reduce corruption.

Corruption in hospital administration

*Taryn Vian*¹

The hospital sector represents a significant risk for corruption, in both developing and developed countries alike. In the United States alone, fraud and abuse in health care has been estimated to cost US \$11.9 to 23.2 billion per year; much of this expense is attributable to hospital-based care.²

The size and complexity of hospitals allows the possibility for many kinds of corruption. As many economists have pointed out, corruption is a ‘crime of calculation’ and is more likely to occur where budgets are large and ‘rents’ or possibilities for people to gain from decisions made by officials are high. Hospitals meet these criteria for vulnerability. Globally, hospitals account for 30–50 per cent of total health sector spending (public and private); in some regions, such as Eastern Europe, the percentage may be as high as 70 per cent.³ Hospital spending may also include large investments in building construction and purchase of expensive technologies, areas of procurement that are particularly vulnerable to corruption. The need to manage multiple stakeholders with different interests and asymmetries in information at many levels (between medical personnel and patients, doctors and administrators, and procurement specialists and clinicians, to name just a few) also creates an environment that is susceptible to corruption (see Chapter 1).

Corruption in hospital administration has a direct negative effect on access and quality of patient care. Employee theft of supplies can leave patients without medicines, and extorted, under-the-table payments create anxiety and reduce access to care. As resources are drained from hospital budgets through embezzlement and procurement fraud, less funding is available to pay salaries and fund operations. This in turn leads to demotivated staff and greater absenteeism as medical personnel seek private income from outside jobs, again lowering access and decreasing quality of services. Financial arrangements between hospitals and doctors intended to increase hospitals’ and doctors’ profits can lead to waste of public money, or medical decisions that are not in the patients’ best interests. Persistent corruption in the hospital sector makes it harder to reduce hospital spending as a proportion of overall health expenditures, a goal in many developing countries where needs can be met more cost-effectively in primary care settings, such as health centres and maternal and child health clinics. If officials in power are gaining personally from the current patterns of spending in the hospital sector, why would they favour changes to expand primary care, an area where there is less opportunity for private enrichment?

Table 3.1 provides a typology of corruption in hospital administration. Key areas of concern include the procurement function; embezzlement and theft; payment system fraud; and personnel issues such as absenteeism, informal payments and sale of positions.

Table 3.1: Major types of corruption in hospital administration

<i>Category</i>	<i>Type</i>	<i>Description</i>
Procurement	Overpayment for goods and services	Engaging in collusion, bribes and kickbacks in procurement processes, resulting in overpayment for goods and contracted services; not enforcing contractual standards for quality.
Embezzlement and theft	Embezzlement	Diverting budget or user-fee revenue for personal advantage.
	Theft	Stealing medicines and medical supplies or equipment for personal use, use in private practice or re-sale.
Personnel	Absenteeism	Not showing up for work or working fewer hours than required, while being paid as if full time.
	Informal payments	Extorting or accepting under-the-table payments for services that are supposed to be provided free of charge; soliciting payments in exchange for special privileges or treatment.
	Abuse of hospital resources	Using hospital equipment, space, vehicles or budget for private business, friends or personal advantage.
	Favouritism in billing, spending	Waiving fees or falsifying insurance documents for particular people; using hospital budget to benefit particular favoured individuals.
	Sale of positions and accreditation	Extorting or accepting bribes to influence hiring decisions and decisions on licensing, accreditation or certification of facilities.
Payment systems	Insurance fraud and unauthorised patient billing	Illegally billing insurance companies, government or patients for uncovered services or services that were not actually provided, in order to maximise revenue. May involve falsification of invoice records, receipt books or utilisation records, and/or creation of 'ghost' patients.
	Illegal referral arrangements	Buying business from physicians by creating financial incentives or offering kickbacks for referrals; physicians improperly referring public hospital patients to their private practice.
	Inducement of unnecessary medical procedures	Performing unnecessary medical interventions in order to maximise fee revenue.

Hospital procurement: a hotbed of corruption

Procurement fraud is a large risk in hospitals, as virtually all capital spending involves procurement, and medicines and supplies are often the next largest recurrent expenditure item after salaries. Procurement agents may seek bribes or kickbacks from supply companies, or contractors may engage in collusion or offer bribes to hospital officials in order to win contracts.

Evidence from Argentina, Bolivia, Venezuela and Colombia suggests that these practices drive up the price of supplies purchased. For example, estimated overpayments in 1998 for seven specific medications in 32 public hospitals in Colombia were valued at more than US \$2 million per year, an amount that would have paid for health insurance coverage for 24,000 people.⁴

Small hospitals face special challenges in reducing vulnerability to procurement abuse. Where there are only a few doctors in a specialty, they have more power over the decisions made by administrators. The doctors may demand that the hospital purchase certain equipment or supplies for them, or they will move their practice elsewhere. Some may not consider this corruption but merely an economic driver of medical inflation.

In addition, hospitals may be pressured by consultants to buy more technology than the hospital can afford to maintain, because the additional equipment enables the specialist doctors to demand higher fees. This is particularly true in private hospitals, but may also take place in public hospitals where doctors use public facilities for private practice (officially or not), or are able to demand under-the-table payments from patients.

While essential drug lists and hospital formularies can help by restricting procurement to pre-approved drugs meeting efficacy, cost and quality standards, private drug manufacturers or their agents may still try to bribe officials to see that their medicine or formulation appears on the list. For example, in Albania, a Ministry of Health official claimed in 2003 that offers had been made to purchase the not-yet-approved list of new members appointed to the national committees for drug nomenclature and drug reimbursement. Presumably the bribers wanted the list so that they could individually approach the new members to try to influence their selection decisions, perhaps by offering financial incentives for decisions favourable to the bribers. In a similar bid to influence medicines purchasing and use decisions, TAP Pharmaceutical Products was charged with giving inducements directly to Lahey Clinic, a 259-bed US medical centre and primary care practice, allegedly agreeing to pay some US \$100,000 for a Christmas party, golf tournaments and seminars if the clinic agreed to continue prescribing its cancer drug Lupron instead of a less expensive rival drug.⁵ TAP had already paid a record US \$885 million fine in 2001 to settle similar charges.

Procurement agents may also turn a blind eye when vendors substitute lower-quality building materials or deliver goods that do not meet contractual expectations for quality, as in Malaysia, where the Anti-Corruption Agency recently launched a probe into irregular construction of the Sultan Ismail Hospital.⁶ Risk of corruption is higher if a hospital lacks systems for documenting and controlling contractor performance. Kenyatta National Hospital in Kenya reportedly lost over US \$12 million to procurement

fraud between 1999 and 2002.⁷ Problems cited by the press included failure to control quality of purchases (obsolete items substituted for the modern equipment described in the bid, or fewer supplies delivered than contracted) and hidden charges or construction overruns not included in the original procurement contract, as well as non-competitive bidding processes resulting in higher prices. Hospitals may not have adequate systems for recording receipt and use of drug orders, leading to situations where they pay for orders that are never received.

Better administrative systems for procurement and inventory control can help to prevent corruption by reducing discretion; however, anti-corruption efforts that rely heavily on administrative controls can be stymied by the problem of collusion. In Venezuela, researchers suspected that collusion between hospital administrators and purchasing officers was feeding the corruption by reducing the probability of detection and punishment.⁸

Transparency and accountability measures must be used to hold hospital administrators accountable. In Argentina, the government adopted a strategy of monitoring how much hospitals were paying for medical supplies and disseminated this information among them. Purchase prices for the monitored items immediately fell by an average of 12 per cent. Prices eventually began to rise again, but stayed below the baseline purchase prices for the entire time the policy was in place.⁹ The WHO and Health Action International have also developed a drug-price monitoring tool that could be used for transparency initiatives.¹⁰

In Bolivia, researchers found that increased citizen health board activism and supervision of personnel played a role in deterring overpayment for drugs by procurement agents,¹¹ while in Uganda, health unit management committees with community representation began to enforce accountability, particularly in the area of hospital drug management.¹² Of course, if community board members accept kickbacks or collude with hospital officials, the committees will not be effective.

To increase transparency in procurement of medicines, hospitals can channel decision-making through expert pharmacy and therapeutic committees, or procurement committees. The committee structure helps to balance the influence of clinicians with strong personal interests. Pooled procurement decisions for groups of hospitals may help to increase competition and dissipate power of individual physicians. Some countries, like Albania, have moved to centralise hospital procurement as a way to reduce opportunities for corruption. Chile's centralised health procurement agency, CENABAST, has prevented collusion and lowered prices by introducing computerised, auction-style bidding (see 'Corruption in the pharmaceutical sector', Chapter 5, page 76). Centralised procurement may bring other problems, however, if it is poorly designed and controlled. And even with effective centralised procurement systems, the risks of bribery and collusion remain, and must be dealt with through transparency and review.

Embezzlement and theft

Embezzlement involves the theft of cash payments or other revenue from a hospital by employees charged with revenue collection. Hospitals with weak financial systems

that are not computerised, or are cash rather than accrual-based, are more vulnerable (see Box 3.1). In developing countries, embezzlement often involves user-fee revenues collected from sale of drugs or diagnostic tests, and registration fees paid by patients. One study found that workers pocketed an estimated 68–77 per cent of revenues from formal user-charges in Uganda’s sub-hospital clinics.¹³ Researchers compared expected user-fee revenue based on recorded utilisation in 12 facilities, to actual recorded revenue. Although Ministry of Health guidelines allowed some fee exemptions for the poor, the study found that in practice those unable to pay were actually turned away, and estimated that most of the ‘gap’ in revenue was taken by collectors.

Box 3.1 Cash registers inject transparency – and revenue – into Kenya’s Coast Provincial General Hospital

In Coast Provincial General Hospital in Kenya, government staff used information from patient satisfaction surveys to detect fraud in the user-fee collection system.¹ Employees were allegedly pocketing user fees, draining funds from the hospital. Because systems for reporting revenue collection were not computerised, it was hard to determine what the user-fee revenue should have been, and to compare this with actual receipts. Managers lacked the information they needed to take action.

To combat the problem, management installed a network of electronic cash registers. Programme implementers had to replace the fee collectors, who were resistant to the change.

The reform took three months and cost US \$42,000. User-fee revenues jumped by almost 50 per cent in three months with no change in utilisation rates. The new system revealed other gaps in hospital systems and accountability, which were also addressed. Within three years, annual user-fee revenues were up 400 per cent. Accountability for spending the windfall in revenue was addressed by introducing more transparency in the planning and budgeting process.

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Note

1. C. Stover, ‘Health Financing and Reform in Kenya: Lessons from the Field. Background document for end-of-project conference for the APHIA Financing and Sustainability Project’ (Nairobi: May 2001).

Theft of supplies is another common problem in public hospitals. Although not all theft can be categorised as corruption, the line is crossed when those entrusted with power systematically abuse their position to deplete a hospital’s resources. There are indications that the problem is significant. In a study in Venezuela, two-thirds of surveyed medical staff knew of cases where medical supplies had been stolen, while in Costa Rica over 80 per cent of nurses reported ‘a lot’ or ‘some’ theft.¹⁴ Uganda has huge problems with drug leakage from hospitals and sub-hospital health facilities, where researchers estimated losses of two-thirds of the purchased drug supply.¹⁵ In interviews with 53 health workers in Mozambique and Cape Verde, about half of whom

worked in hospitals, researchers reported frequent misuse of pharmaceutical supply for personal gain.¹⁶

Misappropriation of drug supply and embezzlement of user-fee revenue in poor countries are seen by some as a personal coping strategy for deteriorating work conditions, including falling salaries and irregular pay. Approaches to prevention and control therefore need to include not only monitoring and control systems for detection and punishment, but also reforms to payment systems and reforms to strengthen professionalism. One suggestion, based on fieldwork in Mozambique and Cape Verde, is to 'introduce legislation that makes the head of an organisation or department legally responsible for the actions of that body' as a way of increasing peer pressure and accountability.¹⁷ Performance contracting is another way to increase accountability and provide incentives for performance.¹⁸

'Unhealthy' personnel practices

'Stealing time' is another common abuse. A total of 32 per cent of health professionals interviewed in Peru thought absenteeism was common or very common among hospital staff,¹⁹ while in Venezuela respondents reported that doctors and head nurses were absent during 30–37 per cent of contracted hours (see 'A tale of two health systems', Chapter 1, page 14). Absenteeism has been linked to low salaries and dual-job holding,²⁰ which some consider a 'coping mechanism' rather than corruption. Many doctors are also active in the private sector, driven in part by the inadequate compensation available in the public sector.²¹

To reduce absenteeism, institutional controls must be introduced to increase detection, including personnel supervision, performance measurement systems, and community participation in hospital management. Researchers noted that while control mechanisms can help, 'one size' doesn't fit all. The success of strategies to reduce absenteeism in public facilities will also depend on pay differentials between the public and private sectors, and whether there are barriers to entry into the private sector. Larger reforms to civil service policies and public human resource management systems may be needed, such as shifting from civil service appointments to contractual payment for time and services rendered. If an employee does not perform, the contract would not be renewed. This also permits one to pay a higher hourly rate for hours actually worked.

Informal payments – defined as payments made by patients for services that are supposed to be provided free of charge – are a serious problem in many middle- and low-income countries (see Chapter 4, page 62). Under-the-table remuneration has also been documented in some higher income countries including France and Greece.²² In addition to causing anxiety and uncertainty among patients, informal payments can cause poor people to forgo or delay seeking care, and can have negative effects on the quality of clinical services. Some patients go into debt or sell assets in order to make informal payments, thus impoverishing themselves. Others seek to keep informal payments low by skipping levels of care – going straight to specialists or the hospital, for example, instead of using primary care services or general practitioners.

Box 3.2 Hospital waiting lists open for scrutiny in Croatia

The Croatian health sector is perceived to be among the most corrupt sectors in the country.¹ It is not surprising then that instances of patients paying bribes to reduce time spent on waiting lists are thought to be commonplace. To curb this problem, the health ministry launched a pilot initiative to publish open waiting lists – a measure obliging hospital executives to disclose lists to patients showing them their position in the line-up to receive medical treatment. Lists are made accessible at hospital and clinic reception desks, and patients that do not want to have their names made public can ask to be listed by number instead. Complaints about irregularities can be made to the head of the hospital or to the Health Ministry.

With the help of TI Croatia, waiting lists at two major hospitals in Zagreb, Dubrava and Sveti Duh were published in hard copy and on the Internet in late 2004 and 2005. A hotline run by TI Croatia to monitor the effectiveness of the initiative received 90 calls about the Dubrava Hospital waiting list within the first few months starting in October 2004. In one case, a patient had waited two years for heart surgery but, after lodging a complaint with TI Croatia, was operated on within two weeks. The pilot initiative is set to become a precedent in curbing corruption in health care delivery by making it more open and transparent.

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Note

1. Transparency International's Global Corruption Barometer 2004, a public opinion survey, ranked the health services as the second most corrupt institution in Croatia, second only to the legal system/judiciary and equal to political parties and parliament.

Patients report making informal payments to all kinds of health workers, from guards and cleaners, to mortuary attendants and lab technicians, to the doctors and nurses involved in diagnosis and treatment. Some studies have found that patients who are hospitalised are more likely to make informal payments, and to pay higher amounts, than patients seeking ambulatory care.²³ In the foreboding words of one Albanian informant: 'The most important thing is that you should pay the doctor, because he will never forget the face of someone who has not paid him for the rest of his life.'²⁴

The fact that it is hard to distinguish informal payments from tips, or gifts given by patients to express gratitude, makes the problem more difficult to address. While informal payments may be seen as a coping mechanism for survival when the salaries of doctors and nurses fall below a living wage, other payments are clearly bribes extorted by workers, a practice detected in a Kenyan mortuary and decried by officials. Mortuary attendants have also been implicated in bribery and other corruption schemes in South Africa and Zimbabwe.²⁵

Involving ordinary citizens in oversight or transparency initiatives may be a useful complement to regulatory and bureaucratic reforms to address informal payments. One hospital in Cambodia has had success in reducing informal payments by formalising user fees and promoting professionalism among staff. The hospital created individual contracts with personnel and increased pay scales while enforcing accountability and sanctioning poor performance.²⁶

As in other sectors, private interests may also affect the selection and promotion of staff to fill hospital positions, with posts going to the highest bidder or most connected individuals, rather than to candidates with the best qualifications. One study found that auxiliary nurse-midwives pay bribes of six or seven times the monthly salary to obtain positions in Uttar Pradesh state, India.²⁷ Also in India, the Delhi High Court found that the president of the Indian medical council had accepted bribes to allow medical colleges to 'sell' seats to local students.²⁸ The cost of this type of corruption can be very serious, affecting both the clinical practice of medicine, and the management of hospital systems and performance. To reduce vulnerability, hospitals can try to open up the hiring and promotion decision-making process, making criteria more transparent. Performance monitoring is also essential to provide accountability.

'Just what the doctor ordered': corruption in payment systems

Other forms of corruption – including insurance reimbursement fraud, treatment decisions based on financial motivation rather than the medical need and improper referral relationships between doctors and hospitals (sometimes involving kickbacks) – can be traced to various forms of payment systems.

Reimbursement-system fraud may occur in countries with social insurance funds or a sizeable private health care insurance market (see Chapter 1). Losses can be substantial: the US government has estimated that improper Medicare fee-for-service payments, including non-hospital services, may be in the range of US \$11.9–23.2 billion per year, or 6.8–14 per cent of total payments.²⁹ This sum must be interpreted with caution as it may include unintentional mistakes or controversial decisions about what is labelled 'necessary' care, but it gives a sense of the magnitude of the problem. Health care fraud includes false billing of insurance funds or governments for medical services that are not supposed to be covered, services that were not actually delivered (sometimes because the person is dead or does not exist, so-called 'ghost patients') or services that were not medically indicated. It also includes the practice of 'upcoding' diagnosis related groups (DRGs), that is, classifying a case as more complicated or as having co-morbidities in order to obtain reimbursement at higher rates.

Whether insurance systems are involved or not, hospitals and doctors may have financial incentives to use increased resources in providing patient care. This is referred to as provider-induced demand. Where services are needed, increased demand can be good; however, financial incentives sometimes cause doctors to provide unnecessary treatments, or marginally useful diagnostic tests. Fee-for-service payment systems have been associated with increased utilisation of resources, sometimes to the point of inappropriate use, as providers try to maximise their revenue by providing more care. For example, researchers in Peru documented excessive caesarean section rates in the Social Security Institute and private hospitals where doctors were paid on a fee-for-service basis.³⁰ It is important to note that while demand may rise due to financial incentives, it may still fall within the range of normal medical judgement. Where provider-induced demand becomes abuse is when it is excessive and outside the range normally considered medically indicated, yet this is far from simple to determine.

Less recognised but equally harmful from the viewpoint of patients may be the risks introduced by managed care capitation payments, where hospitals and doctors may engage in fraud resulting in underutilisation of care in order to maximise profit (see 'Corruption in health care systems', Chapter 1, page 19). Again, it is hard to determine where underutilisation falls outside the normal range and becomes abuse.

Another area of concern is when hospitals enter into financial relationships with physicians to increase hospital referrals. Where hospitals are reimbursed by the state or private insurers based on patient admissions or days of care delivered, it can be advantageous for them to increase the number of patients admitted and to maintain high occupancy (see the Columbia/HCA case, 'Corruption in health care systems', Chapter 1, page 20). One way to do this is to offer advantages to physicians who refer patients to the hospital. Yet introducing financial incentives for referrals can present a danger: even if the hospital is not best suited to meet a particular patient's medical needs, the physician may still refer the patient there in order to gain the financial advantage.

Financial incentives are sometimes used to promote medically needed care offered at the most appropriate level, so it is not the use of financial incentives per se that creates the danger for corruption. But the situation must be monitored and controlled to prevent abuse. US federal law prohibits physician self-referrals, and a federal statute proscribes kickbacks. Applying these laws in Nebraska, one hospital was charged with underwriting a loan, paying consultants and providing free drugs and medical equipment to a doctor in exchange for referrals.³¹

The definition of corruption in other situations is not so clear, as when a private 231-bed hospital in the United States owned by Tenet, a large for-profit hospital corporation, was charged with using 'relocation agreements' to bribe doctors. Over a period of several years, the hospital paid US \$10 million to doctors who agreed to relocate their practices to the area.³² Although federal law specifically prohibits hospitals from paying or otherwise compensating doctors for referrals, the question was whether the 'relocation agreements' were devised to get around this law. The court case ended in a mistrial as the jury could not agree on whether this was a violation of the law.

Payment system reforms are important to reduce vulnerability to this type of corruption. In northern European countries, such as Finland, Sweden and the United Kingdom, health reforms have shifted health care provision from fixed-budget bureaucratic institutions to contract payments based on performance.³³ While this increased operating efficiency, it also required the state to play a more sophisticated role in regulating services. Because it is difficult to detect and control where utilisation falls outside the range of normal practice, regulators may have more success with approaches that reward providers for quality improvement.³⁴

A prescription for reform

Strategies to prevent corruption in hospitals must be tailored to the particular ownership structure, policy environment and health-financing situation in the country. The types of corruption one will find, and the resources available for preventing corruption, are likely to be different in low-income countries, compared with high-income countries.

Yet the range of interventions for reducing vulnerability to corruption does include some standard components. Once the types of corruption have been identified and prioritised, reform strategies such as those below should be considered and adapted. These include strengthening management systems and tools, creating incentives, increasing the likelihood of detecting corruption as well as the consequences of getting caught, and developing better information and transparency initiatives to hold hospital officials and medical personnel to account.

Box 3.3 No bribes for healthy business: India's Transasia Biomedicals¹

India's leading manufacturer of high-tech diagnostic machines to check for life-threatening blood diseases is Transasia Biomedicals, based in Mumbai. The brainchild of Suresh Vazirani, Transasia began marketing imported diagnostic equipment in 1985, only branching into manufacturing eight years later with the help of international manufacturers, such as Sysmex, Wako and Nittec in Japan, Finland's Biohit and Trace in Australia.

What marks out Transasia is the dogged stance it takes against corruption. Vazirani says he has never paid a paisa in bribes, but that avoiding corruption takes up more of his time than any other issue. When he wanted to install a fountain in the lunch area, two officials demanded a US \$100 bribe for a 'licence'. It took four years in court, and US \$4,000, to deal with the case.

Vazirani's interest in fighting corruption stems from his nine years as a volunteer with Moral Re-Armament (now Initiatives of Change), running industrial leadership training courses. There he would urge businessmen not to be corrupt, he recalls. "That's all very well," they would reply, "but you've never run a business. You don't know what it's like."

He and a friend decided to go into business in 1979 and as the company grew from a modest importer to a global player exporting to over 30 countries, so did the opportunities for corruption. Vazirani risked losing a DM 20 million (US \$12.6 million) sales contract to Germany because a customs officer wanted a bribe to release imported components. Rather than pay, Vazirani left the components in the warehouse for three months. He went to the top customs officials and 'appealed to their sense of national pride'. The components were released just in time.

Recently, a politician suggested to Vazirani that it would be 'an opportunity' if they each pocketed part of the World Bank aid the politician had received to improve health care. 'Yes, and is it an opportunity if we land up in hospital needing urgent care ourselves?' replied Vazirani. At this, the politician changed his tune, realising that Vazirani was not to be bought.

In September 2003, Vazirani was a keynote speaker at the launch in Mumbai of Transparency International's new Business Principles for Countering Bribery. 'Corruption is a big road block to progress', he says. 'Because of it everything goes wrong. The intimidation leads to wrong decision-making. Transasia can be an example. But many more companies need to be.'

Michael Smith (For A Change Magazine)

Note

1. Excerpt from *For A Change Magazine*, December 2003/January 2004.

Managerial systems and tools

Important managerial systems and tools for preventing corruption in hospitals include hospital drug formularies, review committees to certify need for new drugs or equipment, competitive bidding and other best-practice procurement procedures, and inventory systems to safeguard supplies. Each management system should have clearly defined levels of responsibility and approval of decision-making, with appropriate checks and balances. In addition to procurement, other management systems include budgeting and planning systems to prevent spending that favours pet projects or people and is not needs-based, and internal financial control systems to prevent theft and embezzlement.

Anti-corruption strategies in the hospital sector need to be one step ahead of different actors trying to abuse entrusted resources, and to penalise corrupt practices. Fraud control programmes have proven effective in reducing corruption; for example, the US federal government gets a return of US \$8 on every US \$1 spent on fraud control.³⁵ It recovered US \$8 billion over 15 years through enforcement of the False Claims Act, about half of which was health-related.³⁶ In addition to financial benefits, fraud control efforts can also have health benefits and change patterns of care in desirable ways.³⁷

Incentives and consequences

There are conflicts of interest inherent in most hospital payment systems, and the influence of payment systems on health care utilisation is a well-studied topic in health policy literature. It is an area where careful monitoring and continuous analysis is needed to ensure that patient safety and well-being are not being compromised by actions taken to maximise providers' income. A promising new area of research is in performance-based contracting, especially payment systems that reward quality. At the same time, it is important to promote laws and codes of conduct that explicitly regulate hospitals' and hospital administrators' engagement in practices where conflict of interest is likely to be a problem (for example, owning supply companies), and that encourage and reward professionalism.

Transparency and information

Since collusion among hospital personnel can subvert management control reforms, transparency is an essential anti-corruption strategy. In the hospital sector, transparency initiatives that should be considered include public access to procurement bidding results, monitoring of procurement prices paid (as in the Argentinian example discussed above), analysis of procurement bids for evidence of collusion, and setting performance standards for hospitals and suppliers. This type of information, when shared with other hospitals and citizen health boards or oversight committees, can both detect corruption and serve as a deterrent.

Anti-corruption strategies should not target only agents or officials working in hospitals: many forms of hospital corruption are promoted by the producers or dealers of medical equipment and drugs. Laws and codes of conduct for businesses supplying hospitals should also be revised and enforced to prevent offers of bribes. Transparency

can also be effective here, through the publication of report cards monitoring the compliance of private companies with these laws and codes of conduct. In addition, in centralised, public health systems the government can create a blacklist of suppliers caught bribing. Alternatively, the government can also share 'whitelists' of suppliers who consistently meet or exceed standards of performance.

Anti-corruption programmes should support health-sector financing and structural reforms to assure that public systems are not over-promising and under-delivering. Hospital systems and the medical personnel who staff them should be organised to provide incentives for improved performance. This is especially important in resource-constrained countries, where pressures to engage in corruption as a survival strategy may be strong. To prevent corruption and promote health, hospitals need management systems that are transparent, accountable and fair to both patients and providers.

Notes

1. Taryn Vian is assistant professor at the Boston University School of Public Health, where she conducts research and teaches courses on health care management and prevention of corruption in the health sector. Carol Karutu assisted in researching this paper and Rich Feeley provided feedback on an earlier draft.
2. D. Becker, D. Kessler and M. McClellan, 'Detecting Medicare Abuse', *Journal of Health Economics* 24(1), January 2005.
3. R. Taylor and S. Blair, 'Public Hospitals: Options for Reform through Public Private Partnerships', (Public Policy for the Private Sector Note Number 241) (Washington, DC: World Bank, 2002); J. Healy and M. McKee, 'Reforming Hospital Systems in Turbulent Times', *Eurohealth* 7(3), 2001.
4. R. Di Tella and W. D. Savedoff, 'Shining Light in Dark Corners' in R. Di Tella and W. D. Savedoff (eds) *Diagnosis Corruption: Fraud in Latin America's Public Hospitals* (Washington, DC: Inter-American Development Bank, 2001).
5. *Boston Globe* (US), 7 April 2004.
6. *Bernama* (Malaysia), 27 September 2004.
7. *The East African* (Kenya), 10 March 2003.
8. M. H. Jaen and D. Paravisini, 'Wages, Capture and Penalties in Venezuela's Public Hospitals', in Di Tella and Savedoff, *Diagnosis Corruption*.
9. E. Schargrodsky, J. Mera and F. Weinschelbaum, 'Transparency and Accountability in Argentina's Hospitals', in Di Tella and Savedoff, *Diagnosis Corruption*.
10. See www.haiweb.org/medicineprices/
11. G. Gray-Molina, E. Perez de Rada and E. Yáñez, 'Does Voice Matter? Participation and Controlling Corruption in Bolivian Hospitals', in Di Tella and Savedoff, *Diagnosis Corruption*.
12. D. Kyaddondo and S. R. Whyte, 'Working in a Decentralised System: A Threat to Health Workers' Respect and Survival in Uganda', *International Journal of Health Planning and Management* 18(4), October–December 2003.
13. B. McPake, D. Asimwe, F. Mwesigye et al., 'Informal Economic Activities of Public Health Workers in Uganda: Implications for Quality and Accessibility of Care', *Social Science and Medicine* 49(7), 1999.
14. Di Tella and Savedoff, *Diagnosis Corruption*.
15. McPake et al., 'Informal Economic Activities'.
16. P. Ferrinho, C. M. Omar, M. D. Fernandes, P. Blaise, A. M. Bugalho and W. Van Lerberghe, 'Pilfering for Survival: How Health Workers Use Access to Drugs as a Coping Strategy', *Human Resources for Health* 2(1), 2004.
17. *Ibid.*

18. Management Sciences for Health, 'Using Performance-Based Payments to Improve Health Programmes', *The Manager* 10, 2001.
19. L. Alcazar and R. Andrade, 'Induced Demand and Absenteeism in Peruvian Hospitals', in Di Tella and Savedoff, *Diagnosis Corruption*.
20. Schargrodsky et al., 'Transparency and Accountability', and P. Ferrinho, W. Van Lerberghe, I. Fronteira, F. Hipolito and A. Biscaia, 'Dual Practice in the Health Sector: Review of Evidence', *Human Resources for Health* 2(14), 2004.
21. R. Gruen, R. Anwar, T. Begum, J. R. Killingsworth and C. Normand, 'Dual Job Holding Practitioners in Bangladesh: An Exploration', *Social Science and Medicine* 54(2), 2002.
22. Ferrinho et al., 'Pilfering for Survival'.
23. P. Belli, G. Gotsadze and H. Shahriari, 'Out-of-pocket and Informal Payments in Health Sector: Evidence from Georgia', *Health Policy* 70(1), October 2004; T. Vian, K. Gryboski, Z. Sinoimeri and R. Hall, 'Informal Payments in the Public Health Sector in Albania: A Qualitative Study. Final Report. Partners for Health Reform Plus Project' (Bethesda, US: Abt Associates, Inc., 2004); D. R. Hotchkiss, P. L. Hutchinson, M. Altin and A. A. Berruti, 'Out-of-pocket Payments and Utilization of Health Care Services in Albania: Evidence from Three Districts' (Bethesda, US: Partners for Health Reformplus, 2004).
24. T. Vian, T. Gryboski, Z. Sinoimeri and R. Hall, 'Informal Payments in Government Health Facilities in Albania: Results of a Qualitative Study', forthcoming in *Social Science and Medicine*, 2005.
25. *The Nation* (Kenya), 8 February 2001; *Panafrican News Agency*, 19 July 2003; *African Business* (UK), January 2004.
26. S. Barber, F. Bonnet and H. Bekedam, 'Formalising Under-the-table Payments to Control Out-of-pocket Hospital Expenditures in Cambodia', *Health Policy and Planning*, July 2004.
27. R. Balakrishnan, cited in B. Lee, M. Poutanen, L. Breuning and K. Bradbury, *Siphoning off: Corruption and Waste in Family Planning and Reproductive Health Resources in Developing Countries* (Berkeley: University of California Press, 1999).
28. *The Lancet* (UK), 358, 2001.
29. Becker et al., 'Detecting Medicare Abuse'.
30. Alcazar and Andrade, 'Induced Demand and Absenteeism'.
31. See note 27.
32. *Modern Healthcare* 33, 2003.
33. R. B. Saltman, 'Regulating Incentives: the Past and Present Role of the State in Health Care Systems', *Social Science and Medicine* 54, 2002.
34. *New York Times* (US), 13 March 2005.
35. J. A. Meyer and S. E. Anthony, 'Reducing Health Care Fraud: An Assessment of the Impact of the False Claims Act. Report prepared by New Directions for Policy' (Washington, DC: Taxpayers Against Fraud, 2001).
36. *Pharmaceutical Executive* 21(11), 2001.
37. Becker et al., 'Detecting Medicare Abuse'.