Chapter 1 : Transparency International (Author of Global Corruption Report)

The edition of Transparency International's Global Corruption Report shows the impact that corruption has on health care in rich and poor countries. From high-level bribery in Costa Rica to informal payments in Hungary, case studies from around the world explore the characteristics of the health sector that make it so prone to corruption.

First, they impair the normal functioning of a competitive market that might otherwise be harnessed to constrain illicit behaviour. Finally, these three features constrain efforts to generate reliable information, establish transparency and enforce accountability. Roles and responsibilities within health systems are split between regulators, payers, health care providers, suppliers and consumers in ways that make good decision-making difficult, even when everyone is thoroughly honest. When individuals who are willing to take advantage of this system are factored in, things become even more entangled. To see how this works, it is useful to consider, in turn, how each actor can use its position to defraud others. Regulators ministries of health, parliaments, supervisory commissions The basic uncertainty in health care services creates a potential role for government to protect consumers through supervision and improved information. It is common for governments to assume the role of verifying that medications are safe and effective, that health care practitioners have completed approved courses or have proven skills, and that facilities are adequately staffed and equipped. However, the existence of regulations opens avenues for corrupt activities. Pharmaceutical companies can skew research studies, influence review boards or simply bribe regulators to approve or speed up the processing of their applications. Health care providers and facilities may be tempted to pay a regulator to overlook lapses in licensing requirements. As in any sector, government inspectors can be tempted to abuse their position to extract bribes even when providers are in compliance. Payers social security organisations, health insurers Payers can be defrauded by other actors, but they can also engage in corrupt practices themselves. The public sector can act as a payer either through direct provision of care or as a public insurance agency. In the private sector, payers include commercial insurance firms and non-profit insurance organisations. When the public sector provides services directly, it generally allocates resources through the normal public budgetary process. This creates opportunities for political interests to contravene decisions that are in the best interest of patients. For example, decisions may be made to favour regions governed by political allies, rather than following criteria of equity and efficiency. When the public sector manages an insurance fund, as is common in countries with mandatory social insurance, corruption can occur when officials embezzle funds. The public insurer can also allocate resources for political gain and at the expense of patients or taxpayers. Private insurers, whether for-profit or non-profit, can engage in corrupt activities when they collaborate in public programmes, or are subjects of regulation. They may defraud public sector programmes that subsidise health care through fraudulent billing. They may reject insurance claims that they are committed to reimburse by law. And they may bribe insurance regulators to ignore illegal practices. These risks are one of the reasons that health care professionals are generally bound by professional standards and ethical codes that are expressly aimed at deterring corruption. Patients generally defer to health care professionals in determining what course of action should be taken to treat an illness. When providers are paid a fixed salary, independent of the volume of services provided, there are no financial incentives to oversupply or undersupply services, but there is a tendency to be less productive and provide less care. They can abuse their public sector job by referring patients to their parallel private practice or use public facilities and supplies to serve their private patients. They may defraud the public sector by accepting a full salary while absenting themselves to provide private consultations elsewhere. They may steal drugs and medical supplies for resale or use in other places, and solicit bribes from patients for services that are supposed to be free. Although these practices are generally illegal, they may be excused in many countries by people who see them as acceptable strategies for coping with low pay and poor working conditions. Most payment systems have to rely on the honesty of providers to state the kind and intensity of services that have been provided. They can order tests to be conducted at private laboratories in which they have a financial stake, or prescribe expensive drugs in exchange for kickbacks or bribes from pharmaceutical companies. In addition to health care providers, health

facility officials may accept kickbacks to influence the procurement of drugs and supplies, infrastructure investments and medical equipment. In so doing, they may pay higher prices or overlook shoddy work. Patients Consumers or patients can also participate in corrupt behaviour. In other systems, patients misrepresent their enrolment in an insurance plan by using the insurance cards of friends or family members. This has been documented in Canada where the province of Ontario detected numerous people using forged cards to gain access to free public care. Paying bribes to get privileged access to public care is also a common form of corruption. In some countries, such bribes are socially acceptable and excused as a way to compensate poorly paid, public sector health professionals, or as an understandable response by people who may be in dire need of care. Suppliers producers of medical equipment, pharmaceutical companies Medical equipment suppliers and pharmaceutical companies have privileged information about their own products and deliveries that assist them to corrupt the health care system. Suppliers can skimp on the quality of equipment or repackage expired medications. They can short-change deliveries and bribe procurement officers to authorise higher prices. They can induce providers to use their products at inflated prices, even when cheaper, equally effective alternatives are available. In the mids, Germany investigated hospitals and more than 2, doctors on suspicion of taking bribes from manufacturers of heart valves, life support equipment, cardiac pacemakers and hip joints. Finally, suppliers can bribe regulatory agencies to develop policies in their favour. For example, pharmaceutical companies may influence governments to impede competition from generic drug manufacturers, or equipment producers may try to change regulations so that licensed facilities will be required to purchase their products. Proving intent is difficult Though all five actors are generally present in each system, their relative power and incentives will vary dramatically. For example, doctors paid on a salaried basis have no way to overcharge insurers, and systems that prohibit insurers from establishing exclusive provider networks have less leeway to control costs and billing practices. In all cases, however, detecting corruption in the health system is difficult. As strange as it sounds, distinguishing an act of self-enrichment from systemic inefficiency, human error or just poor judgement is hard. The line between abuse and honest mistakes is frequently blurred. For example, when providers bill the government for treatments that are not medically indicated or not even provided , it may still be difficult to determine whether the decision represented an intentional effort to defraud the government, poor training or a simple mistake. These difficulties in proving intent encourage a situation in which impunity is commonplace. The compliance programmes required a hospital to develop written standards of conduct, train staff in the appropriate use of codes, establish hotlines for complaints and monitor its own compliance, among a wide range of measures. Though health care providers, payers, consumers, regulators and suppliers are active in all health systems, the actual relationships, responsibilities and payment mechanisms will vary. Some countries have relatively well financed public health services that are directly provided by national or local governments Sweden, Spain. In other high-income countries, the public sector pays for health services that are provided by private and public health care providers Canada, Germany. In most low- and middle-income countries, the health system is fragmented. It may include a public insurance scheme for formal sector workers; direct public provision of health care for the indigent; private insurers and providers contracted by wealthier households; and a large share of private practitioners who are paid directly by their patients, both rich and poor Mexico, South Africa. But the forms of abuse may differ depending on how funds are mobilised, managed and paid. For this reason, it is useful to classify health systems into two broad categories based on their institutional structure: In the case of direct public provision of health care services, the most common forms of abuse involve kickbacks and graft in procurement, theft, illegally charging patients, diverting patients to private practice, reducing or compromising the quality of care, and absenteeism. In systems that separate public financing from provision, the most common forms of abuse involve excessive or low-quality medical treatment, depending on the payment mechanism used, and fraud in billing government or insurance agencies. Systems with direct public provision In many countries, public health systems have been established to provide health care to the population at little or no cost at time of service. Many European countries follow this model. Integrated public health systems display a wide range of structural differences, whether through decentralisation as in Spain or experimenting with autonomous health facilities Sweden , but they share common approaches to allocating

budgets and delivering services. In developing countries, successes involving direct public provision of health care services are rare. In the most effective ones, health services do reach the bulk of the population Chile, Cuba, Malaysia. In most cases, however, the public systems have been unable to reach large segments of the population, or to provide adequate services Venezuela, Indonesia. In the absence of complete coverage, countries sometimes finance, or at least subsidise, non-profit health care institutions, such as mission hospitals in Africa or NGO health clinics in the Americas. The evidence available on corruption in health systems with direct public provision is largely focused on informal, or illegal, payments for services in developing or transitional economies. This form of corruption has a particularly negative impact on access to care for the poor when they cannot afford these payments. Kickbacks and graft in the purchase of medical supplies, drugs or equipment have also been studied in health systems with direct public provision, but these forms of corruption are more difficult to detect and document. This is common in countries with social insurance systems such as France and Germany, in large federated countries such as Brazil and Canada, and in systems with public safety nets such as Medicaid and Medicare in the United States. This separation of public financing and provision is rare in low-income countries, but is common in high-income countries and in the middle-income countries of Latin America and Asia. When public financing is separated from provision, the character of abuses is likely to change, focusing on ways to divert the flow of payments and reimbursements. One central aspect influencing the type of abuse is the payment mechanism chosen by the financers to pay providers for their services. Provider payments on a capitation basis may introduce the right incentives for providers to focus more on preventive than on curative care, but it may also motivate the dishonest ones to neglect the provision of necessary care or to reduce quality below acceptable standards. The public financing agent itself may be a focus for corruption, with officials diverting funds to improper uses or for personal financial gain. Furthermore, public reimbursement of private providers, in systems where this is permitted, raises a wide range of regulatory issues. The government frequently establishes regulations to assure that private providers meet minimum quality standards. Such regulations create opportunities for corruption in licensing procedures and inspections. Whether countries directly provide health services or separate public financing from provision, their systems are not immune to corruption. Only the forms and scale of corruption are likely to vary see Box 1. Common forms of corruption in all health systems Cutting across both types of systems are forms of abuse in the processes of allocating public funds and transferring public funds between national and sub-national entities. Sometimes there is large-scale diversion of funds at the ministerial or senior management levels of a health system; in other cases, funds are diverted from their intended purposes when they are transferred to lower-level political administrators. Though these forms of embezzlement can potentially cost the system more than other forms of corruption that occur at the facility level, they are studied less often and are poorly documented. Both types of health systems share the vulnerability to abuses related to counterfeit drugs, selling faulty equipment, misrepresenting the quality or necessity of medical supplies and conflicts of interest between purchasers, providers, suppliers and researchers. Conclusion Health systems are prone to corruption because uncertainty, asymmetric information and large numbers of actors create systematic opportunities for corruption. These three factors combine to divide information among different actors â€" regulators, payers, providers, patients and suppliers â€" in ways that make the system vulnerable to corruption and that hinder transparency and accountability. When regulations are put in place to remedy these problems, efforts to influence regulators become a new potential source of corruption. Consumers generally lack the organisation and power to discipline other actors by voicing criticism or choosing different health care providers. Colombia and Venezuela are neighbouring Latin American countries with comparable incomes that share many similarities in history, culture and language. Until , the two countries also had similarly fragmented health systems, comprised of a large social security institution serving the formal sector, national or state-level governments that directly provided health care services to the rest of the population, and an active private sector which relied predominantly on direct payment for services by patients and their families. In the early s, Colombia engaged in a series of dramatic health reforms that decentralised public services to the municipal level and, in parallel, created a mandatory universal insurance system with the participation of non-governmental insurers for-profit and non-profit. Under the new insurance system, individuals were given

the option of choosing their insurer. The content and price of the benefit package was defined at the national level with the hope that insurers would compete on quality of care and service. To make the system more equitable, the reform created a national fund that taxed away a portion of the relatively high contributions made by upper-income individuals so as to subsidise the relatively low contributions made by lower-income individuals. In this way, Colombia shifted from a segmented system dominated by large public institutions with integrated provision, to an increasingly universal system dominated by a separation of payers and providers.

Chapter 2 : Global Corruption Report Corruption and health by Transparency International - Issuu

The Global Corruption Report is the only report of its kind, and is an essential reference source for anyone who wants the latest research on how corruption affects everything from health to education and the oil and gas industries.

Chapter 3 : TI Publication - Global Corruption Report Corruption and health

Given the mountain of paper that passes over the desks of most health professionals every day, it is a pity that the special focus of Transparency International's (TI) Global Corruption Report - on health sector corruption - was not more directly emphasized; perhaps by inclusion in the formal title. While possibly a minor point, it may.

Chapter 4 : Books by Transparency International (Author of Global Corruption Report)

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