A PRESCRIPTION FOR HEALTH

ASSESSING AND MANAGING CORRUPTION RISKS IN PUBLIC HEALTH SYSTEM ORGANIZATIONS
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Corruption: There is no universal definition of corruption. The United Nations Convention against Corruption (UNCAC) recognizes that corruption is a continuously evolving phenomenon affected by various factors. Different legal frameworks therefore can vary in how corruption is described. Considering this, the Convention offers a list of universally agreed corruption offences (shown in Box 1) and allows each State to go beyond the minimum standards expressed in the Convention.1

Corruption risk: Corruption risks are weaknesses within a system that may create opportunities for corruption to occur.

Good Manufacturing Practices: Good Manufacturing Practices is a system for ensuring that products are consistently produced and controlled according to quality standards. They are designed to minimize the risks involved in any pharmaceutical production that cannot be eliminated through testing of the final product. They cover all aspects of production from the starting materials, premises and equipment to the training and personal hygiene of staff.2

Health-care provider: Organizations and actors that deliver health-care goods and services as their primary activity, as well as those for which health care provision is only one among a number of activities. They vary in their legal, accounting, organizational and operating structures.3

Health-care organization: Any entity, whether public or private, that provides or coordinates the provision of medical or related goods and services. This term can also be used to refer to a health-care sector facility, defined as any facility, whether public or private, that provides medical or related goods and services, including, but not limited to, military hospitals, mental health units and prison medical wards.4

Health system: A collective group of all legal and natural persons involved in providing and coordinating medical and related goods and services.5 Health systems are also defined by how all health services are provided within a country, including, among others, healthcare finance, the healthcare workforce, healthcare facilities and their management, and the supply of healthcare equipment, drugs and services.

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4 UNODC, Speak Up For Health! Guidelines To Enable Whistle-Blower Protection In The Health-Care Sector (Vienna, 2021).
Examples of Corruption Offences

- **Active bribery** – The promise, offering or giving to a national public official, a foreign public official or an official of a public international organization, directly or indirectly, of an undue advantage, in order to act or refrain from acting in matters relevant to official duties.

- **Passive bribery** – The solicitation or acceptance by a national public official, a foreign public official or an official of a public international organization, directly or indirectly, of an undue advantage, in order to act or refrain from acting in matters relevant to official duties.

- **Embezzlement** – Theft, diversion or misappropriation of property, funds, securities or any other item of value entrusted to a public official in his or her official capacity.

- **Bribery in the private sector** – Active or passive bribery, directly or indirectly, to or by any person who directs or works, in any capacity, for a private sector entity, to act or refrain from acting in breach of his or her duties.

- **Embezzlement of property in the private sector** – Embezzlement by any person who directs or works, in any capacity, for a private sector entity.

- **Abuse of functions** – Performance of, or failure to perform an act, in violation of the law, by a public official in order to obtain an undue advantage.

- **Trading in influence** – Abuse of a public official’s real or supposed influence with an administration, public authority or State authority in order to gain an advantage or influence particular outcomes.

- **Illicit enrichment** – A significant increase in assets of a public official or that cannot reasonably be explained as being the result of his or her lawful income.

- **Money laundering** – The concealment of the origins of proceeds of crime, often by means of conversion or transfers involving foreign banks or legitimate businesses.

- **Concealment** – Hiding or continued retention of property, knowing that it has resulted from corruption.

*Source:* United Nations Convention against Corruption, articles 15–24
- **Primary health care**: A whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution. It focuses on people’s needs and preferences (as individuals, families and communities) as early as possible along the continuum, from health promotion and disease prevention to treatment, rehabilitation and palliative care, and delivered as close as feasible to people’s everyday environment.  
  
- **Substandard medical products**: Products authorized by national regulatory authorities but which fail to meet either national or international quality standards or specifications—or in some cases, both. They can also be referred to as out of specification products.

- **Universal Health Coverage**: Refers to all members of a population having access to the health services they need, when and where they need them, without financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care.

- **Unregistered or unlicensed medical products**: Products that have not been assessed or approved by the relevant national or regional regulatory authority for the market in which they are marketed, distributed or used.

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EXECUTIVE SUMMARY

Corruption poses a significant threat to public health, reducing the effectiveness, quality and availability of health services while inflating their costs. It deprives communities of vital health services, essential products and critical resources, and undermines the right of individuals to adequate and accessible health care.

There are several factors that make health systems particularly prone to corruption at all levels. Health systems are technically complex, involve multiple actors with often conflicting interests, and often entail information asymmetries between stakeholders. Governments typically allocate significant resources to support public health systems, making them vulnerable to embezzlement and other forms of corruption. The vast resources involved in the health-care system can also make it vulnerable to state capture, for example wherein pharmaceutical companies may use their considerable resources to influence national drug policy in their favour.

Corruption within health systems further exacerbates the already-significant difficulties in accessing vital health resources for the most vulnerable and marginalized populations. The nature of health services, where treatment can often be a matter of death and life, can result in vulnerable patients being left with no other option but to pay bribes to access vital services or to avoid long wait times. This, coupled with insufficient transparency, inadequate normative and institutional frameworks, and a low risk of detection of corrupt practices, can further increase the prevalence of corruption risks in public health systems.

The Coronavirus Disease (COVID-19) pandemic has amplified existing corruption risks within health systems worldwide. In times of crisis, standard procurement processes may be suspended indefinitely in an effort to procure essential health products quickly. When standard procedures are bypassed, this can increase the risk of corruption, enabling unqualified suppliers to be chosen who then deliver substandard products, or no product at all. Such actions misuse public funds and damage health outcomes, and can result in health-care providers colluding to set higher prices or to artificially restrict the supply of vital drugs or services. Strong anti-corruption measures will help safeguard crisis response and recovery efforts, and ensure that measures aimed at enhancing health and well-being for all have a significant impact.

This paper seeks to both assist national authorities and managers within public health institutions with the vital task of identifying and managing corruption risks, and to increase awareness and promote discussion of corruption risks within health systems. It also aims to sensitize authorities within public health systems, anti-corruption agencies, students in health professions, and those that provide oversight for government activities such as watchdogs, industry stakeholders, and the media, among others, to the real and palpable threat that corruption poses to the effectiveness of public health systems and equitable access to the services provided.
This paper recommends a preventive anti-corruption approach and is structured as follows:

- **Chapter 1** provides an introduction to this paper and to corruption risks in health systems.

- **Chapter 2** contains an overview of actors in and funding models for health systems.

- **Chapter 3** outlines corruption risks linked to the different actors in health systems.

- **Chapter 4** provides information on how to identify corruption risks within health systems and how to develop strategies to mitigate such risks.

- **Chapter 5** offers examples of corruption mitigation strategies that organizations under-going corruption risk management processes might choose to implement as part of their corruption risk mitigation plan.

As global circumstances change, so too will the ways in which those working within the global health system can effectively identify and manage corruption risks. Therefore, this paper should not be viewed as a static text; rather, it should be viewed as a tool to advance discussion on this important topic and to develop further global knowledge and understanding of the ways in which corruption and corruption risks can harm the global health system.
Chapter 1
INTRODUCTION
1.1 Scope and Objectives

The objectives of this paper are as follows:

- To inform authorities and decision-makers working within health-care systems, as well as anti-corruption stakeholders, on the corruption risks present in health systems, and how these may undermine public health objectives.
- To allow public officials and managers in public health-care systems (as well as other related stakeholders) to become familiar with the benefits of using a structured corruption risk management process to identify and address corruption risks within their institutions and operations, and the steps required to do so.¹
- To help policymakers identify and prioritize areas where anti-corruption efforts need to be focused.
- To offer examples of corruption risk mitigation strategies that may be useful to those tasked with designing them for their agency or organization.
- To promote active discussion on corruption risks within health systems, and to encourage relevant stakeholders to engage in frank dialogues on how best to address this ever-evolving threat to public health outcomes.

The context of each organization is unique and, as such, the guidance contained in this paper should only be used as a starting point upon which a tailored corruption risk assessment and corruption risk mitigation plan can be developed.

1.2 Why Are Health Systems Vulnerable to Corruption Risks?

There are many reasons why health systems can be particularly vulnerable to corruption risks. These include, but are not limited to:

- **Complex governance:** A range of actors participate and exercise influence in the administrative and decision-making processes which govern health systems, often with competing interests. Corrupt actors may use these multiple decision points to mask their illicit activities. An example of this is the registration of medicines or pharmaceutical products, whereby suppliers may bribe government officials to register medicine without the requisite information, or whereby government officials may deliberately delay the registration of a pharmaceutical product to create more favourable market conditions for a preferred supplier, or slow down registration procedures in order to solicit payment from a supplier.² Such illegal behaviour can be hidden from view by an overly complex governance system. Consequently, critical

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government functions designed to ensure standards of quality, efficacy and safety may be compromised in a manner that threatens public health goals.

- **Substantial allocation of public funds**: The value of the global health system is vast. The World Health Organization (WHO) placed global spending on health at US$ 9 trillion in 2020, or almost 11 per cent of global GDP. With such considerable amounts of public money involved, without adequate mechanisms in place to identify potential or existing corruption risks it is clear that health systems will be vulnerable to manipulation by corrupt actors.

- **Multiple stakeholders**: Many stakeholders are involved in the supply and delivery of health care, and the complex web of relationships between these various actors can result in concerns that are often difficult to detect, such as conflicts of interest or the preferential allocation of contracts and tenders. Furthermore, health service delivery is often decentralized and interactions between health-care regulators, payers, providers and suppliers are difficult to monitor or standardize.

- **Information asymmetry**: Within health systems, information is not equally available to all actors, and this information asymmetry can allow one party to leverage information against another for their own benefit. This can be particularly detrimental for vulnerable groups who lack access to essential information. For example, if patients do not know which services can be accessed free of charge or at a low cost, care providers may charge them full price for subsidized or free treatments and pocket the difference. Similarly, information imbalances between suppliers and procurement departments can result in suppliers delivering substandard equipment to governments that do not have the correct inspection procedures in place.

Information asymmetries therefore make it easier for corrupt acts to occur and harder for unscrupulous actors to be held accountable; patients may never realise which services they could have accessed for free, and governments may never identify which services rendered were unnecessary or overpriced. And, even if discovered, corrupt actors may only be deemed indirectly or partially accountable for their actions or losses.

- **Dependence on services**: Patients are dependent on the provision of health services for their health and well-being, and accessing these services can often be a matter of death and life. The demand for health services is therefore inelastic, meaning that demand remains unchanged even in the case of an increase in cost due to a request for an illegal payment. This inelasticity can result in patients not only being forced to make illegal payments for treatment, but also being unwilling to report these bribes or

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5 Ibid.
other forms of corruption for fear that they will be denied access to vital health services in the future.7

- **Regulatory weakness:** In most countries, health systems are heavily regulated with the intention of protecting patients and health professionals. However, the effectiveness of the regulations varies across different countries, with weaker regulatory agencies being more vulnerable to influence or capture by private interests. This can result in regulatory decisions that advance the interests of private sector actors at the expense of the public good, such as bribery to reduce compliance requirements or to overlook non-compliant goods or services.8 The inverse is also true; politicians may use their ability to affect regulatory or health policy decisions for their own political or personal gain.

- **Social, economic and political factors:** The vulnerabilities and corruption risks in health systems are further influenced by social, economic and political factors, some of which are beyond the control of the health-care systems authorities and decision-makers. For example, the presence of significant income inequalities, lower education levels, or existing conflict in an area can all impact the vulnerability of a health system to corruption.

- **Cultural factors:** The prevailing culture within a health system can also affect the likelihood of corruption occurring. For example, even though women make up around 70 per cent of the health-care workforce they are significantly underrepresented in leadership roles, with only about 15 per cent of leadership roles being filled by women.9 This often results in the existence of predominantly male leadership networks, which have been shown to inhibit progress and transparency due to their selectiveness and their entrenchment of the prevailing status quo.10

- **Lack of transparency:** Another factor that may influence the vulnerability of health systems to corruption is the effectiveness of transparency mechanisms, or lack thereof.11 If robust accountability and transparency mechanisms that allow for the monitoring of decisions are in place, the occurrence of corrupt practices related to these areas decreases.12 For example, when regular hospital audits were implemented in one health

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11 Jillian Clare Kohler and Deirdre Dimancesco, "The risk of corruption in public pharmaceutical procurement: how anti-corruption, transparency and accountability measures may reduce this risk", *Global Health Action*, vol. 13 (2020).
system, prices paid by hospitals for goods and services were reduced by ten per cent due to the removal of opportunities for corruption.\textsuperscript{13}

- Non-implementation of existing frameworks: The lack of strong normative and institutional frameworks is yet another factor that may make the health systems more vulnerable to corruption. For instance, the United Nations Convention against Corruption (UNCAC) contains several provisions aimed at strengthening normative and institutional frameworks of States parties. If not implemented, systematic opportunities for corruption can be more easily created, and impunity fostered.

It is important to note that health-care corruption can exist at any level, from low-level acts such as the bribery of a doctor by a patient to be prioritized for a service or product, to the highest levels whereby a particular interest group might offer ministers bribes or gifts in order to manipulate specific national health policies in their favour. No matter the level, corruption threatens vital public health goals and affects all stakeholders directly or indirectly. Crucially, it seriously impacts the ability of a health system to function effectively, which can, if left unchecked, mean the difference between life and death for vulnerable patients.

1.3 Why Do We Need to Address Corruption Risks in the Health System?

Corruption is a significant threat to public health. It can, if left unchecked, erode public trust in health systems and in a government’s ability to protect health as an inalienable human right. It further burdens the already-substantial financial and human resource challenges of public health organizations, while increasing the delivery costs of goods and services due to the wastage of limited public funds. It can also result in decreased effectiveness of health-care services and reduce the number of services available.\textsuperscript{14} Most importantly, it impacts negatively on patient health outcomes.\textsuperscript{15}

For these and many other reasons, the United Nations Special Rapporteur on the Right to Health has called for all States to progressively build resilient health systems.\textsuperscript{16} Further, article 37 of the United Nation General Assembly’s Political Declaration of the High-level Meeting on Universal Health Coverage recognizes the serious barrier that corruption poses to effective resource mobilization and allocation, and notes that without prioritizing the fight against corruption at all levels and in all its forms, resources that are vital for poverty eradication, sustainable

\begin{thebibliography}{9}
\bibitem{13} Rafael Di Tella and Ernesto Schargrodsky, “The role of wages and auditing during a crackdown on corruption in the city of Buenos Aires”, \emph{The Journal of Law and Economics}, vol. 46, No. 1, (2003).
\bibitem{14} Jillian Clare Kohler and Deirdre Dimancesco, “The risk of corruption in public pharmaceutical procurement: how anti-corruption, transparency and accountability measures may reduce this risk”, \emph{Global Health Action}, vol. 13 (2020).
\bibitem{16} See Office of the United Nation High Commissioner for Human Rights (OHCHR), “Special Rapporteur on the right to health”.
\end{thebibliography}
development, and the achievement of universal health coverage may be diverted away from their intended recipients.\textsuperscript{17}

Addressing corruption in the health system can, among other benefits:

- **Protect health as a human right:** Human rights bodies and scholars recognize corruption as an “enormous obstacle to the realization of all human rights”\textsuperscript{18} and to the right to health in particular.\textsuperscript{19} The relationship between corruption and human rights is bidirectional; human rights violations create opportunities for corruption, while corruption enables human rights violations to go unchallenged.\textsuperscript{19}

Corruption exacerbates inequities by creating barriers for access to health-care services and products, depleting resources and undercuts the quality of products and services.\textsuperscript{20} This is particularly true for women and girls requiring reproductive health and maternal services, as well as poor or marginalized populations.\textsuperscript{21} It can also lead to significant risks for other vulnerable populations. For example, in countries where corruption is prevalent, infant and child mortality rates will often increase.\textsuperscript{22}

- **Reduce wastage of public funds:** Corruption wastes public resources allocated to health systems, which increases the cost per unit of service delivered.\textsuperscript{23} However, the wastage of public health funds may not be limited to corruption within the health system; it can also be linked to corruption in other sectors.\textsuperscript{24} For example, the detection of falsified medicines within a medical supply chain may indicate the presence of a corrupt official within the national customs office or inspections bureau.

- **Promote trust in the health system:** When corruption is perceived to be present in health systems, citizens may lose trust in the government’s ability to deliver health care effectively and cost-efficiently. Addressing corruption risks can improve organizational efficiency and accountability, thereby enabling the provision of better public health services and, in turn, enhancing citizens’ confidence in their government. Furthermore,
erosion of trust in a health system can have, as an unintended result, the privatization of health services.\textsuperscript{25} Such privatization can prevent those without the means to afford private health care from accessing vital health services, further increasing inequalities in the health system.

- **Promote the Achievement of the United Nations Sustainable Development Goals:** Identifying and mitigating corruption risks in the health system is critical for country-level efforts to achieve the United Nations Sustainable Development Goals. For health systems, two goals in particular stand out as crucial:

  - **SDG 3 Ensure healthy lives and promote well-being for all at all ages:**

    This goal is relevant to achieving objectives such as Universal Health Coverage (UHC). Corruption undercuts the UHC goals of achieving equity, quality and responsiveness (including financial protection), particularly at the health service delivery level.\textsuperscript{26}

  - **SDG 16 Promote peaceful and inclusive societies for sustainable development, provide access to justice for all, and build effective, accountable and inclusive institutions at all levels:**

    The targets under this goal are to substantially reduce corruption and bribery in all their forms and to develop effective, accountable and transparent institutions at all levels. If achieved, these targets can help ensure that the health care provided by governments is carried out efficiently and transparently.\textsuperscript{27}

Country-level targets to achieve SDG 16 may lead to more resources being directed towards the strengthening of institutions and the building of capacity to improve governance, which may in turn also create opportunities for governments to focus investment on health systems to mitigate potential corruption risks.\textsuperscript{28}


\textsuperscript{27} For a discussion on the SDGs and corruption in the health system, see Tim K Mackey, Taryn Vian and Jillian Kohler, "The sustainable development goals as a framework to combat health-sector corruption", Bulletin of the World Health Organization, vol. 96, No. 9 (2018).

Chapter 2

HEALTH-CARE ACTORS AND FUNDING MODELS
For the purposes of this document, the health system in a country is defined as the collective group of all legal or natural persons involved in providing and coordinating medical and related goods and services, such as medical equipment manufacturers, pharmaceutical companies, medical insurance providers and medical service providers, among countless others. Health systems are defined by how all health services are provided within a country, including, among others, healthcare finance, the healthcare workforce, healthcare facilities and their management, and the supply of healthcare equipment, drugs and services.

The specific form that a country’s health system takes is influenced by the unique mix of economic, fiscal, political, cultural and social features particular to that nation. As such, no two health systems will be exactly the same. Understanding how these features exist and interact with each other is therefore vital for governments and agencies seeking to determine how corruption might occur in their specific context and how it can best be prevented.

To facilitate the analysis of a specific health system, this chapter provides a brief overview of the key actors in the health system, and the main health-care system funding models.

### 2.1 Overview of Actors

As mentioned above, health-care systems are characterized by the way that various health-care actors interact to create a complex, non-linear network. The characteristics of this network are determined by various factors, such as the funding model adopted by each country to finance their health system, as well as the roles and responsibilities given to each actor. Figure I lists some core actors operating within health systems.

![Figure I: Core actors in the health system](image-url)

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• **Regulator:** The role of the regulator within a health system is to create and recognize rights and responsibilities, impose obligations and penalties, establish permanent institutions and institutional arrangements, and enforce regulations. For example, they adopt laws to establish the legal basis for contracting in the health system, provide the legal basis for health system financing, and create detection and enforcement mechanisms to identify when actors operating within the health system fall short of their obligations. They also set and oversee the administrative and other relevant controls that apply to health professions, health services and health products to ensure that these are of good quality and are safe and effective for patients, for example by mandating that health providers disclose certain information to patients to allow them to make informed decisions.  

Health system regulators, therefore, seek to establish and enforce the legal architecture of the health system to ensure cohesion and efficiency. This task requires sound technical knowledge, resource coordination, relevant and effective legislation, and robust institutions in order to determine and enforce the ground rules upon which the health system operates. While this paper only refers to public sector regulators such as national health ministries, regional or local authorities, or autonomous public sector agencies, private actors may also carry out regulatory duties. Whichever body is appointed as the regulator, government involvement in the regulation of the health system is critical.  

• **Payer:** A payer, in relation to health-care systems, refers to any party that finances or refunds the costs of medical products and/or health services for a recipient. The payer could be a government or private health provider that provides free or subsidized access to health care for specific patients, a patient who pays for their health care at the point of service, or a health insurer who reimburses the patient for their billed expenses. Payers interact with nearly all actors within the health system and as such are subject to the regulatory policies set by government regulators. They also interact with equipment and medicine suppliers to determine, for instance, which services will be covered under a patient’s insurance plan.  

• **Provider:** Health-care providers are organizations and actors that deliver health-care goods and services as their primary activity, as well as those for which health care provision is only one among a number of activities. Providers include both public and private physicians, public or private emergency ambulance services, acute and psychiatric hospitals, health centres, laboratories, nursing care facilities and pharmacies, among others.  

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33 Ibid.  
• **Patient:** The patient is any person who is the recipient of health care.\(^{35}\)

• **Supplier:** Suppliers are any persons or legal entities that provide services or products to the payer, provider or patient. This could include medical equipment producers, pharmaceutical companies, construction companies, staffing agencies and outsourcing service providers, among countless others. The scope of a supplier’s role will be determined by several factors, among which is the funding model in place within the country in question (see section 3.2).

Suppliers operate within the legal market and thus, are subject to laws, policies, guidelines and regulations of the country. However, some suppliers operate in the informal sector, potentially circumventing or violating regulations. For example, illegal online pharmacies sell an array of pharmaceutical products, including vaccines, essential medicines and controlled substances, without requiring prescriptions from patients and at a lower price compared to the formal market.\(^{36}\) These illegal practices pose a particular threat to health systems and public health goals by increasing the circulation of falsified, substandard and/or ineffective products, all of which can harm patients.\(^{37}\)

### 2.2 Overview of Health System Funding Models

Financing is a core function of every health system, as it determines the ability of the system to carry out its primary function of delivering adequate service coverage and access to health care for all.\(^{38}\) The funding model adopted by governments will determine the specific role of the actors described above, and therefore how and where corruption risks may arise. This section describes the four most established health system funding models. It should be noted that most countries do not strictly adhere to a single model. Rather, a combination of these models will be utilized, depending on the requirements of the particular health system.\(^{39}\)

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38 WHO, “Health Financing”.

2.2.1 The Beveridge Model: A Single-Payer National Health Service

In the Beveridge model, first developed in 1948 in the United Kingdom, health care is provided by governments and financed predominantly by the state budget. This model is often centralized through the establishment of a national health service. The government acts as the single-payer, removing all competition in the market to keep costs low and benefits standardized. The public payer controls what services public providers can offer and what they can charge. Funding health care through the state budget allows for health care to be free of charge for all. As a result, universal health service coverage is guaranteed by the government, and anyone who is a citizen has the same access to public health services.

In the Beveridge model, public financing and public health care provision traditionally dominate. However, some private sector involvement usually exists. This private sector involvement typically grows in times of reduced economic growth, as public budgets do not grow at the same rate as increased health care consumption or expenditure. The main challenges of a system that is free at the point of service include the potential overuse (or unnecessary use) of the system due to its ostensibly free nature, and therefore the often long waiting times for immediate care and significant waiting lists for procedures. Countries following this model include Cuba, New Zealand, Spain and the United Kingdom.

The flow chart in Figure II below depicts how the Beveridge model is financed. In this system, all patients indirectly contribute to the system through taxation. Money therefore flows from patients to the public payer, who then uses the money to pay for the services of suppliers and public providers, a value which then flows back to the patient at the point of use.

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2.2.2 The Bismarck Model: A Social Health Insurance Model

The Bismarck model, created at the end of the 19th century by German Chancellor Otto Von Bismarck, is financed through the compulsory contributions of employees and employers to a national social security system, which is then supplemented by the State. The Bismarck model is more decentralized than the Beveridge model, in that both the payers and health providers within such a system may be either public or private institutions. However, private payers participating in the health system are required to be non-profit and are heavily regulated. Private insurers exist for self-employed citizens and those who wish to receive elective services not covered by the public providers.

Countries employing the Bismarck model vary in their implementation; some countries such as France offer a single insurer, while other countries such as the Czech Republic and Germany offer the end user multiple, competing insurers. Yet others, such as Japan, offer multiple but non-competing insurers. In this model, the services of private providers are purchased into the public system through contracts by health insurance funds, which often have a semi-public/semi-private status.

One of the biggest limitations of this model is that it was not designed to allow universal health coverage for every citizen but only for those who are part of the workforce.\(^\text{49}\) Figure III below depicts the flow of money in the Bismarck model. Contributions provided by employees allow for sustaining a system in which patients can opt for a public or private payer who will pay for private or public health-care providers. Suppliers are paid for their services or goods by the provider or payer depending on the national characteristics of the system. The regulator maintains control, monitors and makes changes to the system when deemed necessary.

### 2.2.3 The National Health Insurance Model: A Single-Payer National Health Insurance

The National Health Insurance model incorporates aspects of both the Bismarck and Beveridge models. Like the Beveridge model, the government acts as the single payer of a government-run insurance programme that every citizen pays into, and like the Bismarck model, providers can be private. This financing model is, in effect, a universal insurance that does not make any profit or deny any claims that meet prescribed criteria.\(^\text{50}\)

As demonstrated in Figure IV, in this model most suppliers, such as those for medicines, equipment, staff, etc., are paid by the public payer directly. In some cases, secondary services such as laundry services or facilities management may be provided by a private provider contracted by the public payer, who then pays suppliers.

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The balance between public insurance and private practice allows hospitals to focus on service delivery, while reducing the administrative complications which arise from having to bill and take payments from multiple insurance policies. Financial barriers to treatment are generally low, and patients can usually choose their health-care providers, though accessing the service may come with a long waiting time. The classic national health insurance system is found in Canada, but other countries such as South Korea have also adopted this model.\(^\text{51}\)

### 2.2.4 The Out-of-Pocket Model: Market-Driven Health Care

As the term suggests, in the out-of-the-pocket model patients pay for medical care themselves. There is no universal insurance system in place through which care is financed and, as a result, access to health services is determined according to a patient’s ability to pay. As depicted in Figure V, in this system the payer is the patient who directly pays fees to the provider.\(^\text{52}\)

Depending on the services or goods required or prescribed by the provider, the patient will make direct payments to suppliers (e.g., laboratory tests, medicine) or to private providers (e.g., therapy, nursing). Patients may be enrolled in voluntary payment schemes such as private medical insurance policies. Through such schemes, patients make periodic payments to private insurance premiums, and these premiums grant them coverage for services from private providers.\(^\text{53}\)
This model is an essential financing mechanism in many health systems, particularly in developing countries that lack the resources or organizational infrastructure to provide a functioning public health-care system. However, without enough money, patients unable to afford appropriate health care may be left to suffer from, or even die of, easily preventable conditions.


Chapter 3

CORRUPTION IN THE HEALTH SYSTEM
As mentioned previously, there are several features in health systems that make them vulnerable to corruption. Further, the forms that corruption in health systems can take are varied. A selection of these is presented in this section through an analysis of the interactions between various core actors. The information provided in this chapter is not exhaustive; instead, it should be viewed as guidance for those aiming to identify corruption risks as part of a wider corruption risk management process.

### 3.1 Core Actor: Regulator

The effective regulation of health policies, services and products relies on solid regulatory institutions. The combination of weak regulatory frameworks coupled with insufficient funding and the possibility of significant financial gains can give rise to acts of corruption by the regulator. For example, regulators could, in exchange for personal benefits, adopt and apply regulations or alter or disregard rules, depending on power structures and personal relationships.56 The health system regulator’s involvement in corruption can disproportionately impact the service delivery and patient outcomes, for instance by allowing for structural changes that benefit private interests at the expense of patients’ health. As illustrated in Figure VI below, opportunities for corruption may emerge as the regulator interacts with the payer, provider, or supplier.

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Corruption can also occur during the development and adoption of regulations in the form of regulators accepting or seeking financial or non-financial favours in exchange for strengthening or maintaining the political power of particular individuals or groups. For example, a corrupt regulator might request contributions in return for the adoption of favourable regulations that allow private payers to increase their profits, or accept gifts from pharmaceutical companies in exchange for reducing regulatory requirements related to new drug approvals.

3.1.1 Regulator and Provider

How corruption between regulators and providers manifests itself will depend on whether the provider is public or private. When the provider is public, regulators may be tempted to abuse their position to, among others, influence the designation of heads of hospitals and other important public health facilities, or to garner political support in exchange for jobs. Where the provider is a private entity, the regulator may, for example, ask for bribes from private hospitals to issue required operational licences and permits, or may overlook excessive increases in prices charged to patients, or not investigate or take action against increased instances of malpractice.

Corruption risks increase when private health care delivery becomes a significant economic activity, as regulators have fewer incentives to strengthen the public provision of services. Additionally, powerful private health providers can easily influence regulatory decisions by exerting sizeable political and financial pressure. For example, in 2021 there were 25,778 public hospitals in India with 713,986 beds, and 43,487 private hospitals with 1,185,242 beds. Around 60 per cent of patients requiring hospitalization and 70 per cent of patients with ailments were treated by the private sector. But even with such a sizeable market share, there remains a lack of effective regulation of private providers, which can allow private health providers to offer unwarranted treatments and issue inflated bills to patients to maximize profit at the expense of patient welfare.

3.1.2 Regulator and Supplier

The relationship between regulators and suppliers can be particularly prone to corruption, as this is the area in which it is determined under what rules often vast health-care budgets are disbursed, as well as to whom and for what purpose. Corruption, if left unchecked, can create situations in which regulations governing entire healthcare systems are influenced and dominated by privileged groups of suppliers to serve their own interests, a phenomenon known as regulatory capture.

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58 Dr Abhay Shukla, Dr Kanchan Pawar, and Dr Abhijit More, Analysing regulation of private healthcare in India: with focus on clinical establishments acts current status, challenges and recommendations (OXFAM India, 2021).
59 Ibid.
60 Ibid.
61 Transparency International Global Health, “Health System Regulation”.

The approval, distribution and regulation of pharmaceutical products offers an example of the acts of corruption that can occur between regulator and supplier. Pharmaceutical representatives may seek to influence regulators so that their products are included on a national formulary (the list of medicines available for public reimbursement), or they may provide kickbacks and payoffs to the members of medicine selection committees to ensure that their products are included. Conversely, members of medicine selection committees may have business relationships with particular pharmaceutical companies but not disclose these conflicts of interest, or may actively seek bribes or other benefits from those companies seeking approval for their products. For example, high-level officials of a health ministry may irregularly gain access to a COVID-19 vaccine still under clinical trial from a particular supplier, and in exchange for this illegal benefit seek to favour that supplier during future procurements or seek to influence or unduly encourage the closing of contracts between their ministry and that particular vaccine suppliers.

Suppliers may also bribe regulators to register a product without meeting the necessary registration requirements, or to speed up the entry time of a product into the market. Additionally, pharmaceutical manufacturers may give bribes to the regulator to overlook unmet compliance standards. As an example, manufacturers may pay off inspectors to secure regulatory approval for Good Manufacturing Practices (GMPs) for a manufacturing facility even though it falls short of the required standards.64 Government officials may also deliberately delay the registration process for a medical product in order to solicit illegal payments from its manufacturer, or to provide a competitive advantage to another supplier.65

Corruption in the relationship between regulators and suppliers erodes the process of selecting cost-effective medicines, and results in the questionable inclusion of pharmaceutical products on formularies, overvalued pricing for medicine, medical equipment and health services, and lower quality and safety of health-care products, among others, all of which can have a significant and detrimental impact on health outcomes.67 Such corruption can, when discovered, also reduce public trust in the ability of the regulator to appropriately carry out its mandate.

62 WHO, Integrating a focus on anti-corruption, transparency and accountability in health systems assessments (Geneva, 2018).
63 A formulary is a manual containing clinically oriented summaries of pharmacological information about selected drugs. The manual may also include administrative and regulatory information pertaining to the prescribing and dispensing of drugs. A national formulary generally concentrates on available and affordable medicines that are relevant to the treatment of diseases in a particular country. See WHO, How to develop a national formulary based on the WHO model formulary: a practical guide (Geneva, 2004).
3.2 Core Actor: Payer

Corruption risks arising from the interaction between the payer and other actors will differ based on whether the payer is a public or private entity, which is in turn determined by the funding model (or combination of models) adopted by that country. Figure VII below illustrates the significant corruption risks that can arise in the payer’s relationship with the regulator, provider and supplier.

Figure VII

Example opportunities between payers and other actors

- Bribery to ignore illegal practice
- Abuse of office for political gains
- Abuse of office
- Embezzlement of funds or medical products
- Collusion (i.e. to use a particular drug or device)

3.2.1 Payer and Regulator

In the Beveridge and National Health Insurance models, where the payer is public and the public sector allocates resources for health care through regular budgetary processes, opportunities may be created for political interest to contravene decisions that are in the best interest of patients. For example, decisions may be made to favour particular regions governed by political allies, rather than choosing regions by following the criteria of needs, equality and efficiency. In the Bismarck model, whereby the public sector manages an insurance fund, corruption can take the form of officials embezzling these funds. The public payer may also reallocate resources, using public funds that should have been used for patient care instead for their own political gain.

Additionally, private payers, such as those found in countries adopting the Bismarck Model, may bribe insurance regulators to ignore illegal practices.68

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### 3.2.2 Payer and Provider

In countries where the Bismarck model is utilized, payers may collude with individual providers, or providers may seek to bribe payers to accept inflated reimbursement requests for administered drugs, services, or products. Additionally, private payers, whether for-profit or non-profit, can engage in abuse of office practices or embezzlement of funds as they interact with providers, for instance by blacklisting or delaying payments to providers who do not pay them bribes.

Additionally, in the out-of-pocket model where patients may require voluntary insurance coverage, private payers in the market may collude to reduce the coverage offered by their plans, or collude to increase the cost for the same coverage. Such collusion forces patients into paying more for health services.\(^\text{69}\)

In countries where the out-of-pocket model is extensively applied, the role of donors as payers is also prevalent. Health spending in low income countries between 2000–2019 was financed primarily by out-of-pocket spending, with 44 per cent of all health-related spending being borne by the patient.\(^\text{70}\) However, external aid also financed 29 per cent of the provision of health care\(^\text{71}\) and, with the COVID-19 pandemic, this dependence is expected to have escalated. Donor funds are also not exempted from the risk of corruption; providers may embezzle or misuse funds allocated to them to deliver particular health services, while funds can also be diverted at the ministerial level or as donor funds flow from the national to the subnational levels. An example of corruption where the payer is a donor is depicted in Box 2 below.

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Diversion of grants in Cameroon, Madagascar and Papua New Guinea

In 2018, external aid in the global health sector (including official development assistance through grants and concessional loans from bilateral and multilateral donors, and grants from private donors) totalled US$ 16.2 billion. Management of these contributions can entail significant corruption risks, especially in countries that implement out-of-pocket health funding systems and which often do not have robust public health provisions. In such cases, funds can be easily diverted or prone to embezzlement, and during public health crises these risks can be amplified as large sums are disbursed quickly and monitoring of funds is piecemeal or inadequate.

For example, investigations by Gavi, the Vaccine Alliance, a public-private partnership that aims to increase access to immunisation in middle- and low-income countries, concluded that grants that the Gavi Alliance had entrusted to the governments of Cameroon, Madagascar and Papua New Guinea had been partly diverted away from their intended recipients. Reported violations included ineligible expenses, fraudulent or irregular expenses, questionable expenditures and unjustified disbursements.

Investigations concluded that key areas where violations occurred included budgeting and financial management, and expenditure and disbursements. Among the factors that facilitated the irregularities were the absence of segregation of duties, a general lack of checks and balances, weak financial control systems and collusion among staff.

All three governments signed agreements to remediate the identified issues and reimburse the Gavi Alliance. Cameroon agreed to reimburse US$ 3,691,054 (2012), while Madagascar agreed to reimburse US$ 1,635,260 (2018) and Papua New Guinea US$ 719,255 (2017). These amounts can be seen as tangible costs of corruption; citizens of these countries had to pay twice for the same benefit.

Sources:
Gavi Secretariat, Memorandum on the Republic of Madagascar Programme Audit and Investigation reports (Geneva, 2018).

3.2.3 Payer and Supplier

Opportunities for corruption may also exist where payers are able to circumvent existing procurement rules to favour a certain supplier, or where adequate procurement rules do not exist. For example, payers may collude with suppliers to increase the quoted costs for medical products or services, accept bribes to favour one supplier over another more suitable supplier, or award contracts directly to one supplier without seeking competing bids. Additionally, both public and private payers may receive incentives from unscrupulous suppliers to include
treatments or medicines which lack a sound scientific basis in the list of approved medicines or treatments covered by the payer. Box 3 provides an example of payers and suppliers colluding to circumvent procurement rules, in this case, to inflate the cost of vital COVID-19 vaccine.

**Box 3**

**Breaches of procedure in the procurement of Sputnik-V COVID-19 vaccines**

In 2021, the parliament of Ghana established an ad hoc committee to investigate a procurement contract signed between the Ghanaian government, a United Arab Emirates (UAE) based business consulting group, and a private Ghanaian company, for the supply of Sputnik-V COVID-19 vaccines to Ghana.

The mandate of this Committee was to determine whether the cost paid for these vaccines represented value for money for the Ghanaian State, to assess whether the Ghanaian Ministry of Health was compliant with the government’s procurement rules when contracting the suppliers for the vaccine, and also to seek justification, if necessary, for the cost paid for the supply of the vaccine by the Ministry of Health.

The Committee found that:

- UAE-based business consulting group was the provider of the vaccines.
- Procurement and supply of the Sputnik-V vaccines between the Ghanaian Ministry of Health and the consulting group was an international agreement, and therefore required prior approval by Parliament, which was not requested.
- Further, the Ministry of Health did not receive approval from the Board of Public Procurement Authority for the procurement of the vaccines as required by law, neither did the Ministry seek the approval of Cabinet.
- The agreed price of the vaccine under the Ministry’s Agreement with the consulting group was US$ 19.00 per dose, while the ex-factory price of the Sputnik-V vaccine was US$ 10.00 per dose.
- Although the Minister for Health denied knowledge of any payments to the supplier, an amount of US$ 2.85 million (representing 50 per cent of the contract sum of US$ 5.7 million) was paid to the consulting group.

The Committee concluded that even if the situation in the country at the time the agreement was signed was that of an emergency, the due process established by law should still have been followed. Given the contravening of procurement rules and the inflated costs agreed by the Ministry of Health per dose compared to the factory cost, the Committee urged the Minister for Finance to take steps to recover the amount of US$ 2.85 million paid to the consulting group.

Source:
3.3 Core Actor: Provider

The opportunities for health-care providers to engage in corruption are frequent and varied, due in no small part to their decision-making powers related to vital services such as prescribing medicines, determining the length of a hospital stay, ordering tests and referring patients for additional consultations or services, among others. In making these decisions, health-care providers may be motivated by interests other than the health of their patients. These motivations may include personal financial gain, increased prestige, greater power, or improved working conditions.

The funding model adopted by each country will determine if the provider is public or private, and the corruption risks will differ accordingly. Most countries’ health systems involve a combination of public and private health-care providers, with the latter often far less regulated than the former. Figure VIII below depicts possible corruption risks in the interaction of providers with the payer, supplier, and patient.

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3.3.1 Provider and Payer

Health-care providers, whether public or private, may collude with the payer to access subsidies or receive reimbursements under favourable terms. The provider can also deceive the payer by over-reporting the kind and quantity of services provided. Forms of corruption linked to public providers and payers include:

- **Ghost workers:** Ghost workers, or individuals who exist on payrolls but not within the workplace, are a global phenomenon and a common corruption risk for health systems. They may be employees who have died, retired, or exited from civil service and whose change in status was not recorded, or they can be entirely fictitious persons with an income that is stolen by corrupt workers. This phenomenon wastes resources that otherwise could have been allocated to vital health-care services.

The risk of ghost workers being present on payrolls increases when human resource information systems are weak or unmaintained, where there is limited or no oversight of record keeping, or where there is a lack of accountability within the department responsible for the detection of record-keeping errors. Ghost workers are usually the result of corruption within administrative departments such as payroll and human resources, rather than amongst health workers themselves.

- **Absenteeism:** Absenteeism is a form of unethical conduct in which public services are not delivered to patients because health-care workers responsible for delivering these services are absent, deceitfully avoiding their professional responsibilities, which have a detrimental impact on the organization and its resources. In other words, absenteeism represents the theft of public funds through the payment of wages for non-delivery of agreed services. Causes of absenteeism include infrequent supervision, lack of professional consequences, limited accountability, and public health-care workers holding additional employment elsewhere. By addressing absenteeism, organizations can promote a culture of integrity, professionalism and accountability, and foster a more efficient and ethical work environment. Often most prevalent in rural or poorer areas where detection and reporting are weakest, absenteeism poses a

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77 Ibid.
threat to equitable and equal access to essential public health services.\(^79\) It can also lead to a lack of patient trust in the ability of the health system to meet their needs.\(^80\)

Absenteeism is challenging to detect, rarely punished, and often suffers from a lack of political will to confront the issue in the public sector. As a result, it can be endemic in vulnerable health systems. For example, in one rural area in Uganda, a staggering 47 per cent rate of absenteeism was observed.\(^81\) Absenteeism can be pervasive because it mainly impacts poorer patients who lack the power and resources to complain, and who are using underfunded health systems that lack the resources to effectively address the issue.

Furthermore, dual practice, whereby a health professional works in both the private and public sectors, not only increases the risk of absenteeism in public health services but can also result in predatory behaviour (i.e., physicians pressuring patients to purchase services at their private practice) and conflicts of interest (whereby physicians may attempt to lower the quality of care in their public health-care position to drive patients into their private practice).\(^82\) It can also create other opportunities for corruption, such as embezzlement of medical products.

- **Embezzlement**: Another corruption risk through which the payer may be forced to incur unnecessary expenses is in the embezzlement of medicine and medical supplies by providers for resale or use in private practices. For example, a dual-practicing physician may embezzle medical products, which have already been paid for by patients through taxation, from the public sector to their private practice, or public employees may steal valuable medicines, tests, or vaccines to sell for a profit on the illicit market. In one Latin American country, for example, 71 per cent of doctors and 83 per cent of nurses reported that equipment and materials had been stolen in their hospital,\(^83\) while in the UK three arrests were made following the theft from a truck of COVID-19 lateral flow testing kits worth over GBP 100,000.\(^84\)

These illegal acts reduce access to health services and products for those reliant on public health care, and increase the often already considerable resource gap between public and private health-care institutions.\(^85\) Furthermore, illicit health-care providers may abuse health systems for money laundering or other illicit purposes.

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3.3.2 Provider and Supplier

Suppliers may seek to bribe health-care providers in both public and private institutions to favour their products over others. Given the close and often unclearly defined relationship between health-care providers and the health-care industry, corruption in the marketing practices utilized by suppliers is a significant risk. For example, pharmaceutical companies may offer physicians financial or other material incentives to prescribe their products, which may pressure providers to prescribe unnecessary or overpriced treatments to unaware patients. By incentivising the provider, who is in a position of power in relation to the patient, to prescribe specific products, patients and health systems need to be made aware of the different options available to them in order to avoid unnecessarily overpaying for potentially substandard products.

Such incentives may not always take the form of cash transfers, but can take the form of vacations disguised as conferences, overpaid consultations, elaborate dinners, or fictitious trainings. Sometimes, rather than offering incentives or bribes to individual practitioners, suppliers may try to influence key opinion leaders in the medical community who, in turn, promote a particular health product. This risk is particularly high in out-of-pocket funding systems, where it may be the case that neither regulator nor payer monitor which drugs or treatments are prescribed.

In addition, decision-makers within public health-care providers may accept bribes to influence the procurement of specific medicines, supplies, or medical equipment. In doing so, they may pay inflated prices, purchase inappropriate products, or overlook inadequate services provided. Providers also outsource a wide range of services from private actors, from the installation and maintenance of specialized equipment to laboratory services, ambulance services, food services, laundry services and security services, among countless others. The tendering of these services can create corruption risks; for instance, officials may exert influence to benefit a specific supplier in exchange for bribes, may overlook a supplier’s poor performance in exchange for an unlawful reward, or may make calls for unnecessary tenders in collusion with preferred suppliers. Boxes 4 and 5 showcase examples of the damage these corruption risks can cause if they are allowed to materialize.

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87 Ibid.
Corruption in a regional Australian health service

In 2018, the Corruption and Crime Commission of Western Australia reported a case of bribery in the tendering and administration of maintenance and service contracts within one regional Australian health service responsible for managing a number of major hospitals.

According to the investigations, public officers accepted gifts of interstate and overseas travel and accommodation, entertainment, alcohol, as well as thousands of dollars of cash payments from contractors in return for awarding them contracts, or for allowing them to keep existing ones.

Public officers also helped contractors to illegally invoice the health service to cover the costs of these gifts and bribes. A public officer even used a contractor to renovate his private residence at a discount, and then allowed them to illegally invoice the health service for approximately AUD 125,852 for the works carried out on his private residence.

Source:

A pharmaceutical company’s alleged payoffs to doctors

A multinational pharmaceutical company agreed to pay US$ 591,442,008 to resolve claims that it paid kickbacks to doctors to induce them to prescribe the medicine it produced. The supplier used, for example, a ‘speaker programme’ through which they paid doctors compensation for delivering a lecture regarding the supplier’s medication. However, many of these programmes were nothing more than social events held at expensive restaurants, with little or no discussion about the medicine. Indeed, some of the so-called speaker events never even took place; the speaker was simply paid a fee to prescribe the supplier’s medicine.

Source:
3.3.3 Provider and Patient

Physicians and other health-care providers who engage in dual practice can also create opportunities for privileged access to public health services in exchange for bribes or other informal payments. For example, in some Southern European countries, it is not uncommon for a patient to bypass lengthy public hospital waiting lists by visiting a physician in their private clinic and paying them through private insurance along with an informal payment. Once the physician is paid, the patient is then admitted directly to the public hospital and placed higher on a waiting list for the required surgery or other health-care service.  

Health systems based on the out-of-pocket funding model entail a higher risk of corruption occurring within the provider-patient relationship than in systems that utilize other models. This is because the regulations governing health systems using the out-of-pocket funding model are usually weaker than in other funding systems, and the profit-driven nature of this funding model can motivate actors to engage in corruption in order to increase profits. For example, the inelasticity of the demand for health services may force patients to make significant informal payments to see a doctor, or pay for unnecessary additional tests.  

Further, providers may perform unnecessary medical interventions or illegally refer patients to specific suppliers (such as a particular pharmacy or laboratory with whom they have fixed an inflated price for the service, for example) to maximize profits. Health-care providers operating within such systems therefore have ample opportunity to abuse their power for financial benefit. Such schemes can, in the best case, force patients to pay more than necessary for health-care products and services and, in the worst case, cause vulnerable patients to face financial catastrophe, impoverishment, and in situations where the illicit costs for accessing health services are too high to bear, avoidable suffering or even death.  

3.3.4 Related Risks

The dependency of a patient’s wellbeing on their health-care provider requires professionals working within these public and private providers to demonstrate strong ethical values and integrity. Providers, whether public or private, need to be able to recognize health care related dilemmas and corruption risks, be able to show sound judgment and take decisions based on their values, and be able to do all this while adhering to the laws under which their work falls. However, even at the beginning of their education, health providers may be confronted with corruption and unethical behaviour that continues to influence their actions throughout their professional careers.

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From the earliest stages of medical education, universities and other higher education institutions related to the training of health professionals may be involved in corrupt practices. For example, some medical schools may alter student’s admission grades in exchange for illegal benefits, or approve a student’s admission due to nepotism.

Medical educators may also demand sexual services in exchange for admission to popular programmes of study, or for better grades. This form of corruption, in which sex rather than money is the currency of the bribe, is defined as the abuse of power to obtain a sexual benefit or advantage. Many anti-corruption frameworks do not explicitly criminalize forced sexual acts as a form of bribery or corruption, allowing perpetrators to escape repercussions.

Once students are accepted into a medical educational establishment, professors may conceal misconduct for students with powerful connections or who pay them bribes, or avoid reporting identified instances of misconduct in order to maintain the reputation of their institution. These instances can erode public trust in medical professionals, as well as in the educators tasked with training them. Corruption may also create barriers for health students when entering the workforce; better qualified graduates may be passed over for certain public positions in favour of less qualified but more connected individuals. Unqualified or underqualified health professionals may also make illicit payments to authorities to approve or issue medical licenses. These corrupt practices foster a culture of dishonesty, hindering ethics in the health-related professions.

Box 6

Allocation of government funds in exchange for university admission

A senior education ministry official in an Asian country was discovered to have accepted a request to give favourable treatment to a specific medical university during the selection process for the ministry’s Private University Subsidy Programme. This selection process determined which private institutions would receive substantial government subsidies. In exchange for ensuring that the medical university in question was chosen for the scheme, the academic results of the senior official were artificially inflated in order to let him meet the university’s entrance criteria.

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94 UNODC, “Exposing and Preventing Sextortion in the Judiciary”.


3.4 Core Actor: Patient

While it is typically the patient who suffers the most as a result of corruption, they can also be active participants, or even the perpetrators of corrupt acts. In health system financing models in which the main provider is public, such as in the Beveridge or Bismarck Model, demand for services may exceed capacity, and as a result waiting times to receive care may be excessively long and unregulated. This service delivery bottleneck can lead to patients offering or agreeing to illegal payments to providers in order to access health services. Such payments are more common among patients who lack the knowledge to question providers on the legality of the payments being demanded, and who lack the power to refuse payment due to the inelastic nature of health care. Patients may view such payments as a reasonable way to increase their chances of receiving better (or any) service, or as gratitude payments for the health services provided, as exemplified in Figure IX below.

Informal payments and other forms of corruption limit equitable access to health-care services and products, particularly for poor and marginalized communities. Corruption can also disproportionately affect women; providers may withhold reproductive or maternal care from women if they are unwilling or unable to pay a demanded bribe, resulting in avoidable postnatal complications or in extreme cases, the death of the woman, the child, or both. Providers may also intentionally create artificial medicine shortages, in order to obtain supplementary payments from desperate patients seeking to obtain them. In the private sector, providers may give patients no choice but to purchase expensive medication even when generic or cheaper alternatives exist, influenced to do so by so-called Pay-For-Prescribe

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schemes in which pharmaceutical companies pay bribes to hospitals or doctors to prescribe their particular medicine or treatment at the expense of other, often more suitable alternatives.

Patients with the financial resources to do so may also offer bribes or other incentives to a hospital administrator or health-care provider for various reasons. For example, incentives may be offered by patients to be prioritized for a health service or procedure, to gain access to a non-required prescription for controlled or restricted products (such as opioids), to receive difficult-to-source, expensive, or experimental medicines from the public health system, or to obtain non-medical benefits such as health certificates for driving licences, certificates to avoid military service, or credentials to receive disability payments, among others.

In some countries, such bribes are accepted as a way of doing business within the health system, with payments justified as, for instance, a way to compensate poorly paid public sector health professionals, or as an understandable response by desperate patients who might be in urgent need of care. Such justifications are dangerous, as when such payments become institutionalized the result is an unequal system whereby wealthier people can access better and more timely care while those without the means to pay bribes languish at the bottom of health-care waiting lists.101

3.5 Core Actor: Supplier

Suppliers are typically private sector actors and, as such, they depend on the decisions made by regulators, payers and providers in order to generate profits. For example, regulators will decide if certain medicine or devices are approved for use or not, payers will determine which medications will be covered by national insurance programmes, and providers will prescribe medicines and treatments to patients at the point of service. Consequently, there is a significant risk that suppliers will use corruption as a tool to influence the decision-making processes of each of these actors, as illustrated in Figure X. When analysing the role of suppliers, it should also be considered that some suppliers may simply be illegal actors aiming to defraud the health system, or may be seeking to use the health system to launder proceeds of crimes.

101 Ibid.
3.5.1 Supplier and Regulator

The multiple points of contact between suppliers and public officials, in tandem with the ample financial resources of the health industry, can result in undue pressure being exerted by suppliers on regulators, or in bribes or collusion between suppliers or regulators to develop policies in their favour. For example, pharmaceutical companies may seek to influence governments to have more stringent patent protection in an effort to impede competition from generic medicine manufacturers, or bribe regulatory officials to reduce the testing requirements for a new drug in order to speed up its market entry.

A more detailed discussion on the corruption risks related to health-care regulators can be found in section 3.1 above.

3.5.2 Supplier and Provider

Medical equipment suppliers and pharmaceutical companies may seek to secure lucrative contracts with health-care providers through corrupt means. For example, they may bribe procurement officers to choose their bid over a more competitive bid for a high-value contract, they may offer gifts to government officials to authorize overvalued prices for their products or services, or they may influence providers to use their products at inflated prices when cheaper, equally effective alternatives may be available.

The sheer number of products and services required to create a functioning health system means that opportunities for corruption may be found at any point in which a supplier interacts with a provider. From the low-value contracts where a supplier inflates the price of printer paper and then bribes a procurement manager to approve the payments, to kickbacks paid by
construction companies to government ministers responsible for the awarding of multi-million dollar hospital construction contracts, opportunities exist for suppliers to use corruption as a tool to secure profit. Box 7 below provides an example of how corruption can occur in the interaction points between supplier and provider. More information on providers and their corruption risks can also be found in section 3.3 above.

**Procurement scandal in the Honduran health system**

In 2014, a corruption scandal involving money laundering, influence peddling, embezzlement of public funds and other corruption offences emerged in Honduras, in relation to the management of the Honduran Social Security Institute (IHSS). As part of this investigation, senior state officials, members of the Honduran business community, well-known politicians and their connections, and external investors were implicated and arrested.

In 2018, the Honduran Prosecutor’s Office released information of 14 convictions secured from around 50 accused personnel, including that of the former manager of the IHSS, sentenced in 2015 to seven years in prison for receiving approximately US$ 190,000 from a company selling overvalued ambulances to the IHSS. Similarly, the former Executive Director of the IHSS was found guilty of receiving over US$ 2.1 million in exchange for expediting the disbursement of a contract signed with the IHSS. Approximately US$ 12 million was recovered from perpetrators.

Source: Honduras Public Prosecutor’s Office, “14 Fallos Condenatorios hasta el momento reporta el MP en el caso IHSS” [14 Convictions so far reported by the Prosecutors’ Office in IHSS case], 5th July 2018.

Suppliers who engage in corruption in relation to providers fall into two groups; those seeking to gain an undue market advantage for an otherwise legitimate product, and those seeking to insert illegitimate, counterfeit, or falsified products into legitimate markets. Criminal groups seeking to insert such items into legitimate procurement systems may try to take advantage of weak or non-existent due diligence processes within health systems by bribing officials to approve falsified documents, accept delivery of counterfeit medicines, or otherwise infiltrate a market with falsified medical products. Falsified medical products and related corruption thrive in times of crisis when shortages exist, demand spikes, time is short and controls are relaxed or overlooked. Such products, which are unlikely to adhere to regulations related to safety or effectiveness, can endanger patient outcomes and in extreme cases cause significant harm, or even death.

The corruption risks described above can also apply to interactions between the supplier and payer, though this will depend on the funding system in place.  

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104 Annex A of this document provides a summarization of the example corruption risks mentioned in Chapter 3 alongside the relationships between core actors.
Chapter 4

CORRUPTION PREVENTION THROUGH CORRUPTION RISK MANAGEMENT
As highlighted in the preceding section, there are many weaknesses and vulnerabilities inherent within health systems that can create opportunities for corruption. When these corruption risks are left unaddressed, the resulting corruption can cause a substantial drain on public resources and pose a significant barrier not only to improving or transforming health systems, but also to achieving the target under Sustainable Development Goal 3 of Universal Health-care Coverage by 2030. Most importantly, unaddressed corruption limits or denies access to life-saving medical products and services to all, and disproportionately affects those most in need of affordable or free health care such as the poor, the vulnerable and the marginalized. 

This paper recommends a proactive and preventive risk-based approach to addressing corruption through the identification and mitigation of corruption risks before they have a chance to manifest as corrupt acts and undermine the delivery of public health services. Prevention is better than cure; in the same way that it is better (and far more resource-effective) for a doctor to help a patient live a healthier life than to wait for them to have a heart attack, it is better for health authorities to proactively take steps to reduce the chance that corruption will occur, rather than to wait for it to occur and then reactively deal with the negative consequences.

However, when it comes to implementing a risk-based methodology for addressing corruption risks there is no single approach; the process may, for instance, be conducted at a sectoral level or at an organizational level, and those tasked with designing and implementing the corruption risk management process must take into account the national context, the actors involved, their mandates and interlinkages, as well as the funding model of the health system when choosing their approach.

This paper provides advice on corruption risk management at the organizational level, limiting the scope of the process to one organization or a particular department or operation within that organization. The benefit of adopting an organizational-level corruption risk management process is that the implementation of the risk mitigation plan derived from the corruption risk assessment process will fall within the control of specific managers who possess the authority to ensure its effective implementation within that organization.

The goal of an organizational-level corruption risk management process is to devise a set of structured, systematic and feasible strategies that the organization can take to prevent corruption, ensuring that all members of the organization work with integrity to achieve the organization’s mandate. Further, the corruption risk assessment and the implementation of a corruption risk mitigation plan should not be seen as a one-off exercise, but rather as a cyclical process which becomes embedded in the working culture of the organization. Finally, to gain the most benefit from the process, after completing all corruption risk assessment and

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105 WHO, Integrating a focus on anti-corruption, transparency and accountability in health systems assessments (Geneva, 2018). See also the resolution adopted by the General Assembly, 25 September 2015 (A/RES/70/1).


management steps, the results of the mitigation strategies should be monitored, evaluated and adjusted, and the findings fed back into the next iteration of the corruption risk management cycle.

This chapter describes the main steps of a corruption risk management process. It follows the guidance of the UNODC publication *State of Integrity: A Guide on Conducting Corruption Risk Assessments in Public Organizations*, which offers a more comprehensive but generalized guidance on the corruption risk assessment and mitigation process. This paper, on the other hand, has been adapted to specifically reflect the needs of public health systems.

Figure XI illustrates the corruption risk management process recommended by this paper. It is based on the methodology proposed by the International Standards Organization (ISO) Risk Management Guidelines (ISO 31000:2018). UNODC has adapted this methodology, taking into considering the specificities of public sector organizations.
4.1 Preparing for the Corruption Risk Management Process

A lack of preparation before initiating a corruption risk management process will likely result in the process falling short of its potential. This is because decisions taken at the preparation stage will guide the entire process, and will ensure that staff and other resources necessary for the successful implementation of the process are in place upon commencement, and are ready to carry out their roles effectively. Therefore, to allow the process the highest chance of success, it is important at the preparation stage to:

4.1.1 Determine the Scope

The corruption risk management process is adaptable to the different characteristics and needs of the various public actors within a health system. These actors carry out different roles and interact differently with other actors in the health system, and will therefore need to tailor their risk management processes to their unique needs. For instance, a suitable risk management process for a regulatory agency (such as a health ministry) will look different to the process that best suits a payer (such as a private medical insurance provider, Medicare, or the National Health Service), and both of these will look different to the risk management process that best suits a health-care provider (for example a hospital, clinic, or a local medical station).

When determining the scope that the corruption risk management process will cover, the size and complexity of the assessed organization, the overall health system and the funding model in place should be considered. Should the assessment target the entire Ministry of Health, for example, or is it more beneficial to target specific functions such as procurement and distribution of medical supplies and equipment, or perhaps is it better to look at particular hospitals or units? External events that trigger the need for a risk assessment, e.g., a corruption scandal within a specific hospital or unit, may also guide decisions related to the scope of the risk assessment process.

Figure XII below illustrates three potential risk assessment scopes within a hypothetical health ministry. As shown, the risk management process could cover the entire ministry, a specific directorate, or a specialized hospital.
Illustration of three potential risk assessment scopes

Risk assessment scope may cover:
1. The entire health ministry
2. The Directorate of Medicaments and Drugs and the sub-offices only
3. Specialized hospitals only
4.1.2 Secure Commitment & Resources

Senior management of the assessed organization must approve, adequately resource and visibly support the corruption risk management process. The resources that must be allocated are not only financial, but should also include experienced staff and their time.

4.1.3 Appoint and Empower the Working Group

The risk management process is a collaborative exercise that brings together public officers from different departments and levels within the assessed organization. The process requires the involvement of those who are able to implement change within the organization, as well as the buy-in of the front-line employees that might be responsible for actioning many of the mitigation strategies that will be proposed as a result of the process.

The working group undertaking the corruption risk management process should be small enough to maintain efficiency but large enough to have relevant expertise available. In addition, it should be gender balanced and inclusive to ensure that the concerns of all relevant stakeholders are addressed, including (where pertinent) relevant external stakeholders who may be able to provide external viewpoints which broaden the scope of the issues being discussed.

The working group should be led by a senior and knowledgeable official who can secure the active participation of group members, lead the process independently and, when needed, have direct access to the leadership of the organization. Larger health organizations may require a larger working group and more time to assess risks and develop a risk mitigation plan.

Group members must also be empowered with authority to perform the necessary risk assessment and mitigation actions. It is recommended that an internal expert or external facilitator conduct an initial briefing session for the working group on the risk management process in order to explain why the organization is conducting one, and the role of each participant or group within the process. It is recommended that the head of the organization participates in the session, emphasizing the importance of the process and that it has the full support of management.

Care should be taken to ensure the working group (and consequently the whole organization) understands that the corruption risk assessment process is not a witch-hunt or an investigation into past corrupt practices, but rather is a proactive process to identify the weaknesses and vulnerabilities that may enable corruption to take place in the future.
4.2 The Corruption Risk Management Process

This paper recommends that organizations follow a five-step cyclical corruption risk management process. Step 1 takes place before the risk assessment, while Steps 2–4 comprise the actual corruption risk assessment. Once the assessment has taken place, Step 5 focuses on the development and implementation of mitigation strategies to respond to, or treat, prioritized corruption risks.

4.2.1 Step 1: Establish the Context

Once the necessary preparations have been made, the first step in the risk assessment process is for the working group to establish the context in which the assessed organization operates. This step takes place before the substantive portion of the risk assessment, but is nonetheless crucial if the process is to have the best chance of success.

It is important at this stage to reflect on any external factors that may influence corruption risks, the power that the organization has over these factors, and what constraints the organization may face in addressing them. In examining the external context, the working group should consider how their organization interacts with other public and private actors in their health system. This analysis may, for example, allow the working group to establish if there are other stakeholders that should be invited to participate in the corruption risk management process, either as observers or active participants.

Another external factor that can affect the type of risk management process that the assessed organization chooses to implement is the health system funding model within which they operate. Analysis of the funding system allows the working group to better comprehend how particular operations of the organization are financed, and also enables a more complete understanding of the operating structures within the health system as well as the roles being fulfilled by each actor. Alongside an analysis of the funding model in place, the legal, regulatory, technological, social, economic and competitive environment should also be considered by the working group.  

Questions that the working group may wish to explore include, among others:

- Which laws govern the operations of the organization?
- What powers do these laws grant the organization?
- Which other public bodies does the organization interact with? In what context?
- Who oversees the organization?
- Which health system funding model is in place?

Internally, the organization must consider the context surrounding its governance, mandate, organizational structure, roles and responsibilities, as well as the specific procedures it must adhere to, such as those governing procurement processes and personnel management.

Assessments should also consider the laws and regulations governing the recruitment, promotion, discharge and conduct of public servants in the health system, as well as any applicable integrity and anti-corruption laws that cover conflicts of interest. The working group should also assess the organization’s gender equality and inclusivity position, as shortcomings in this regard may constitute another corruption risk.

Figure XIII illustrates a selection of the internal and external factors that should be analysed when determining the context in which a health provider, in this case a public hospital, operates. These factors will vary according to the organization being assessed. This step is not intended to be a time-consuming exercise, rather the working group should aim to produce a high-level analysis of the organization’s operating context within a short timeframe in order to then move on to Step 2 of the process.

4.2.2 Step 2: Risk Identification

The second step of the process is for the working group to create a list of corruption risks. This exercise should be forward looking, focusing on potential future corruption risks rather than serving as an investigation into past corruption. Again, it is important to emphasize that this is an exercise to determine what-might-be or what-if, with the aim of discovering any weaknesses within the organization that might allow for corruption to occur in the future. This should be clearly understood by the working group, and explicitly communicated to the organization’s other relevant staff.
A brainstorming session is one way to promote sharing of ideas about possible risks. This step aims to produce a realistic, manageable list of risks from which priorities can then be determined. Chapter 3 of this paper provided some common examples of corruption risks related to health systems which could be considered during the session to encourage discussion. However, it should be made clear that these examples are simply starting points from which a discussion of risks in the context of the specific organization can emerge. Additionally, the work undertaken to establish the context in Step 1 should be used by the working group to ensure that any risks identified during this session are within the organization’s scope of action.

As the working group compiles its list of potential corruption risks, it should identify ways to consolidate specific or localized vulnerabilities into broader categories. For example, even though government pharmacies at various locations will be responsible for accepting cash payments, rather than listing each location and the money collected for each service separately, they could be consolidated under the heading ‘chance of skimming cash receipts’.

The working group may also wish to group risks according to the specific processes or responsibilities within the organization, to ensure risks that all key functions have been covered during the brainstorming session. At this stage in the process, it is better to include risks than to leave them out, as the opportunity to exclude risks will come at the analysis and evaluation stages. Table 1 provides an example of possible risks grouped according to specific organizational functions that might emerge during the risk identification session for a public hospital.

<table>
<thead>
<tr>
<th>Table 1</th>
</tr>
</thead>
</table>

**Example of a risk identification session by the working group of a public hospital**

<table>
<thead>
<tr>
<th>Organizational function</th>
<th>Corruption risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Procurement</strong></td>
<td>Trading in influence to award medical supplies procurement contracts to unsuitable suppliers.</td>
</tr>
<tr>
<td></td>
<td>Inadequate monitoring of external service suppliers (e.g. security services).</td>
</tr>
<tr>
<td><strong>Human resources</strong></td>
<td>Absenteeism / Ghost workers.</td>
</tr>
<tr>
<td></td>
<td>Bribing officials in the recruitment process of new staff.</td>
</tr>
<tr>
<td></td>
<td>Abusing of functions to allocate paid leave to friends.</td>
</tr>
<tr>
<td><strong>Service delivery</strong></td>
<td>Doctors provide preferential treatment to patients that visit their private practice.</td>
</tr>
<tr>
<td><strong>Asset management</strong></td>
<td>Health officials embezzle medicine and medical supplies.</td>
</tr>
</tbody>
</table>
4.2.3 Step 3: Risk Analysis

Once the working group has created its list of potential corruption risks, an analysis can be undertaken to understand the nature of each of those risks, their characteristics and the type of impact they could have if they were to materialize. During this step, the working group may choose to interview staff, review existing controls such as laws, policies, procedures, processes, or management systems, or examine internal documents such as past audit reports or investigations, accounts, or procurement records. When conducting the above analyses, suspicious patterns may become apparent, such as repeated anomalies with a particular supplier or suspiciously high expenditures in a particular location compared to others.

For example, a document analysis may identify suspicious patterns in the data on which suppliers win what percentage of public contracts in relation to the procurement of medical supplies which, along with contract amounts and other related information, may suggest a possible corruption risk in the awarding of public contracts. If such information is not readily available, the mitigation plan (Step 5 of the corruption risk management process) should include provisions to ensure its future availability, such as the implementation of e-procurement tools.

Corruption risks in the health system, indeed any sector, can be classified into three overarching types of impact: financial, reputational, or related to the organization's ability to carry out its mandate. The risk analysis step, therefore, should be used to develop an understanding within the working group of the type of impact that could result from each identified risks. Consider, for example, a health provider whose mandate includes the management of lists of approved medical supplies. A bribe from a private supplier to include a certain non-essential product on this list can lead to higher financial costs for the provider, and furthermore if and when the corrupt act is exposed, it could have a significant impact on the organization's reputation and ability to carry out its mandate effectively in future. Table 2 provides an example of the expected outcome of this step.

Categorizing risks in this way will also be particularly useful in the next step of the process when the working group evaluates the impact of each risk, as the results of the risk analysis will enable group members to make informed decisions in Step 4 regarding the priority level to assign to each identified risk.
## Example corruption risk analysis from a public hospital

<table>
<thead>
<tr>
<th>Organizational function</th>
<th>Corruption risk</th>
<th>Type of potential impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procurement</td>
<td>Trading in influence to award procurement contracts for medical products to unsuitable suppliers.</td>
<td><strong>Financial:</strong> Economic resources would be lost.&lt;br&gt;<strong>Mandate:</strong> The regulator or payer may decide to absorb the medical supplies procurement function.&lt;br&gt;<strong>Reputation:</strong> If there is a perception that the procurement process is not fair, fewer suppliers may be willing to take part in future procurement processes, limiting competition.</td>
</tr>
<tr>
<td></td>
<td>Inadequate monitoring of external service suppliers (e.g. security services).</td>
<td><strong>Reputation:</strong> Patients may publicize the bad quality of services they received.</td>
</tr>
<tr>
<td>Human resources</td>
<td>Absenteeism / Ghost workers</td>
<td><strong>Mandate:</strong> Absenteeism of administrative staff affects the ability of the provider to effectively manage and process patients, while absenteeism of medical staff impacts patient outcomes and health service provision. In turn, the core function of the hospital, to provide and manage the care of patients, cannot be achieved.&lt;br&gt;<strong>Reputation:</strong> Patients who continuously do not receive the expected services or whose health care is delayed may complain publicly or to the press.&lt;br&gt;<strong>Financial:</strong> The provider is losing money by unnecessarily paying the wages of absent staff.</td>
</tr>
<tr>
<td></td>
<td>Bribing officials to recruit less qualified individuals at the expense of more qualified candidates.</td>
<td><strong>Reputation:</strong> Qualified professionals may decide not to take part in future recruitment processes.&lt;br&gt;<strong>Mandate:</strong> The delivery of services may be poor if incompetent personnel are hired.&lt;br&gt;<strong>Financial:</strong> The provider may need to re-hire for the position, creating additional onboarding and other related costs.</td>
</tr>
<tr>
<td></td>
<td>Abuse of functions to allocate paid leave to friends.</td>
<td><strong>Financial:</strong> Paid leave denotes a financial expense for the provider and, if granted without all requirements being filled, translates into an economic loss.</td>
</tr>
<tr>
<td>Service delivery</td>
<td>Doctors provide preferential treatment to patients that visit their private practice.</td>
<td><strong>Mandate:</strong> Such practices affect the procedures and processes established within the organization. Additionally, those unable to pay for private visits to the doctor’s practice will face longer waiting times or may not be able to access services, threatening the ability of the provider to carry out its mandate.&lt;br&gt;<strong>Reputation:</strong> The hospital will become known for its corrupt practitioners, harming its reputation.</td>
</tr>
<tr>
<td>Asset management</td>
<td>Health officials embezzle medicine and medical supplies to sell on illegal markets.</td>
<td><strong>Financial:</strong> The supplies that are lost will need to be replaced, doubling the cost for the provider.&lt;br&gt;<strong>Reputation:</strong> The hospital will become known for having reduced or little stock of necessary medicines and supplies, and patients will be forced to buy the embezzled medicine when it is not available at the hospital, adding to the perception of the hospital as corrupt.</td>
</tr>
</tbody>
</table>
4.2.4 Step 4: Risk Evaluation

It is not likely to be feasible for an organization to be able to address all of its identified corruption risks, nor would it be practical to do so. During this step of the process, therefore, the working group should evaluate which identified corruption risks should be prioritized in the mitigation plan. The risk evaluation step is essential when many risks have been identified, or when resources are scarce.

One approach for deciding which risks to prioritize is to identify the risks where corruption is most likely to occur, or where, if corruption was to occur, the impact would be most severe. As demonstrated in Figure XIV below, a combination of these two assessments can then be used to determine what priority rating should be assigned for each risk. The impact analysis of each corruption risk (conducted in Step 3) should be considered when assessing the potential severity of impact of that risk on the organization. Box 8 below additionally provides a list of questions and factors which the working group could consider at this stage.

**Box 8**: Estimating the likelihood and impact of a corruption risk

When estimating the **likelihood** of a corruption risk occurring, the following questions could be considered:
- How complex is the potential corruption scheme, and how many are required to perpetrate it?
- Have similar types of corruption occurred in the health organization that undergoes the assessment or in other government organizations?
- How many other employees of the assessed health organization or officials in other organizations would have to look the other way for the scheme to succeed?
- Do existing internal procedures raise sufficient safeguards to deter those who would want to take advantage of this corruption risk?

When estimating the **impact** of a corruption risk occurring, the following factors could be considered:
- Factors that may impact the organization financially:
  - The cost of wasted resources.
  - The cost of conducting internal investigations.
- Factors that may impact the organization **reputationally**:
  - The harm to beneficiaries.
  - The impact on the quality of service delivery and health outcomes.
- Factors that may affect the ability of the organization to carry out its mandate:
  - The loss of organizational reputation.
  - The impact on the staff morale.
  - The impact on public trust.
There is no objective method exists for calculating the likelihood or potential impact of a corruption risk; however, the group can develop estimates based on their knowledge of the organization and the information made available to them. First, each identified risk should be rated for its likelihood and impact using a straightforward scale (high, medium and low, for example), after which the given likelihood and severity ratings for each risk can be plotted on a risk matrix as a single measure showing which risks are major risks requiring immediate attention and resources, and which risks are minor or moderate risks requiring no immediate attention or resource allocation due to their low likelihood, low impact severity, or both. The most straightforward technique for creating a risk matrix is to construct a three-by-three grid with the rows listing likelihood and the columns denoting the impact, as illustrated in Figure XIV.

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Impact Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Medium</td>
<td>Medium</td>
</tr>
<tr>
<td>High</td>
<td>High</td>
</tr>
</tbody>
</table>

Risks in the three upper right-hand cells would all be considered major risks, as the likelihood and impact are both high, or one factor is high and the other is medium. Similarly, if both the likelihood and impact are low, or one is low and the other is medium, the risk is considered minor. Those falling between the two are ranked moderate. By rating the likelihood and impact severity of each identified risk, the working group can ascertain which of their identified corruption risks should be prioritized and where limited resources may be best directed.

The example shown in Figure XIV above demonstrates how the working group can prioritize risks to use their financial and human resources most effectively when implementing any mitigation strategy. In the hypothetical example of the public hospital, when evaluating and prioritizing the risk of preferential treatment to patients that visit a doctor’s private practice, they assign the likelihood of this form of corruption occurring as high and determine the impact on the organization's reputation and mandate, if it occurred, would also be high. The combination of high/high would put that risk in the upper right-hand of the matrix and be rated as a major risk and prioritized accordingly.
A second risk identified is that staff may embezzle medicines and divert them to the black market. After analysing documents and checking existing safeguards during the risk analysis stage, the group concludes that the likelihood of this risk occurring is low and that if it did, the impact on the organization’s reputation and finances would also be low. The low/low combination puts the risk in the cell in the bottom left-hand corner, rating it as a minor risk.

A third risk is evaluated, absenteeism. A lack of oversight and attendance recording in the hospital means that the likelihood of this corruption risk occurring is high. However, after analysing attendance data, the working group concludes that the work of the staff most prone to be absent from work does not directly affect health outcomes (and therefore their mandate as a health-care provider), nor does it have a strong reputational impact. As a result, the potential impact severity is rated as low, and this high/low rating gives the risk a moderate rating.

While absenteeism and staff embezzling medicines may appear at first glance to be a significant issue, using the likelihood/impact matrix allows the working group to prioritize the risk not only according to the impact of the act, but also the likelihood that it will occur. The working group can now prioritize the assigning of resources to tackling preferential treatment given by doctors to patients that visit their private practice, while keeping the second and third risks to be dealt with at a later date. Table 3 below provides an example of how to record the findings of this step.

It should be noted that these ratings, although subjective, are not guesswork. The impact and likelihood severity ratings given by the working group should be justifiable and based on the evidence gathered in the risk analysis stage of the corruption risk assessment process, and the working group’s knowledge of the organization. Evidence that will enable the working group to accurately evaluate each risk may include past audits, interviews, reviews of current processes, analysis of patient data, patient or employee surveys, among others. Where such evidence or data is unavailable, the working group should ensure that preparations are in place for the required information to be available for future iterations of the risk assessment cycle.

Table 3 shows how each corruption risk can be accurately assessed and an overall rating be given, which can then be plotted on a risk matrix.
Table 3

<table>
<thead>
<tr>
<th>Organizational function</th>
<th>Corruption risk</th>
<th>Categorization</th>
<th>Impact</th>
<th>Likelihood</th>
<th>Overall rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procurement</td>
<td>Trading in influence to award procurement contracts for medical products to unsuitable suppliers.</td>
<td>Mandate</td>
<td>3</td>
<td>2</td>
<td>High –6</td>
</tr>
<tr>
<td></td>
<td>Inadequate monitoring of external service suppliers (e.g. security services).</td>
<td>Reputation</td>
<td>1</td>
<td>3</td>
<td>Medium –3</td>
</tr>
<tr>
<td>Human resources</td>
<td>Absenteeism</td>
<td>Mandate</td>
<td>1</td>
<td>3</td>
<td>Medium –3</td>
</tr>
<tr>
<td></td>
<td>Bribing officials to recruit less qualified individuals at the expense of more qualified candidates.</td>
<td>Mandate</td>
<td>3</td>
<td>3</td>
<td>High –9</td>
</tr>
<tr>
<td></td>
<td>Abusing of functions to allocate paid leave to friends.</td>
<td>Financial</td>
<td>1</td>
<td>3</td>
<td>Medium –3</td>
</tr>
<tr>
<td>Service delivery</td>
<td>Doctors provide preferential treatment to patients that visit their private practice.</td>
<td>Mandate</td>
<td>3</td>
<td>3</td>
<td>High –9</td>
</tr>
<tr>
<td>Asset management</td>
<td>Health officials embezzle medicine and medical supplies.</td>
<td>Financial</td>
<td>3</td>
<td>1</td>
<td>Low –1</td>
</tr>
</tbody>
</table>

4.2.5 Step 5: Risk Treatment

The next stage of the corruption risk management process is the treatment of the prioritized corruption risks through the creation and implementation of tailored risk mitigation strategies. These strategies, when put together, will form the organization’s corruption risk mitigation plan. Ideally, the plan should be incorporated into the organization’s operational and strategic workplans to ensure that enough funding and personnel are allocated for the implementation of the mitigation plan.

In this step, the working group defines the controls that the organization aims to strengthen or put in place to mitigate the prioritized corruption risks. Controls are the laws, policies, procedures, processes and management systems, etc., that aim to prevent, deter and/or detect improper actions. Robust controls will help reduce the risk of corruption to which the organization is exposed.
Any controls proposed by the working group should only be adopted after considering the cost and feasibility of their implementation; expensive and challenging measures can steal resources from other more feasible measures, and carry a lower chance of success. For example, major political or institutional reforms or changes in the nation's laws or its constitution may benefit the organization in question, but due to the vast amount of resources that such reforms would entail, the odds of achieving the sought-after reforms within a meaningful timescale are low. Therefore, recommending such challenging measures as part of the risk mitigation plan requires careful consideration.

Even mitigation measures that seem feasible should be costed and only adopted if the costs of their implementation can be covered by the organization and the damage that would result from the corruption risk occurring is greater than the cost of implementing the proposed risk mitigation measure. For example, assigning an official to perform unannounced visits to manufacturing facilities that operate with good manufacturing practices (GMPs) is a robust and worthwhile control. However, the organization must also consider transportation expenses, accommodation costs, a per diem, and the cost of their time away from existing duties. An organization with limited resources may find such costs prohibitive, and an alternative mitigation strategy may be more appropriate.

The mitigation strategies proposed by the working group must also be detailed enough for the organization's staff to implement effectively. This includes details on how the risk will be mitigated, what the indicators are for the mitigation to be deemed successful, what the timeframe is for completion, where exactly financial and human resources need to be deployed, and which position within the organization is responsible for the implementation of the key actions needed for the successful mitigation of the risk.

The process for developing mitigation strategies is described in detail below:

1. **Identify the underlying cause or causes**: The working group should first identify the underlying cause or causes of each of the prioritized corruption risks to determine which controls must be assessed and then analyse the extent to which those controls are effective, or if those controls are even in place. This is important as different underlying causes of corruption risks will require different mitigation strategies. For example, if the underlying cause of a corruption risk is determined to be lack of oversight, then the mitigation strategy will differ from risks whose underlying causes are determined to be a lack of clear procedures or low staff morale. If there is more than one underlying cause for an identified risk, care should be taken to treat each cause separately.

2. **Review existing controls**: The next step is to identify and determine the adequacy of existing controls for each underlying cause of the corruption risks. This, however, will not always be obvious, and in some cases controls will not yet exist. The working group will need to make judgments based on their experience and expertise, and refer to data such as the interviews with staff and other documentary evidence gathered during the context establishment (Step 1) and risk analysis stage (Step 3) stage of the process.
To determine the adequacy of controls, or to identify areas in which controls are lacking, the working group could follow the flow chart in Figure XV in an iterative fashion for each identified cause. The flow chart also highlights whether the required risk treatment should target processes or people; when controls are inadequate or non-existent, the mitigation strategy should focus on developing or refining processes, but when controls exist and are adequate but are not adhered to, the mitigation strategy should target people. Rigorously following this simple approach will prevent oversights when developing the mitigation strategies that will eventually form the organization’s corruption risk treatment plan.

3. **Strengthen or develop controls:** If the working group has found that an organization’s control for a specific corruption risk does not exist or is not adequate, the group will need to develop and implement the required controls or strengthen existing ones. A useful way to organize the thoughts of the working group is through a table listing each risk, the causes, the control or controls currently in place to mitigate it, a description of what risk remains, and the additional controls needed to mitigate the remaining risk, an example of which is provided in Table 4. In instances where no controls are in place and new procedures are enacted, the working group should communicate them to the organization’s staff in a timely and thorough manner.
<table>
<thead>
<tr>
<th>Corruption risk</th>
<th>Priority cause or causes</th>
<th>Existing controls</th>
<th>Remaining risk</th>
<th>Strengthen or develop controls (process / people)</th>
</tr>
</thead>
</table>
| Trading in influence to award procurement contracts for medical products to unsuitable suppliers. | Likelihood: Medium [3]  
Impact: High [3]  
Overall priority: High (9) | There is no supervision of the recruitment procedure results. | The recruiting procedure does not include reference to monitoring and evaluation of the results of new hires. | Process:  
Include supervision processes within the recruiting procedure.  
People:  
Periodically provide anti-corruption and ethics training to human resources staff. |
| Bribery officials to recruit less qualified individuals at the expense of more qualified candidates. | Likelihood: Medium [3]  
Impact: High [3]  
Overall priority: High (9) | There is a documented procedure for hiring staff. | The recruiting procedure does not include reference to monitoring and evaluation of the results of new hires. | Process:  
Include supervision processes within the recruiting procedure.  
People:  
Introduce a probation period for new hires with final evaluations carried out by trusted personnel.  
People:  
Periodically provide anti-corruption and ethics training to human resources staff. |
| Doctors provide preferential treatment to patients that visit their private practice. | Likelihood: Medium [3]  
Impact: High [3]  
Overall priority: High (9) | Doctors are not trained on how to manage conflict of interest and ethics. | The code of conduct does not make reference to conflict of interest.  
Doctors do not receive training on ethics and anti-corruption. | Process:  
Include reference to conflict of interests in the code of conduct.  
People:  
Periodically train doctors on ethics, anti-corruption and conflict of interest. |

**Table 4: Examples of assessing controls related to identified corruption risks**

- **Trading in influence to award procurement contracts for medical products to unsuitable suppliers.**
  - Likelihood: High (2)
  - Impact: High (3)
  - Overall priority: High (6)
  - Procurement processes are extremely complex and paper based. There is no transparency mechanism in the procurement process.
  - There is a documented medicine procurement procedure.
  - The procedure is paper-based, complex.
  - The procedure is not transparent and it is full of unnecessary steps.
  - Process: Implementation of an e-procurement system.
  - Process: Include a procurement section in the institutional website.

- **Bribery officials to recruit less qualified individuals at the expense of more qualified candidates.**
  - Likelihood: Medium (3)
  - Impact: High (3)
  - Overall priority: High (9)
  - There is no supervision of the recruitment procedure results.
  - There is a documented procedure for hiring staff.
  - Staff does not act according to the code of conduct.
  - Staff does not act ethically.
  - Process: Include supervision processes within the recruiting procedure.
  - People: Periodically provide anti-corruption and ethics training to human resources staff.

- **Doctors provide preferential treatment to patients that visit their private practice.**
  - Likelihood: Medium (3)
  - Impact: High (3)
  - Overall priority: High (9)
  - Doctors are not trained on how to manage conflict of interest and ethics.
  - There is a code of conduct in place.
  - The code of conduct does not make reference to conflict of interest.
  - People: Periodically train doctors on ethics, anti-corruption and conflict of interest.
In addition to the organization’s procedural controls, the working group may also consider reviewing staff policies that might create opportunities for corruption. For instance, the organization could have sufficient controls in place to mitigate the prioritized corruption risks, but if staff do not understand how to use and manage those controls, or are not motivated to follow internal procedures, the effectiveness of these controls will be significantly reduced. In this scenario, mitigation strategies might include recruitment screening to ensure that new recruits demonstrate integrity, requiring staff to make regular asset declarations, introducing specialized training, rotating staff to different positions or locations from time to time, or introducing mandatory leave during which another staff member is assigned to the role.

4. **Finalize and adopt the mitigation plan:** Before finalizing the plan, the working group should seek feedback from personnel and relevant stakeholders, and obtain the approval of senior management. The plan should clearly outline the strategies and actions that the organization will implement to mitigate the corruption risks identified and address their underlying causes, and the expected timelines and scope of each strategy, as illustrated in Table 5 below. The working group should also include mandatory reporting and oversight mechanisms into the mitigation plan timeline to ensure that the plan is delivered efficiently and in a timely manner.
### Table 5

<table>
<thead>
<tr>
<th>Corruption risk</th>
<th>Cause</th>
<th>Risk mitigation strategy</th>
<th>Verifiable indicator</th>
<th>Responsible</th>
<th>Resources</th>
<th>Timeline dd/mm/yy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trading in influence to award procurement contracts for medical products to unsuitable suppliers.</td>
<td>The procurement procedure is extremely complex and paper based.</td>
<td>Computerize and simplify procurement system.</td>
<td>New system implemented and compared against previous system</td>
<td>Director of Information Technology, Ministry of Health</td>
<td>Time to design of the process: 3 months</td>
<td>31/08/XXXX</td>
</tr>
<tr>
<td></td>
<td>There is no transparency mechanism in the procurement process.</td>
<td>Publicize procurement process in the institutional website.</td>
<td>Information on the process is available online.</td>
<td>Director of Information Technology</td>
<td>Staff time</td>
<td>30/09/XXXX</td>
</tr>
<tr>
<td>Bribing officials to recruit less qualified individuals at the expense of more qualified candidates.</td>
<td>There is no supervision of the recruitment procedure results.</td>
<td>Include supervision processes within the recruiting procedure.</td>
<td>Recruitment procedure has been revised and updated to include monitoring and supervision steps or processes.</td>
<td>Director of Human Resources</td>
<td>Time to review and update: 6 month</td>
<td>20/08/XXXX</td>
</tr>
<tr>
<td></td>
<td>Staff does not act ethically.</td>
<td>Periodically provide anti-corruption and ethics training to human resources staff.</td>
<td>Trainings provided</td>
<td>Director of Human Resources</td>
<td>Staff time to attend trainings</td>
<td>15/11/XXXX</td>
</tr>
<tr>
<td>Doctors provide preferential treatment to patients that visit their private practice.</td>
<td>Doctors are not trained on how to manage conflict of interest and ethics.</td>
<td>Include reference to conflict of interests in the code of conduct.</td>
<td>Code of conduct updated</td>
<td>Director of Human Resources</td>
<td>Staff time to update the code of conduct</td>
<td>06/02/XXXX</td>
</tr>
<tr>
<td></td>
<td>Periodically train doctors on ethics, anti-corruption and conflict of interest.</td>
<td>Trainings provided</td>
<td></td>
<td>Director of Human Resources</td>
<td>Financial resources to provide workshops: $5,000</td>
<td>12/07/XXXX</td>
</tr>
</tbody>
</table>
5. **Incorporate the plan into the organization’s operational and strategic workplans:** Incorporating the mitigation plan into the organization’s operational and strategic workplans, under the supervision of key personnel who are responsible for its success, will ensure that the organization commits sufficient time and funds to implement the corruption risk mitigation plan. This will ensure that funds are appropriately sourced and allocated, especially if resources are not immediately available, and that personnel with relevant skills are tasked with implementing the newly identified controls.

6. **Implement the plan:** Finally, once the plan has been approved, it should be implemented. The working group should decide how much of the plan to make public, and how much to maintain as an internal document. One consideration that the group should discuss when deciding the extent to which they will publicize the mitigation plan is that while it is good to make public the organization’s commitment to anti-corruption measures, publishing specific details of control processes could help people evade them and therefore be counterproductive. The plan should also be communicated to staff responsible for the implementation of the corruption risk mitigation strategies, in case they were not part of the working group. A launch meeting may be held in order to provide employees the chance to ask questions or provide their own feedback, and to reiterate to them that this is a future-focused preventative process and not an investigation into any impropriety on the part of the organization’s staff.

7. **Monitor and evaluate the implementation of the plan:** As demonstrated in Table 5 above, specific verifiable indicators should be developed for each risk and corresponding mitigation strategy to enable the health organization to monitor and evaluate whether each strategy has been successfully implemented and, if not, to adjust the mitigation plan accordingly. The mitigation strategies identified in the plan should be monitored in a systematic manner for effectiveness and, along with any outstanding or newly emerging corruption risks, should be fed back into the cycle of risk management, making adjustments to the process, infrastructure and capacity as necessary in preparation for the next iteration of the risk management cycle (see Figure XI).

Over time, this cycle can embed a culture of integrity within the organization and support them in the goal of achieving transparency and accountability in the management of public finances, as promoted by the United Nations Convention against Corruption.\(^{109,110}\)

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\(^{110}\) Annex B provides a summary table of the corruption risk management process.
Chapter 5

EXAMPLES OF CORRUPTION RISK MITIGATION STRATEGIES
Corruption risk mitigation strategies that consider the particular circumstances and constraints of the public health organization being assessed will have the highest chance of success in reducing the risk of corruption for that organization, enabling it to better carry out its mandate of providing, funding, or regulating health care. Therefore, it is important to ensure a thorough understanding of the specific corruption risks of the organization (through a corruption risk assessment or through other means), rather than simply resorting to generic strategies or strategies used by other countries or organizations.

A successful preventive approach to addressing corruption in the health system therefore requires:

- A solid understanding of the social, political and cultural environment in which a health organization operates.
- Coordination between a variety of interconnected actors and stakeholders within the health systems.
- An understanding of the health funding system in place.
- The presence of capable and knowledgeable managers and policymakers who have the ability to carry out the corruption risk assessment and implement the subsequent corruption risk mitigation strategies successfully.

Undertaking a corruption risk management process (as detailed in chapter 4 of this paper) can assist health organizations in the identification of vulnerabilities or gaps in legislation, regulatory frameworks, processes and procedures related to the fulfilment of their mandate. It can also assist them with the enforcement of rules and regulations by helping them develop strong and targeted mitigation strategies to address those vulnerabilities or gaps. A selection of mitigation strategies tailored to the health systems that organizations undergoing the corruption risk management process might like to consider adapting and adopting are presented below.

This list is not exhaustive, but instead aims to provide examples of strategies that have proven effective in certain contexts. They are divided into three groups:

- **Process-based**: Strategies that foster a preventive approach aimed at implementing or strengthening controls.

- **People-based**: Strategies that foster a preventive approach but focus on the people carrying out the process rather than on the process itself.

- **Enforcement-based**: Even with the best corruption risk mitigation plans, it is inevitable that some corruption will still occur. Enforcement-based strategies address the corrupt act after it has occurred.
5.1 Examples of Process-Based Risk Mitigation Strategies

- **Increasing transparency and accountability:** Efforts to improve transparency and accountability within the health system can include adopting open contracting in health-care procurement, which may entail publicizing of procurement data, publishing of rules and regulations, increased digitalization and real-time access to records across health agencies and even, where possible, legislative reform.111 Examples include:

  - Creating a centralized and secure document portal so that health workers can easily access patient information to deliver adequate treatment.
  - Making information about grants and donations publicly available.
  - Creating mechanisms for review, validation and verification of procurement data to ensure that it is complete and of a high-quality prior to publication.
  - Implementing other open contracting initiatives such as integrity pacts, e-procurement, open contracting data standards and monitoring red flags.112
  - Adopting measures to avoid conflict of interest in procurement processes, such as enhanced scrutiny of bidding entities and prominent public officials, and mandatory beneficial ownership declarations for all involved entities.
  - Promoting collection and publishing of beneficial ownership information or facilitating access to such information through registries or online systems based on adequate, accurate and up-to-date information.113
  - Engaging with other stakeholders such as the private sector, civil society and academia in the identification of risks related to public procurement and developing joint recommendations on how such risks can be mitigated.114
  - Ensuring that due diligence checks related to potential suppliers are carried out, including:
    - Verifying the legal status and type of organization of potential suppliers, including the jurisdiction of incorporation.
    - Identifying any issues related to beneficial ownership of potential partners.
    - Assessing and verifying the financial or organizational ownership structures of potential suppliers, and determining any conflict of interests.
    - Conducting a review of the potential supplier’s corruption-related track record, for example if there are any past incidents or debarment cases on record.
    - Evaluating the quality of any existing anti-corruption programmes carried out by the potential partner.

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111 For detailed guidance on strategies that can help governments improve their procurement practices across the full cycle of procurement, including quantifying needs, identifying suppliers, managing the tender and bidding process, ensuring the quality of medicines supplied, and monitoring the performance of contracts, see Open Contracting Partnership, Open Contracting for Medicines: A guide to reforming medicines procurement for better value and better patient outcomes (2023).

112 Open Contracting Partnership, “How does the OCDS work?”.

113 For more information on how to implement beneficial ownership transparency, including legal frameworks, the design of data collection systems and the publication of data, see Open Ownership, Guide to Implementing Beneficial Ownership Transparency (2021).

114 For an example of such efforts see the “On the Level: Business and Government against Corruption in Colombia” project on the UNODC Business Integrity Portal.
Improving access to information: Within health systems, access to information by citizens is vital so they can oversee government activity, promote accountability and provide external oversight of areas where abuses of power and other illegal activities may have been otherwise hidden. Often, even low-cost improvements that foster the disclosure of information and the ability of the public to access information can bring significant gains. Examples include:

- Launching a citizen oversight committee to supervise the distribution of vital medicine, vaccines, or treatments or including representatives from community-based organizations and civil society in relevant health decision-making processes through committees or other multi-stakeholder structures.
- Strengthening freedom of information legislation, for example by expanding the scope of information covered, limiting reasons for denying access, and ensuring short timelines and follow-up when requests for information are received so that citizens have access to budget, supplier and organizational data.
- Publishing up-to-date prices paid for medical products and services for the public to view, in order to mitigate opportunities for price gouging.
- Clarifying, in patient-friendly language, fees for services or any additional charges.

Simplifying processes: Policies, procedures and rules should be clear and easier to understand, and the number of steps required to access health services minimized. Overly complex procedures can be frustrating for users and therefore, may consequently create an opportunity for health-care workers to demand bribes from those requiring services from the authority to guide them through or quicken the process. Examples include:

- Implementing a centralized online appointment service.
- Making patient feedback easier to submit.
- Implementing an e-procurement system to replace overly complex paper-based systems.

In relation to implementing e-procurement systems effectively, more guidance on this topic can be found in the UNODC Guidebook on Anti-Corruption in Public Procurement and the Management of Public Finances,\textsuperscript{115} as well as the G20’s Principles for Promoting Integrity in Public Procurement.\textsuperscript{116} These guides both promote the use of electronic procurement and open data standards to enhance transparency and promote fair competition. Additionally, working groups seeking guidance on developing or implementing e-procurement systems may wish to refer to the series of resource guides produced by the Open Contracting Partnership, which includes a good practice guide on the types of information and data that should be shared in health-specific cases.

\textsuperscript{115} UNODC, Guidebook on anti-corruption in public procurement and the management of public finances: Good practices in ensuring compliance with article 9 of the United Nations Convention against Corruption (Vienna, 2013).

\textsuperscript{116} UNODC, “G20 Principles for Promoting Integrity in Public Procurement”, 2015 Turkey G20 (2015).
Examples of corruption risk mitigation strategies: Steps to increase the use of technology and databases can help make information available consistently, can improve efficiency in service delivery, and can serve as a key tool in promoting transparency and preventing corruption. Technology alone cannot reduce corruption, but in tandem with other strategies, it can be an effective tool. Examples include:

- Using technology to reduce the time for audit reports to be finalized, and ensure follow-up on the findings.
- Storing sensitive medical data and other confidential information safely.
- Digitally storing data related to medicine and medication distribution to remove opportunities for unjustified prescriptions of medicine or treatments, and to facilitate monitoring of the organization’s compliance with health service standards and regulations.
- Moving from a paper-based closed-tender procurement system to an e-procurement system where details of bids and bidders are automatically published on the health agency’s website after the contract has been awarded.

Strengthening reporting mechanisms: Patients are often the ones who will witness or experience acts of corruption and their negative effects. However, such incidents are rarely reported because patients do not always know how and where to report them. Additionally, if they do know how and where to report incidences of corruption, they may instead be fearful of having their access to health services denied or of their complaint being ignored. Front-line health workers are also frequent witnesses to acts of corruption, and should also be able to report these without fear of the consequences. However, the fear of retaliation and victimization can prevent them from reporting colleagues or managers for their acts of corruption. The use of technology is increasingly playing an instrumental role in facilitating citizen and health workers reporting of corrupt acts, and these technologies can be incorporated into mitigation strategies. Examples include:

- Creating or strengthening institutional whistle-blower policies. More guidance on this topic can be found in the UNODC document *Speak Up for Health! Guidelines to Enable Whistle-Blower Protection in the Health-Care Sector.*
- Introducing gender-sensitive whistle-blower reporting and protection systems. Such initiatives have been shown to be of greater importance to female than to male whistle-blowers, as women are generally more fearful than their male counterparts of reporting corruption due to a lack of protection from reprisals and low confidence that reports will be treated confidentially.

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117 See Open Contracting Partnership, *Open Contracting for the COVID-19 Vaccine: A good practice guide* (2021) and “Best practices for developing open contracting data portals (with examples)”.  
- Developing websites and smartphone applications that enable citizens to report incidents of corruption easily and anonymously.\(^{120}\)
- Publishing citizen report cards of health systems.
- Gathering, and where pertinent publishing, information on identified conflicts of interest.

**Addressing conflict of interest issues:** Conflicts of interest create an environment in which public systems can be manipulated for personal gain, and decisions resulting from conflicts of interest that redirect public resources or services unfairly can have a devastating impact on patient outcomes. Examples of mitigation strategies include:

- Introducing or enforcing mandatory interest declarations for all employees above a certain rank, and a system for their verification.
- Administering a strict enforcement and sanctioning regime for non-compliance with interest declaration requirements.
- Publishing of guidelines for managing conflicts of interest with clear definitions of key terms such as interested persons, permitted and non-permitted relationships, financial interest, etc.
- Carrying out research into the impact of conflicts of interest on health service delivery to provide a more substantial evidence-based policy design and implementation.

**Utilizing indicators for service delivery:** To reduce corruption risks, service delivery indicators should be included in any performance contracts (e.g., service delivery outputs) with external organizations. Examples include:

- Incorporating indicators into procurement contracts to, for instance, prevent counterfeit items such as medicine or medical equipment and devices from reaching patients.
- Tracking the variation between the proposed budget for a service contract and the actual end-cost, in order to identify potential corruption risk areas.
- Publishing data on the numbers of marginalized and vulnerable groups that have accessed treatment through the service provider.
- Publishing indicators for absenteeism, reported wastage, patient feedback, etc.
- Develop and monitor Key Performance Indicators (KPIs) before payments.

**Coordinating with other sectors and stakeholders:** Linkages should be made with strategies adopted by other relevant sectors that intersect with the health system, such as finance or customs. Examples include:

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- Engaging in collective action with other key stakeholders (such as public sector organizations, private businesses, academia, and civil society) to jointly strengthen integrity in the health system.\textsuperscript{121}
- Developing an inter-agency forum for coordination and sharing of best practice.

Some countries have formalized inter-agency communication through, for instance, the initiation of an anti-corruption policy coordination body (as implemented in South Korea) or creating ministerial roles such as the State Minister for Reform Coordination charged with coordination of anti-corruption policies between public bodies (as implemented in Georgia).\textsuperscript{122}

- **Ensuring that there are sufficient checks and balances:** When functions of the health system are decentralized or handed over to the private sector, oversight, transparency, and monitoring mechanisms must be in place.\textsuperscript{123} Checks and balances may include:
  - Patient survey on quality of services received.
  - Periodic unannounced visits by public officials.

Additionally, there should also be adequate checks and balances in place to ensure that public bodies carry out their mandates, especially if oversight of those entities is difficult (for example, a remote rural public hospital). Checks and balances may include:

  - Periodic unannounced visits by regulators.
  - Creation of an independent public Ombudsman service to handle complaints.

### 5.2 Examples of People-Based Risk Mitigation Strategies

- **Creating and disseminating codes of conduct:** Codes of conduct are essential integrity instruments that inform officials that corrupt behaviour will not be tolerated. A code of conduct also ensures staff is informed of the values and professional standards expected from them. Training on the code of conduct should be provided, and should include information on why codes of conduct matter and how to uphold them in a given health-care setting.

- **Training on corruption risks in the health system for health staff:** Health-care personnel need to be educated on the corruption risks that may be found within a

\textsuperscript{121} See for instance, the Global Network for Anti-corruption, Transparency and Accountability in Health (GNACTA) and the database of Collective Action initiatives worldwide, "Collective Action: B20 Hub".
\textsuperscript{122} Marie Chêne, "Coordination methods of Anti-Corruption institutions", U4 Expert Answers (2009).
\textsuperscript{123} United Nations, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 14 July 2017 (A/72/137).
health system, how to recognize them, and what to do if they are observed. Such training could include, for example, behavioural insight training or ethical dilemma training.

- **Strengthening human resources management**: Removing opportunities for corruption at all stages of the employment process, from recruitment to retirement, will allow patients to receive better health-care services, and will ensure that human resources systems are transparent, systematic, efficient and based on objective criteria such as merit, equity and aptitude. Examples include:
  
  - Introducing frequent unannounced audits to check for ghost workers and absenteeism.
  - Requiring regular asset declarations for staff with access to finances and accounts, or who are in a position to seek payment for assigning jobs.
  - Introducing rotation systems for managers to limit the opportunity for officials to create corrupt networks in lucrative posts such as customs or border inspections.\(^\text{124}\)

- **Corruption risk education for health professionals**: It is often administrators, human resources and finance-related employees within health systems who are the focus of anti-corruption training; however, doctors, nurses and pharmacists should also be educated on the corruption risks within health systems starting from the earliest point in their training. Such education should include recognizing corruption risks and what to do if and when they encounter them. Examples include:
  
  - Mainstreaming anti-corruption training and education modules into health professional curricula as early as possible.
  - Introducing mandatory behavioural insight training and ethical dilemma modules into the health training curriculum.
  - Prioritizing the integrity of academic medicine over economic interests. The integrity and independence of medical research is key for the realization of the right to health, and medical professionals should be trained on the conflicts of interest that can arise if economic interests are allowed to take precedence over the quest to further medical knowledge.\(^\text{125}\)

### 5.3 Examples of Enforcement-Based Risk Mitigation Strategies

- **Instituting internal disciplinary procedures**: Any staff member who is found to have engaged in corruption should face visible disciplinary action, and these procedures

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\(^{125}\) United Nations, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 14 July 2017 (A/72/137).
must be meaningful in order to act as a deterrent for others. Disciplinary procedures should be clearly explained, including the escalation of actions that may be taken (for example a written warning for first offences, or dismissal and prosecution for major corruption), and should be easily accessible for staff to view.

- **Developing effective internal corruption investigation and resolution processes:** These are crucial in deterring, reporting and resolving corruption cases, and increasing health-care providers’ and patients’ confidence that their reports will be investigated. All internal investigations should be carried out in a transparent and objective manner, and management should take steps to ensure that investigations are not used as a tool to pressure or intimidate others within the organization. Examples include:
  
  - Ensuring that a comprehensive internal investigation policy is developed, and that all staff members are trained in the policy and how it impacts their roles, responsibilities and rights.
  - Establishing effective communication channels with law enforcement authorities, so that cases where internal investigations conclude that a crime might have taken place can efficiently transferred to the appropriate law enforcement authorities for further action.
  - Putting into place procedural safeguards to guarantee that the actions of internal disciplinary bodies are free from internal or external influence, as well as from any form of conflict of interest.\(^\text{126}\)
  - Ensure that safeguards are in place to protect whistle-blowers.

- **Communicating enforcement outcomes:** Publishing or otherwise communicating the results of internal disciplinary measures or external law enforcement activities can act as a deterrent to potential perpetrators, who may reconsider their course of action if they see adverse consequences as a real and likely prospect. Steps to take in this regard may be:
  
  - Publishing statistical data on the enforcement of integrity standards in order to provide insights into key risk areas.\(^\text{127}\)
  - Creating a public-relations team to work with local and national media to publicize successful anti-corruption enforcement cases.

The opposite is also true, in that alongside publishing successful corruption investigations, disciplinary measures, or prosecutions, resources can also be directed towards publicising and rewarding the actions of employees who demonstrate integrity as they carry out their duties. Ensuring that positive role models are publicly celebrated is as vital to the achievement of an organization’s anti-corruption goals as ensuring that wrongdoing is publicly shamed.

\(^\text{127}\) Ibid.
CONCLUSION
Corruption is one of the most potent threats to a population’s right to health, and its presence can threaten the effectiveness and sustainability of health-care systems worldwide. Corruption in health systems can take many forms and be present at all levels, from the smallest bribes paid by patients to physicians, to the multi-million dollar scandals which have taken place in hospitals, health ministries, and even entire governments. Certain characteristics of health systems make them particularly susceptible to corruption, from the complex network of relationships among actors within the health-care system to the high levels of public funding involved, the power imbalances among actors, and the information asymmetries that exist between providers and patients.

These characteristics require those seeking to reduce the impact of corruption on their organization to develop a comprehensive understanding of the network of actors involved in the health system, their roles, and the relationships between them. Only when this context is understood can the effective identification and mitigation of corruption risks take place. Further, the specific role of every actor will be determined by the national health funding model in place.

Public actors in the health system can more efficiently use their limited resources to prevent and mitigate corruption if they implement a structured corruption risk assessment and management process. This paper recommends a corruption risk management process based on the ISO 31000:2008 guidelines as a tool to recognize and prevent corruption in health systems. Implementing this process can allow organizations to identify where corruption is most likely to cause the greatest damage, and then use that knowledge to focus resources on implementing realistic measures that reduce the risk of those corruption schemes occurring. In this way, organizations can effectively address the most likely or most damaging threats to their financial integrity, their reputation and their ability to achieve their mandate.

Successful implementation of a corruption risk mitigation process relies on the working group created by the organization to first establish the internal and external context in which it operates (Step 1). This underpins the subsequent corruption risk assessment, in which corruption risks are identified (Step 2), analysed (Step 3) and evaluated (Step 4). During the evaluation step, risks are prioritized through an estimation of their potential impact severity and likelihood, and then plotted on a risk matrix to ascertain which risks pose the greatest threat to the organization and therefore should be allocated resources first. Finally, a set of corruption risk mitigation strategies are devised (Step 5), with the feasibility of each strategy assessed against the resources and operating context of the organization to ensure that the resulting risk mitigation plan is within the control and means of the actor.

This paper provides several examples of corruption risk mitigation strategies. It encourages actors in the health system seeking to implement a successful corruption risk management process to use the provided examples as a starting point upon which they can build a tailored set of strategies unique to their organization’s needs. The strategies chosen by the working group should be informed by an understanding of the unique characteristics of their health system and the operating context in which they exist.

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128 United Nations, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 14 July 2017 (A/72/137).
CONCLUSION

group will fall into three broad categories; process-based preventive measures that increase transparency, improve patient and public access to information, strengthen reporting mechanisms and procurement procedures, address conflict of interest issues and foster coordination among actors, among others; people-based measures such as developing and disseminating codes of conduct, raising awareness and providing regular anti-corruption training to staff, or cultivating anti-corruption education within health-related curricula, and; enforcement-based mitigation measures to deter corrupt behaviour such as the implementation of internal disciplinary procedures or the development of effective internal corruption investigation and resolution processes.

Perhaps the most important point to note in relation to the corruption risk management process is that it is dynamic. As risks can diminish or increase over time, or be impacted by the treatments designed to mitigate them, it is recommended that this process be repeated at regular intervals, with the findings and results from previous iterations feeding into the planning for the next. This ensures that the corruption risk mitigation plan is dynamic and responds to the findings of each review cycle.

Furthermore, as organizations carry out successive cycles of the risk management process, the values of transparency and accountability can begin to embed themselves within the culture of the organization. By demonstrating their commitment to the management of corruption risks, actors within the health-care system can strengthen integrity and build their capacity to respond to the corruption that continually undermines the delivery of vital health services.

Member States are encouraged to actively promote the use of this paper among their relevant national agencies. Further, the authors welcome any comments related to the contents of this paper, and hope that the information contained in this document will stimulate and encourage discussion of this important topic.
ANNEXES
Annex A: Overview of Corruption Risks Between Health-Care Actors

Figure A1 below provides an overview of some of the various corruption risks between core actors in a health-care system, as described throughout chapter 2. It is important to note that the examples of potential corruption risks provided in this figure is not an exhaustive list; rather, they are provided to illustrate some key ways in which opportunities for corruption may present themselves.

It is also important to recognize, when using this figure, that:

- The Funding Model utilized by specific health systems will determine the interactions between players.
- Conflicts of interest exist as a corruption risk between all actors.
- All corruption risks are influenced by the prevailing social, political and cultural context.
Example opportunities for corruption between actors in a health-care system

Annex B: Summary of the Corruption Risk Management Process

Table B1 below provides a step-by-step summary of how to identify corruption risks and mitigate them. This table is based on the UNODC document *State of Integrity: A Guide on Conducting Corruption Risk Assessments in Public Organizations*.

| Table B1 |
|------------------|---------------------------------------------------------------|
| **A summary of the corruption risk management process** |
| **STEP 1 – Establish the context** |
| **Objective:** | All group members have a common, accurate understanding of the environment in which the organization operates and what powers it has to affect it. |
| **How?** |
| - Analyse the factors that define the mandate of the organization, including legal, regulatory, financial, technological aspects. |
| - Use analytical tools to establish the context, identify actors and processes in the organization. Analysis of the organizational functions and stakeholders is recommended. |
| **STEP 2 – Risk Identification** |
| **Objective:** | Identify and create a list of corruption risks to which the organization is or might be exposed. |
| **How?** |
| - Brainstorm, freely exchange ideas about possible corruption risks. Include potential future risks. |
| - Review existing documents and processes to identify possible opportunities for corruption. |
| **STEP 3 – Risk analysis** |
| **Objective:** | Establish the nature, impact and characteristics that the identified corruption risks have on the organization. |
| **How?** |
| - Interview staff, examine internal documents (e.g., past audit reports, investigations, accounting or procurement records), or review existing corruption control measures. |
| - Analyse if the impact of corruption risks is financial, reputational or if it affects the institutional mandate. |
**STEP 4 – Risk Evaluation**

**Objective:**
Determine which corruption risks will be prioritized in the mitigation plan.

**How?**
- Estimate the likelihood of risks occurrence and their potential impact.
- Rate their likelihood and impact. Descriptive words such as ‘low’, ‘medium’ or ‘high’ can be used.
- Prioritize the risk by determining which ones are more likely to occur and pose the most serious threat to the organization if they were to occur.

**STEP 5 – Risk Treatment**

**Objective:**
Develop a corruption risk mitigation plan.

**How?**
- Identify the causes driving the prioritized corruption risks.
- Review existing controls (such as laws, processes, procedures, rules and measures) that aim to prevent and detect corruption as they link to the identified causes of the risks.
- Develop mitigation strategies by analysing and determining whether the controls in place need to be strengthen or if new control should be developed.
- Propose mitigation strategies that are affordable and feasible.
- Allocate resources, responsibilities and timeframes.
- Once implemented, the efficacy of each mitigation strategy should be monitored and evaluated.
- The corruption risk mitigation plan should then be adjusted, taking into account the findings of the evaluation, in order to inform the next cycle of the process.