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Anti-corruption in the health sector in Southeast Asia

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Southeast Asian countries present economic, cultural and political conditions that have varying effects on the reform and implementation of anti-corruption efforts in healthcare systems. The most common corrupt practices in the health systems of several of Southeast Asian countries are nepotism, mismanagement of resources, capture of the sector by pharmaceutical and medical providers, bribery and informal payments. Anti-corruption interventions in the medical and pharmaceutical sectors in the region have consisted of promoting integrity, transparency and accountability, quality control testing and social accountability. There is a lack of conclusive empirical evidences about the impact of anti-corruption interventions in the health sector in these countries.

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Query

What is the experience with and lessons learned from direct or indirect anti-corruption interventions in the health sector among countries in Southeast Asia? Of particular interest are the cases of Vietnam and Cambodia.

Contents

Background: Southeast Asia, corruption and the health sector

The anti-corruption experience in Southeast Asia varies from country to country and reflects the heterogeneity in the region. Southeast Asia is composed of 11 countries –Brunei, Cambodia, Timor-Leste, Indonesia, Laos, Malaysia, Myanmar, Philippines, Singapore, Thailand and Vietnam – and is resident to around 640 million people. Some of the countries differ significantly in terms of their population size – Indonesia being the most populous with around 255 million and Brunei the least with 443,500 inhabitants – economic growth, human development and corruption levels.

Differences among Southeast Asian countries can also be found in human development levels and levels of corruption. Singapore stands out with a very high human development index (HDI) (0.93, being 1.00 the maximum score) in contrast to the medium HDI in Myanmar (0.57) and Cambodia (0.58) (UNDP 2018).

As for corruption, Transparency International's Corruption Perception Index 2017 (CPI) (Transparency International 2017a) data shows that the Southeast Asian region hosts one of the cleanest countries – Singapore (with a score of 84,

Main points

— In some Southeast Asian countries, anti-corruption interventions to promote integrity in the health sector clash with social expectations of how social interactions should take place.

— National programmes to guarantee health coverage to poorer populations have indirectly helped to reduce the incentives for bribery in health service delivery.

— International initiatives to promote transparency and accountability in the pharmaceutical sector have been implemented in several countries in the region.

0 being highly corrupt and 100 very clean) – and one of the most highly corrupt countries – Cambodia (with a score of 21) – in the world. Indonesia is one of the few cases that have improved in the last five years, moving from a score of 32 in 2012 to 37 in 2017.

A remarkable characteristic in the region is the economic growth of many of the countries, which has implications in the health sector. The booming business environment has turned Southeast Asian countries into attractive investment opportunities

for private healthcare providers (Jacquemyn 2017). The creation of modern and technically advanced private medical centres offering high quality treatment for lower prices than in rich countries is creating medical tourism streams in Thailand, Singapore and Malaysia (Jacquemyn 2017; McKinsey 2018; Hashim et al. 2012). In turn, it is also creating a significant separation between public and private healthcare providers and the distinct population they assist (Jacquemyn 2017).

Regarding public health, the governments of Thailand, Myanmar, Indonesia and the Philippines are investing in health system models to reach the most remote areas (Jacquemyn 2017). Several Southeast Asian countries have recently implemented pro-poor financing schemes, such as the health card and 30 baht (flat rate) schemes in Thailand, the health fund for the poor in Vietnam, health equity funds in Cambodia and Laos, and the Medifund for indigent patients in Singapore.

The financing of healthcare systems has been under revision in some countries and some have adopted innovative forms of public-private models, like the corporatisation of public hospitals in Singapore or the Swadana (self-financing) hospitals in Indonesia (Hashim 2012). The Philippines, Vietnam and Indonesia decentralized their health services. Other experimental measures involve compulsory medical savings and social insurance for long-term care (Hashim et al. 2012).

Some governments have passed laws to establish national health insurance systems and mandated universal coverage (Hashim et al. 2012). The Vietnamese Health Economics Association (VHEA) developed a payment system defined as case-based reimbursement methodology to replace the fee-for-service reimbursement (Vian et al 2011). This system is based on the estimation of resource needs for standard care, which, they believe, would reduce providers' incentive to use diagnostic tests or ineffective treatments to maximise revenue (Vian et al 2011).

Corruption in the health sector

The complexity of the health system is characterised by large flows of money, expensive equipment, and complex organisational structures, making it especially vulnerable to corruption. There are three main areas to consider: budget allocation, personnel, and supplies and goods. Corruption offences in budgets can imply budget leakages, fraud in the transfer of budgets, embezzlement or the diversion of public money into private accounts, which can lead to drug shortages and poor quality services (Albisu and Chêne 2017). For instance, in Cambodia it is estimated that between 5 per cent and 10 per cent of the health budget disappears before it is transferred to the Ministry of Health (Albisu and Chêne 2017).

As for supplies and goods, faulty equipment or weak, dangerous or even counterfeited drugs are often the result of fraud, theft, unlawful use of equipment and embezzlement, with potentially significant consequences for patient health. In addition, bribes to influence monitoring and the inspection of facilities or to speed up the process of drug approval, quality inspection and manufacturing are common practices in certain contexts.

Corruption vulnerabilities related to personnel take place in the appointment, training, promotion, and compensation of public officials and health staff. Patronage, favouritism and nepotism in the selection, accreditation and certification of health professionals, selling and buying of positions and promotions, can happen. A common problem is the absenteeism of medical staff and use of public paid time for private practice.

Other forms of corrupt behaviour in the health sector are the dilution of vaccines, the pilferage of medical equipment and medicines, the diversion of patients to private practices, induced demand for unnecessary procedures and the prescription of unnecessary treatments (USAID 2005). Favouritism and personal arrangements can be frequent in the relationship between doctors and medical suppliers and pharmaceutical firms. Thus, corruption in the health sector takes place at

different levels: policymaking, organisational resources, and service delivery and client interface (Albisu and Chêne 2017).

Undue influence by interest groups can result in the design of health policies and priorities that benefit certain social group at the expense of others. Decisions on the prioritisation between primary and hospital care, benefit packages or the accreditation of health professionals might change direction through the payment of bribes. This also applies to medical suppliers or pharmaceutical firms that lobby and bribe government officials to influence decisions regarding drug approval or to secure the market for them (Kholer et al. 2016).

Bribery is a frequent transaction in the interaction of doctors and nurses with patients in many developing countries to get better and timely treatment, preferential treatment – for example to skip operation or organ transplant queues – better medication or even to obtain drugs that have not been prescribed. The receipt of informal payments from the patients is often justified to supplement the low salaries medical professionals have in those countries. In Vietnam, in-kind informal payments increased during the post-war economic crisis and turned into "envelope payments" with the opening of the country to the market-oriented economy (Thu Ha et al. 2011). To some in Vietnam, informal payments are an expression of appreciation for the service provided; but to the majority of healthcare users, informal payments are made to receive a better service (Thu Ha et al. 2011).

Other corrupt practices in service delivery are to refer patients to private clinics rather than treat them in the public service, so doctors working both in the public and the private sector can benefit. The falsification of insurance documents for particular patients, the illegal billing of insurance companies for services that have not taken place and the falsification of invoice records are also among existing corrupt offences in the delivery of care services.

Examples of anti-corruption interventions in the health sector

Interventions to counter corruption and fraud in the health sector have been implemented in several countries in Southeast Asia. Those experiences address corruption risks in the areas of promoting integrity, transparency and accountability, quality control testing, social accountability and the reduction of incentives for bribery. However, there is no conclusive evidence in the research to show how effective these interventions are (Rashidian 2012; Gaitonde et al. 2016; Kiwanuka 2014).

Promotion of integrity

In general, a common approach to raise the ethical standards of public officials and health professionals is the elaboration of codes of conducts and ethical training by health ministries or by professional institutions like doctors' associations (Albisu and Chêne 2017). Studies show that the promotion of integrity through the creation of norms against certain behaviour can have an effect on corruption levels (Gaitonde et al. 2016), especially in countries where the rule of law is implemented. In Southeast Asian countries, however, the exchange of favours is deeply rooted in how social networks and relationships are built, and the power of codes of conducts and regulations to shape behaviour is diminished by social expectations on how social interactions should take place.

For example, in Indonesia, the anti-corruption campaign *berani jujur, hebat* (be honest and be great) promoted by the government is disempowered by popular beliefs such as *bagi-bagi rejeki* (sharing the fortune) and *utang budi* (debt of deed) used to describe the practices of showing gratitude for a service provided or sharing one's fortune (Pertiwi 2018). Hence, informal payments, gifts and favouring some at the expense of others respond in part to the value given in Indonesia to preserve relationships.

Also in Indonesia, in 2016, the Corruption Eradication Commission (KPK), the Ministry of Health, the Indonesian Doctors Association, the

Indonesian Doctors Council, the Collegiate Board of Indonesian Doctors, the Disciplinary Ethics Board of Indonesian Doctors, the National Agency of Drug and Food Control, hospital representatives, the Pharmaceutical Companies Association and representatives of national and international pharmaceutical companies reached an agreement regarding gratification in the healthcare sector. This agreement regulates conflicts of interest in the provision of sponsorships for doctors, relationships between pharmaceutical firms, medical providers and doctors. Evidence of the impact of this agreement has not been found, but similar agreements in the past raised concerns about the formalisation of this agreement into a more detailed government regulation (Sukirno and Soesabdo 2016).

Transparency and accountability

Promoting good governance and transparency in the medical and pharmaceutical sectors has been the strategy of some international initiatives to increase awareness of potential corruption risks and minimise those risks in the health sector. Southeast Asian countries have been part of those initiatives. For example, the project Good Governance of Medicines Programme, launched by WHO in 2004, was joined by Laos, Malaysia, the Philippines and Thailand in 2005, and by Cambodia and Indonesia in 2006.

The Good Governance of Medicines Programme aims to contribute to health system strengthening and preventing corruption by promoting good governance in the pharmaceutical sector. One of the tools to achieve this goal is the Pharmaceutical System Transparency and Accountability Assessment Tool. This tool is a 2018 revision of a tool to measure transparency in the pharmaceutical sector. The aim is to assist countries with the assessment of public availability of key documentation that facilitates accountability of the pharmaceutical system. The tool assesses the transparency of processes and decisions and monitors progress in the areas of registration and marketing authorisation of pharmaceutical products, licensing premises, regulatory injections, pharmaceutical promotion, clinical trial oversight, medicine selection, public procurement and distribution.

Clinical pathways and payment system reform

Bribing doctors and nurses for their services is common practice in several countries in Southeast Asia. The VHEA's case-based reimbursement methodology also aims to improve transparency and reduce incentives for corruption at the moment of service delivery (Vian et al. 2011). Case-based payments are calculated based on estimated resource needs for standard care and replace fee-for-service reimbursement. It is expected that this system will reduce the incentive to use many diagnostic tests or questionable effective treatments to maximise revenue. The system was piloted for cases of pneumonia and appendicitis. Criteria were developed for each case of admission and discharge, indications for mandatory and other diagnostic tests, guidance for the selection of drugs and criteria for other interventions (Vian 2011).

Quality control testing

In the pharmaceutical sector, there have been developments in the establishment of best practices and quality standards for pharmacists around the world through the International Pharmaceutical Federation (FIP) and the World Health Organization (WHO). In 2007, Southeast Asia adopted the Bangkok Declaration of the Good Pharmacy Practice (GPP) in Public Pharmacies with commitments from member associations to improve the quality of pharmacy services (FIP/WHO 2011). Even if there is not explicit reference to corruption, these guidelines recognise the need of integrity in the medicine supply chain to assure the value of medicines used for the prevention of disease and the treatment of patients.

Social accountability

Social accountability can occur through monitoring activities and complaint mechanisms, which requires whistleblower protection. Complaint mechanisms can be helpful to detect fraud and corruption, as well as for quality control processes.

Transparency International's experience through the Advocacy and Legal Advice Center (ALAC), which receives complaints from citizens who cannot afford legal help, have been particularly successful in Pakistan and other countries. After receiving several complaints from citizens regarding the poor conditions in the only hospital in Usta Mohammad (small city in Baluchistan), TI Pakistan contacted several government officials and, as a result, a committee of government and private sector health professionals came together to address the issues (Transparency International 2017b). After four months, people from Usta Mohammad reported a significant improvement to the local hospital's conditions and the adherence of the doctors to their times and responsibilities in the public health service. Moreover, the province's health ministry designed regulations to ban doctors from operating in the private service and guidance on the effective implementation of these regulations.

The Affiliated Network for Social Accountability for East Asia and the Pacific (ANSA EAP) has developed tools and resources to increase citizens' engagement in accountability, and it has been involved in initiatives to train the youth to monitor local service delivery in Cambodia, citizen report cards in the Philippines and participatory budgeting in Indonesia (Vian et al 2011). In Vietnam in 2009, the Hanoi National Hospital for Paediatrics introduced a patient feedback system composed of six tools to collect feedback from doctors and patients, including information on the payment of informal fees. The tools were well received and are used to set benchmarks and to identify problem-solving issues.

Reducing bribery incentives

One way to prevent bribery is to reduce the reasons that are often used justify it, such as ensuring stable financial conditions for health staff and the formalisation and transparent systems. The health equity funds (HEFs) in Cambodia are a good example of this. HEFs are schemes in which NGOs reimburse the public health service for the treatment of poor people with money from the government and a donor (Kelsall and Heng 2014).

Part of HEFs' success is that they have high-level political backing expressed in their inclusion in 2003 in the Government's Poverty Reduction Strategy and Health Strategic Plan, and in an interministerial decree from 2007 on the use of the state health budget to support the reimbursement of poor people's user fees. Every three years, the Ministry of Planning provides pre-identified poor households with their ID Poor scheme, which entitles them to free care in health centres and hospitals where HEFs operate. The HEF reimburses the health facilities based on a standardised care rate. The distribution of the funds are 60 per cent to staff salary supplements, 39 per cent to running costs and 1 per cent to the provincial treasury (Kelsall and Heng 2014).

The positive results of this practice have been the formalisation of payment methods in the health sector, providing a significant source of additional revenue to health facilities, reducing under-the-table payments, providing an incentive to improve performance, and introducing internal and external monitoring systems that help to improve the quality of care (Kelsall and Heng 2014).

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