Corruption in health: what every policymaker should know

By **David Nussbaum**, Chief Executive, Transparency International

Corruption in the health sector has direct implications for the collective goals of the Commonwealth health ministries. This article illustrates the nature and reasons for corrupt practices in the health sector and examines how these reasons undermine health policies and initiatives, deprive those most in need of access to health care and severely hamper the potential to achieve the health-related Millennium Development Goals (MDGs). The Framework for Commonwealth Principles on Promoting Good Governance and Combating Corruption, adopted in 1999, emphasises the rigour needed to manage services provided in the public interest. Health systems across the 53 countries of the Commonwealth can reinforce these principles by taking measures to ensure transparency and accountability, prevent corrupt practices and prosecute those that still occur.

"Just as the painful ordeal of childbirth finally ended and Nesam Velankanni waited for a nurse to lay her squalling newborn on her chest, the maternity hospital's ritual of extortion began. Before she even glimpsed her baby, she said, a nurse whisked the infant away and an attendant demanded a bribe. If you want to see your child, families are told, the price is $12 for a boy and $7 for a girl."
'New York Times' 30 August 2005.

This story of extortion in an Indian hospital is but one of countless examples of corruption in the health sector. Each year, hundreds of millions of dollars are lost to fraud, embezzlement, theft and other forms of corruption. Corruption deprives people of access to care, impoverishes households and leads to poorer health outcomes, morbidity and mortality. Certain corrupt practices have widespread systemic consequences, undercutting health policies and global health initiatives. For example, counterfeit drugs could completely undermine treatment of victims in a pandemic. How does corruption happen, and what can governments and health ministries do to prevent it?

Why is the health sector so prone to corruption?*

The health sector is an attractive target for corruption because so much money, public and private, is involved. Certain other features of this sector make it particularly vulnerable, including the large number of dispersed actors across a health system and the imbalance or asymmetry of information among these actors. Health professionals normally have more information about illness, treatment and diagnosis than patients; pharmaceutical and medical device companies know more about their products than public officials entrusted with spending decisions; individuals have certain kinds of information about their health that are not necessarily available to health care providers or insurers.

The nature of corrupt practices is largely determined by the type of health care system. Examining how a country's system functions, reviewing underlying incentives for provision of care and analysing its particular vulnerabilities are key to designing strategies to tackle corruption and implementing measures to effectively reduce abuse and fraud.

Systems can be divided into two broad types: those in which the public sector both finances and directly provides health care services (e.g. Malaysia, UK) and those in which the entity that finances the services is separate from the entity providing the services (e.g. Canada, Australia). Types of corruption and resources available to prevent them will also differ in low-income and high-income countries.

In systems with direct public provision of care, corrupt practices largely manifest as illegal charging of patients (informal payments) and overcharges in the purchase of medical supplies, drugs and equipment. There may also be illicit use of public facilities for private practices and absenteeism. In some systems, especially in fragile or transition states, the rate of illegal payments has led to public care provision becoming de facto privatised. In systems that separate public financing from provision, there is a wide range of financing arrangements (public and private) to provide health care service. A major corruption concern in these systems is fraud in the billing of government or insurance agents.

> Each year, hundreds of millions of dollars are lost to fraud, embezzlement, theft and other forms of corruption.

From the perspective of the patient, corruption affects the quality of care in different ways, depending on the financing structure of the health system. In a fee-for-service system, patients might be offered tests or procedures that are not medically indicated. In capitation systems, there may be neglect in the provision of necessary services and underperformance by medical staff.

Procurement corruption in hospitals

Hospitals deserve special attention in assessing corruption since, globally, they account for 30-50 per cent of total health sector spending, both public and private. Hospital spending can include large investments in building construction and purchase of expensive technology. These areas of procurement are particularly vulnerable to corruption. Prevention of corruption in hospitals must also be tailored to the health system situation.

Risk of procurement corruption is higher if a hospital lacks systems for documenting and controlling contractor performance. Vendors may substitute lower-quality building materials or deliver goods that do not meet contractual expectation for quality. In Kenya, the press reported that the Kenyatta National Hospital lost over US$12 million to procurement fraud between 1999 and 2002. A failure to control the quality of purchases was one of the problems cited: obsolete items were substituted for the modern

This article was published in the Commonwealth Ministers Reference Book 2006, which is produced by Henley Media Group on behalf of the Commonwealth Secretariat.

equipment described in the bid, hidden charges were made and construction costs ran well above the estimates included in the original procurement contract.

Other types of corruption in hospitals include embezzlement, theft of medicines and medical supplies and fraud in the payment system. Hospitals with weak financial systems that are not computerised, or are cash-based, are more vulnerable. At another hospital in Kenya, the Coast Provincial General Hospital, introducing a network of electronic cash registers injected transparency and revenue into the hospital. Previously, the real revenues from user-fees were difficult to determine since they could not be compared to actual receipts. With the cash register network in place, annual user-fee revenues went up 400 per cent over a three-year period.

It is vital to note that persistent corruption in the hospital sector makes it harder to reduce hospital spending as a proportion of overall health expenditures. This is 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.

Unhealthy human resource practices

The 2006 Commonwealth Health Ministers meeting is addressing the issue of human resources for health, along with the realisation that a growing shortage of health workers poses a major threat to health systems in developing countries. Even in discussing corruption, we recognise that the majority of health workers are dedicated professionals. However, the same factors that drive migration may also drive corrupt practices. Many health workers are coping with difficult environments, sometimes with low pay, poor management and support systems and weak infrastructural accountability mechanisms. These factors may give rise to 'stealing time' or absenteeism and charging payments for services that are supposed to be provided free-of-charge. Staff may use their positions to further private interests. Examples from India show auxiliary nurse-midwives paid bribes of six or seven times a normal one-month's salary to obtain their positions, and 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.

Health ministries can introduce institutional controls to increase detection and provide incentives for ethical conduct. They may need to assess pay differentials between public and private sectors and increase pay scales. Promoting professionalism among staff, community participation in hospital management and performance contracting are other tools available to curb such practices. Reforms along these lines have become widespread in northern Europe. Various countries, including the UK, are shifting dramatically from fixed-budget bureaucratic institutions to contract payments based on performance. This requires the state to play a more sophisticated role in monitoring and regulating services. The UK created a Counter Fraud Service in 1998, as part of the National Health Service, which aims to track losses to fraud and corruption in each area of the NHS budget to an accuracy of one per cent. It reports to have reduced losses from corruption by US $303 million from 1999-2005, as part of a total financial benefit of US $1.2 billion. This is a return of 13:1 on the budgetary investment and the equivalent to the cost of building 10 new hospitals.

Pharmaceutical sector

Pharmaceuticals are the largest public health expenditure after personnel costs in most low-income states and often the largest household health expenditure of all. Lack of access to pharmaceutical products can be life threatening. This is most dramatically illustrated in sub-Saharan Africa where almost 30 million people are infected with HIV/AIDS and the majority lack access to anti-retroviral therapies. International drug policy faces a morally worrying 'drug-gap', despite the plethora of programmes devoted to improving access to medicines. Corruption widens that gap by inflating prices and hampering distribution. Corruption also feeds the counterfeit drugs market when regulators and customs officials collude with the manufacturers and traffickers of fake drugs. The World Health Organization estimates that one-third of the global population lacks regular access to essential medicines.

The need for heavy regulation of the pharmaceutical sector is one reason it is vulnerable to corruption. Regulation protects the population from sub-standard and unfairly priced goods, yet governments also want to support economic competitiveness, innovation and efficiency of the pharmaceutical sector. These goals sometimes work at cross-purposes. Regulators are subject to pressure and aggressive promotion from commercial interests. Each step in the post-manufacturing regulatory process, from registration to selection, procurement, distribution and service delivery is vulnerable to corruption. Drug selection committees must be composed of impartial persons with appropriate technical skills. As with hospital construction, drug procurement is particularly susceptible unless there are open bidding processes, good technical specifications and consistent and transparent processes for redress.

The UK created a Counter Fraud Service in 1998 which has had a 13:1 return on budgetary investment, the equivalent of building 10 new hospitals.

The pharmaceutical industry's influence on physicians is of special concern in industrialised and developing countries but can be particularly dangerous in contexts where doctors receive low salaries. Drug companies may offer doctors commissions for prescribing their drugs or enlist doctors to recruit patients for clinical trials while having them on their payrolls. While unethical pharmaceutical practices have received much attention in recent years, and many industry associations and individual corporations have passed codes of conduct and ethical guidelines, these still need to be monitored for compliance. Similarly, professional guidelines for physicians are ineffective unless enforced.

Stricter laws and regulations

Some governments are beginning to introduce stricter laws and regulations to address the potentially corrosive influence of the pharmaceutical sector over health service provision. In the UK, a special committee on the pharmaceutical sector recommended tougher restrictions on physicians to avoid inappropriate prescribing and an end to Department of Health relationships with the drug industry, in favour of the Department of Trade and Industry. Nigeria's National Agency for Food and Drug Administration and Control (NAFDAC) has employed a dual strategy to take serious action against counterfeit drugs through massive education campaigns and a more rigorous testing and enforcement regime. NAFDAC Director General Dora Akunyili, winner of the 'Transparency International Integrity Award' in 2003, has also called on the international community to address the problem more fully, advocating for an international convention for the control of counterfeit drugs, similar to the existing one on psychotropic substances.

Corruption and the MDGs

Three of the eight MDGs relate directly to health: reducing child mortality, improving maternal health, and combating HIV/AIDS, malaria and other diseases. Achievement of these goals is

This article was published in the Commonwealth Ministers Reference Book 2006,
which is produced by Henley Media Group on behalf of the Commonwealth Secretariat.

Credit: Themba Hadebe/AP

Demonstrators at a protest march in Johannesburg in May 2002 after the government's appeal of a court ruling forcing it provide a key AIDS drug to HIV-positive pregnant women.

severely hampered by the corrupt practices in the health care sector. Among income sectors in the population, as one would expect, the poorest are disproportionately affected by corruption. They are less able to afford to bribe for services that are supposed to be free or to pay for private alternatives.

Progress on combating HIV/AIDS is exponentially affected in this equation by the sheer scale of the pandemic, the stigma of the disease and the high cost of drugs and treatment programmes needed to address it. At the grand end of the scale is theft of funds that are allocated for treatment by ministries and national AIDS councils and misappropriation or counterfeiting of medicine. At the petty end are doctors who extort 'tips' for medicines or for the use of clean equipment. There are also patients who sell their medications because it is the only commodity of value they have.

Sums of money now disbursed to tackle HIV/AIDS have provided a huge boost to existing health budgets of many countries. The magnitude of budgetary inflow may lead to corrupt practices if performance is assessed by how rapidly the funds are disbursed, rather than by health outcomes. Some donors are moving towards budgetary support, which needs to go along with support for structures of public financial management and accountability. The Global Fund to Fight AIDS, TB and Malaria has attempted to reduce misuse of funds by including all stakeholders in the design of programmes, from governments to NGOs to disease sufferers themselves. Donors and recipient governments both need to be open and explicit about giving and receiving funds. Donors should ensure that aid is used in concert with good procurement guidelines and should work with pharmaceutical companies to encourage responsible behaviour.

What health ministries can do

At its base, reducing corruption in the health sector requires transparency, which may mean fundamentally redressing the 'information imbalance' between governments, service providers and patients. Health ministries can publish and widely disseminate information on:

- Budgets and performances at national, local and health delivery centre level;
- Rules and responsibilities in the relationships between medical suppliers, health care providers and policy-makers;
- Continuous monitoring of payment mechanisms, whether fee-for-service, salary or capitation; and
- The cost of hospital supplies.

In the 'regulation of pharmaceuticals', health ministries should ensure that the following are in place:

- Nationwide systems for reporting adverse drug effects, including mandates and incentives for physicians to report this information;
- Accessible and up-to-date public databases listing drug protocols and results of clinical drug trials, as well as all financial and other contributions from pharmaceutical companies to medical research units; and
- Rules governing conflicts of interest in the interaction between physicians and health authorities and external monitoring of relationships between health departments and the drug industry.

To 'prevent corruption in procurement' processes, governments and health authorities should:

- Introduce 'integrity pacts', which bind bidders and contracting agencies to neither offer nor accept bribes (see www.transparency.org/tools);
- Debar companies found to have engaged in corrupt practices for a specified period of time; and
- Equip anti-corruption and anti-fraud agencies with the necessary expertise, resources and independence to carry out their functions and ensure protection of these groups by independent courts.

'Codes of conduct' for the sector should also be developed on both institutional and individual levels for regulators, medical practitioners, pharmacists and health administrators. Such codes should:

- Make explicit reference to prevention of corruption and conflicts of interest that can lead to corruption;
- Detail sanctions for breaches; and
- Establish guidelines for an independent body to monitor and enforce these codes.

Health systems also reduce incentives towards corruption by ensuring 'decent wages' commensurate with education, skills, training and experience for doctors, nurses and other health professionals.

'Donor agencies' can do their part by reporting activity in the health sector, ensuring coordinated support and evaluating health programmes by outcome, not by speed of disbursement. This is especially critical in humanitarian emergency situations where oversight mechanisms are often bypassed.

Finally, governments must ensure a robust role for civil society, journalists and watchdog organisations to report on and confront government and industry figures. This includes introducing whistleblower protection and ensuring continued public access to information on policies, practices, budget formulation and expenditure reporting.

**This text draws on Transparency International's 'Global Corruption Report 2006,' in particular essays by William Savedoff and Karen Hussmann, Taryn Vian, Jillian Clare Cohen, and Liz Tayler and Clare Dickinson. The full text is available at www.globalcorruptionreport.org*

David Nussbaum is Chief Executive of Transparency International. As CEO, he is responsible for TI's International Secretariat, which acts as the headquarters for the worldwide anti-corruption movement. He is also the chair of Traidcraft, the leading UK fair trade company. David, a British citizen with degrees in theology and finance, has published articles and chapters on topics ranging from globalisation to the governance of not-for-profit enterprises.

Transparency International (TI) is the leading international non-governmental organisation devoted to combating corruption. Through its International Secretariat in Berlin and its 99 independent national chapters around the world, TI works at both the international and national level to curb the supply and demand of corrupt practices. Information used in this essay by the author was taken from the '2006 Global Corruption Report', the annual Transparency International publication.

Transparency International (TI), Alt Moabit 96, Berlin 10559, Germany
Tel: +49 30 343 8200 E-mail:dnussbaum@transparency.org
Fax: +49 30 3470 3912 Website: http://www.transparency.org

This article was published in the Commonwealth Ministers Reference Book 2006,
which is produced by Henley Media Group on behalf of the Commonwealth Secretariat.