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Summary Sheet: Corruption and paying for health care[i]

Every year, the world spends more than US $3.1 trillion on health services, most of which is financed by governments. European members of the OECD collectively spend more than US $1 trillion per year and the United States alone spends US $1.6 trillion. In Latin America, around 7 per cent of GDP, or about US $136 billion, is consumed by health care annually, of which half is publicly financed. In lower-income countries, private health spending is often greater than public health spending, although the latter is still a significant amount. The share of total government revenues spent on health care ranges from under 5 per cent in Ethiopia, Egypt, Indonesia and Pakistan to more than 15 per cent in Ireland, Germany, the United States and Costa Rica. These large flows of funds are an attractive target for abuse.

The stakes are high and the resources precious: money lost to corruption could be used to buy medicines, equip hospitals or hire badly needed medical staff. The diversity of health systems worldwide, the multiplicity of parties involved, the paucity of good record keeping in many countries, and the complexity in distinguishing among corruption, inefficiency and honest mistakes make it difficult to determine the overall costs of corruption in this sector around the globe. But growing evidence from around the world indicates that corruption, fraud, and abuse are resulting in significant losses of public money and denial of good quality health services to millions of people.

Transparency International defines corruption as 'the abuse of entrusted power for private gain'. In the health sphere the abuse includes examples of corruption such as bribery of regulators and medical professionals, manipulation of information on drug trials, the diversion of medicines and supplies and corruption in procurement; but also examples of fraud, such as the overbilling of insurance companies. The perpetrators of corruption in the health sector include many private actors, notably medical professionals, who are considered to be bound by professional ethics that require them to serve the common good.

Why is the health sector so prone to corruption?

Certain characteristics make all health systems – whether public or privately funded, in rich and poor countries – vulnerable to corruption:

• An **imbalance of information** prevails in health systems. Health professionals have more information about illness than patients, and pharmaceutical and medical device companies know more about their products than public officials entrusted with spending decisions. Making information available can reduce losses to corruption. A study from Argentina showed that the variation across hospitals in prices paid for medical supplies dropped by 50 per cent after the ministry began to disseminate information about how much hospitals were paying for their supplies.

• The **uncertainty in health markets** – not knowing who will fall ill, when illness will occur, what kinds of illnesses people get and how effective treatments are – is another challenge for policy-makers, as it makes it difficult to manage resources, including the selection, monitoring, measuring and delivery of health care services and the design of health insurance plans. The risk of corruption is even higher in humanitarian emergency situations when medical care is needed urgently and oversight mechanisms are often bypassed.

• The **complexity of health systems**, particularly the large number of parties involved, exacerbates the difficulties of generating and analysing information, promoting transparency, and detecting and preventing corruption. The relationships between medical suppliers, health care providers and policy-makers are often opaque and can lead to distortions of policy that are bad for public health.

How to diagnose the problem of corruption in health care systems

- Measure and document abuse through focus group, expert, client, price information and facility surveys. Public officials can also contract forensic accountants to analyse financial records for evidence of malfeasance and to provide practical recommendations for improving financial control.
- Conduct regular random audits such as unannounced visits to public facilities to assess absenteeism or verification that billed services were medically indicated and provided. Technology should assist rather than replace human surveillance.
- Continuously monitor payment mechanisms (whether fee-for-service, salary, capitation, global budgeting or other)
- Provide whistleblower protection to individuals working in procurement bodies, health authorities, health service providers and suppliers of medicines and equipment.

Different health systems are vulnerable to different types of corruption

Abuses in the health system aimed at personal gain are not exclusive to any particular country or health system. But the forms of abuse will vary depending on how funds are mobilised, managed and paid. A system that directly finances the supply of services will be most vulnerable to corruption in procurement and to abuses that undermine the quality of services. A system that relies on a great deal of billing and financial transactions will be most vulnerable to diverting funds and to fraudulent claims. For this reason, it is useful to classify health systems into two broad categories based on their institutional structure: systems in which financing and provision are integrated, and systems that separate financing from provision.

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.

<u>Problems in integrated systems</u>

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. The most common structure for such systems involves a ministry of health, or its equivalent, which hires the necessary administrative, medical and support staff, builds facilities and organises the purchase and

distribution of medications, equipment and supplies. Many European countries follow this model, with the UK's National Health Service representing an example of such systems. Integrated public health systems incorporate a range of structural differences, whether through decentralisation (as in Spain) or experimenting with autonomous health facilities (as in Sweden), but they share common approaches to allocating budgets and delivering services.

In developing countries, successes of integrated public health systems are quite rare. In the most effective ones, health services do reach the bulk of the population (for example Chile, Cuba and Malaysia). In most cases, however, the public systems have been unable to reach large segments of the population or to provide adequate services (for example, Venezuela and 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 Latin America.

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. In China and many former communist countries of Eastern Europe and Central Asia, the apparent existence of such illegal payments has led observers to conclude that the health care system has been 'privatised', that it functions like a private health care market and is only nominally public. Formalising fees in Cambodia and Kyrgyzstan reportedly reduced the cost of services to people who were previously subjected to illegal charges and distributed the financial burden more equitably.

The next most common focus for studies of corruption in health systems with direct public provision is *theft* by employees, *self-referral* of patients, *absenteeism* and the *illicit use of public facilities for private practice*. *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. Some studies have been able to estimate the magnitude of *overcharges* to the public sector for medical supplies and drugs by comparing prices paid by different hospitals.

Problems of systems with financing-provider split

In many health systems, the entity that finances health services is separate from the entity providing those services. 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 extremely rare in low-income countries, and is most commonly found in the middle-income countries of Latin America and Asia and among high-income countries.

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. For example, medical professionals who are reimbursed on a fee-for-service basis have no incentive to be absent from work, but dishonest ones may be tempted to *overcharge for services, bill for services that were not provided, or order tests and procedures that are not medically indicated*.

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. Examples of abuses include: *embezzlement of capitation funds* paid by the state; the use of *fraudulent subcontracts* as a method of diverting funds to friends or family; *improper*

enrolment or dis-enrolment practices (such as seriously ill patients being driven out or refused admission to a health care plan, or bribes being paid to secure younger and healthier patients); *denial of treatment* without proper evaluation; *failure to inform patients of their rights and entitlements*; *failure to provide sufficient medical professionals* to meet the needs of the enrolled population; and *requiring patients to fight their way through extensive appeals* processes in order to obtain necessary treatment.

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.

Health care fraud in the United States: lessons learned

The United States spends more on health care than any other industrialised country: more than US $1.6 trillion in 2003, or 15.3 per cent of the country's GDP. The US Department of Health and Human Services has given estimates that government programs lose 10 per cent of their funds through fraud each year, an annual sum close to US $50 billion.

Health care delivery in the United States is largely contracted out to the private sector, or independent, not-for-profit entities, but paid for by government programmes or by commercial insurers who offer health insurance to individuals, to groups or to employers (who buy coverage for their employees as an employment benefit). The majority of services are reimbursed on a fee-for-service basis, whereby health care providers are trusted to determine the appropriate levels of care, and then trusted to bill the insurer for the services they perform.

Fee-for-service payment systems are consolidated into massive, highly automated payment systems. The bulk of claims are paid through auto-adjudication, which means the claim was received, subjected to a rules-based examination, approved and paid, all electronically, with no human scrutiny. The whole system is designed with honest physicians in mind, incorporating the values of speed, efficiency, accuracy, predictability and transparency. The edits and audits built into computerised claims-processing systems serve the purpose of checking pricing, policy coverage and medical orthodoxy (based on the diagnosis reported in the claim). But the control systems generally assume the claim itself to be true, and do little or nothing to verify that the patient actually received the services claimed, or even that the diagnosis was real.

Given the failure to curb fraud of static, procedural checks, whistleblower statutes have proved crucial. Most of the big cases brought against major corporations for defrauding government health care programmes in the past decade arose from, or relied heavily upon, qui tam suits (allowing private citizens to file lawsuits charging fraud in government programmes) brought under the federal False Claims Act by employees or ex-employees of the offending corporation. Under the Act (originally designed to reduce corruption in defence contracting) whistleblowers receive a share of any eventual settlement.

How to reduce corruption in health care systems

Governments, health authorities and hospital boards should:

- Increase civil society and community participation in hospital boards, open forums and public oversight of procurement and drugs selection
- Publish regularly updated information on the Internet on health budgets and performance at the national, local and health delivery centre levels
- Open public policies, practices and expenditures to public and legislative scrutiny, and make all stages of budget formulation, execution and reporting fully accessible to civil society
- Conduct independent audits of government departments, hospitals, health insurance entities and other agencies handling health service funds
- Continuously monitor payment mechanisms (whether fee-for-service, salary, capitation, global budgeting or other)
- Introduce and promote codes of conduct through continued training across the health system for regulators, medical practitioners, pharmacists and health administrators
- Provide whistleblower protection to individuals working in procurement bodies, health authorities, health service providers and suppliers of medicines and equipment
- Pay decent wages to doctors, nurses and other health professionals, commensurate with their education, skills and training
- Tackle corruption in procurement by publishing offers to tender, terms and conditions, the evaluation process and final decisions on the Internet; applying an Integrity Pact (a binding agreement by bidders and contracting agencies not to engage in bribery) to major procurement in the health sector; and debarring companies that have found to have engaged in corrupt practices
- Rigorously pursue corrupt acts that are clearly proscribed by law

[i] Based on William Savedoff and Karen Hussman, 'Why are health systems prone to corruption?' in Transparency International's *Global Corruption Report 2006* (London: Pluto Press, 2006). The case study on the US health system is taken from Malcolm Sparrow, 'Corruption in health care systems: the US experience', ibid.