

Corruption in the Health Sector in South Africa and India

Some Considerations and Reflections

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ABSTRACT

The article is an integral part of a comprehensive comparative empirical study on corruption in the BRICS countries (Brazil, Russia, India, China and South Africa). The article begins with the context and parameters of the research identifying a number of core concepts associated with the phenomenon. The anti-corruption legislation in the two aforementioned countries is presented next with South Africa seemingly introducing a diverse range of anti-corruption laws, rules and regulations that tackle almost all aspects of the phenomenon in comparison to India. A number of the most significant laws and instruments relevant in the fight against corruption in the healthcare sector is briefly analysed. The methodology followed in the study combined diverse empirical approaches, such as primary documentary research released by the South African and Indian Treasuries and the Auditor-General authorities, unstructured interviews with researchers, experts and government officials in both countries as well as content analysis of the print media. The data analysis provided the realities of fraud, corruption and collusion, its types and reasons for perpetration in a comparative perspective. The key differences between the two as revealed by the findings is that while in India the rampant corruption is more evident in the private sector, the opposite is true for South Africa. A number of explanations based on the empirical findings are advanced.

Keywords: *corruption; private sector; public sector; health care; South Africa; India*



ABBREVIATIONS

- **ACCC** (Anti-Corruption Coordinating Committee)
- **AU** (African Union)
- **BMJ** (British Medical Journal)
- **FDI** (Financial Disclosure Framework)
- **FICA** (Financial Intelligence Centre Act)
- **NACF** (Asset Forfeiture Unit, National Anti-Corruption Forum)
- **NPA** (National Prosecuting Authority)
- **OECD** (Organisation for Economic Co-operation and Development)
- **PAIA** (Promotion of Access to Information Act)
- **PAJA** (Promotion of Administrative Justice Act)
- **PDA** (Protected Disclosure Act)
- **POCA** (Prevention of Organised Crime Act)
- **PRECCA** (Prevention and Combating of Corrupt Activities Act)
- **SADC** (Southern African Development Community)
- **SCM** (Supply Chain Management)
- **SIU** (Special Investigating Unit)
- **UNCAC** (United Nations Convention against Corruption)
- **UNDP** (United Nations Development Program)
- **WHO** (World Health Organisation)

INTRODUCTION AND CONTEXT

It can be understood that there are many human, organisational, and political reasons that contribute towards corruption in the health sector such as the lack of financial accountability in the organisational structures and its effects on good governance, personal greed, imbalances in power relations in the administrative/political power in the public sector including salary imbalances (Vian 2008:84–85). In the public and private sectors including the health sector institutions, middle and lower salary groups, petty corruption is used as a ‘cope mechanism’ / “survival corruption” (Woods and Mantzaris 2012).

In all instances, the multiplicity of types depend on diverse circumstances, settings and rationalisations. All these dimensions need to be examined and analysed if corruption is to be fought effectively, efficiently and decisively. In such situations fraud and abuse is the rule (European Commission 2013:4–5).

The health sector, especially has been faced with the corruption conundrum because massive sums of public funds, especially in low and middle income countries, find their

way into the pockets of a wide range of corrupt politicians, administrators, private and public health providers and professionals, suppliers and other service providers. It is a very vulnerable sector (Samuel & Frisancho 2015:126–127). Internationally, the situation with corruption in the health sector is replete with ‘grey areas’, but scientific calculations have provided certain knowledge which point towards the immensity of the phenomenon. In the USA, for example, the country’s Attorney-General asserted that corruption in the health sectors is the “number 2 crime problem in America”, after violent crime (UNDP 2011:44). In Russia, estimations have revealed that 56% of the health expenditure takes place through informal payments. Several years ago, the World Health Organisation calculated that 7.29% of global health (or approximately USD 415 billion) is lost to fraud each year (European Commission 2013:17). Such calculations highlight the fact that the performance of the health system of a particular country is negatively affected and is instrumental in increasing existing inequities. This reality makes the study, analysis and dissection of corrupt practices and processes key in the fight against the phenomenon.

This fight is directly and indirectly related to comprehensive legislation, strong and independent judiciary, legitimate politics, solid and honest communication channels between politicians and the entire population and independent, accountable and well-trained anti-corruption agencies that is instrumental in producing better health outcomes (De Jaegere and Finley 2009:14–15; Knox 2009:119).

Corruption in health care affects general life expectation, infant mortality and especially under-five mortality rate negatively. Corruption in the health sector is directly related to lower levels of health expenditure in the gross domestic product, and poor health outcomes (Vian 2008:87). There is a wide category of corrupt practices in the health sector such as theft, bribes, bureaucratic corruption and misinformation, supply chain and procurement related purchases including pharmaceuticals, medicine distribution, services provisions by medical personnel and other health workers, quality regulation in services, facilities and product, for example, interaction between patients and health professionals, tax payers and hospitals, and hospitals and suppliers (Barr *et al.* 2009:226–227).

Having briefly looked at the general depiction of corruption in the health sector, a discussion of both legislation and anti-corruption agencies in South Africa and India follows.

LEGISLATION AND ANTI-CORRUPTION AGENCIES IN SOUTH AFRICA

South Africa’s first democratic Constitution adopted in 1996 based its powerful preamble on the promise of improving the quality of life of all citizens and to free the



potential of each person. This preamble was supplemented by Section 27 of the Bill of Rights of the Constitution that affirms the promise that everyone has the right to have access to health care services, including reproductive health care. The same section dictates that the State takes legislative and regulatory steps to realise the progressive realisation of this right. These fundamentals were supplemented with the promulgation of the National Health Act in 2004 that set up a number of parameters and frameworks of a uniform health system.

As corruption expanded since the dawn of democracy in 1994, the country's government has introduced a plethora of anti-corruption laws, rules and regulations that tackle almost all aspects of corruption. The government is a signatory of the United Nations Convention against Corruption (UNCAC), Southern African Development Community (SADC) Protocol against Corruption, African Union (AU) Convention on Preventing and Combating Corruption, and the OECD Convention on Bribery of Foreign Public Officials in International Business Transactions.

There has also been the promulgation of key laws such as the Prevention and Combating of Corrupt Activities Act, 12 of 2004 (PRECCA), Promotion of Administrative Justice Act, 3 of 2000 (PAJA), Protected Disclosure Act, 26 of 2000 (PDA) or The Whistle-blowing Act, Promotion of Access to Information Act, 2 of 2000 (PAIA), Financial Intelligence Centre Act, 38 of 2001 (FICA), Prevention of Organised Crime Act, 121 of 1998 (POCA), International laws and the laws of Revised Public Service Integrity Management Framework, Public Service Anti-Corruption Strategy, Public Service Charter, Charter for the Public Service in Africa (5 February 2001), Public Services Act, Proclamation 103 of 1994 and Local Government: Municipal Finance Management Act, 56 of 2003.

A significant number of rules and regulations as well as official initiatives against corruption include the Code of Conduct for the Public Service, Code of Good Conduct for Supply Chain Management Practitioners, Financial Disclosure Framework (FDF), Asset Register for Accounting Officers, Financial Intelligence Centre, South African Police, Anti-Corruption Task Team, Multi-Agency Working Group on Procurement, Special Investigating Unit (SIU), National Prosecuting Authority (NPA), Specialised Commercial Crimes Courts, Asset Forfeiture Unit, National Anti-Corruption Forum (NACF), Inter-Ministerial Committee on Auditor-General, Public Service Commission, Government Departments, Public Protector, National public service anti-corruption hotline system (0800 701 701), Anti-Corruption Coordinating Committee (ACCC) and the Public Service Anti-Corruption Forum (Woods and Mantzaris 2012).

Amongst these laws, there are significant anti-corruption innovations in a number of laws such as the Companies Act designed to intervene and impact on the fight against the

phenomenon both in the private sector as well as in respect of supply chain and procurement fraud, collusion, nepotism and political interference. These are planned to stop the proliferation of political and senior administrator's interference in awarding tenders to businessmen close to the ruling party. (Mantzaris 2014a: 68–69; Mantzaris 2014b: 80–81).

Several of the newly introduced measures have followed the guidelines and recommendations of the OECD in respect of the implementation of well-planned anti-corruption initiatives and procedures, to aspire to corrupt activities. Thus, the South African health care companies in the private sector as well as public entities are legally obligated to comply with the anti-corruption provisions of the Companies Act, (71/2008) and a series of regulations promulgated in 2011 including a number of other local anti-corruption laws, which include the Prevention of Combating of Corrupt Activities Act (12/2004) and the Financial Intelligence Centre Act (38/ 2001). These regulations apply to all state organisations, listed public companies and companies that have in two of the previous five years scored more than 500 points in relation to Regulation 26(2). The score is based on the calculations as follows: one point per average employee number; one point per every R1 million in third-party liability; one point for every R1 million in turnover; one point for every person with direct/indirect beneficial interest in issued securities; and for non-profit organisations, one point per member or per association that is a member (Woods and Mantzaris 2012).

On the other hand, despite having been promulgated more than a decade ago, the Prevention and Combating of Corrupt Activities Act (12/2004), is harsh on gratification, one of the more common corrupt acts in the South African healthcare sector as well bribery that is classified as clear criminal acts. The Act is comprehensive and classifies a wide array of acts as corrupt and criminal, including those implicating South African and foreign government officials based in South Africa. It also addresses corruption in supply chain and procurement violations, public contracts, suppliers and agents, politicians, administrators, members of the judiciary, sports events and games of chance.

There are harsh penalties for convicted corrupt individuals, including long periods in prison as well as substantial financial penalties for companies implicated in anti-competitive collusion, bribes, gratification and other offences.

LEGISLATION AND ANTI-CORRUPTION AGENCIES IN INDIA

In India, the principal anti-corruption law is the Prevention of Corruption Act of 1988 that penalises corrupt acts by public servants related to illegal gratification, bribes and fraud.



The Penal Code covers fraud and bribery issues and fraud matters, including those committed in the private sector. The Companies Act of 2013 includes a number of corporate governance provisions such as 'fraud' and bribery that is punished through increased penalties, introduction of anti-corruption mechanisms and audit committees including increased responsibilities for independent directors (Business Anti-Corruption Portal 2016).

The Whistle-blowers' Protection Act of 2011 protects whistle blowers from corruption, while the Lokpal and Lokayuktas Act 2013 has created the offices of the Nodal Ombudsman for the central and state governments. The bodies investigate and adjudicate corruption in India.

The Foreign Contribution (Regulation) Act 2010 has been promulgated to regulate the acceptance and use of foreign contributions by corporations and individuals. All such contributions need the approval of the Ministry of Home Affairs. Instances within which this is not done, such contributions are deemed illegal (Business Anti-Corruption Portal 2016). The Prevention of Money Laundering Act 2002 sets the legal parameters against money laundering and carries strict penalties for violation of its provisions, including imprisonment of up to a decade including the attachment or confiscation of property. India has signed the United Nations Convention against Corruption as ratified in 2011. It is also a member of the G20 Anti-corruption Action Group.

RESEARCH METHODS

The methodology followed was based on a mixed-methods approach that included primary research of documents released by the South African and Indian Treasuries and Auditor- General Authorities, unstructured interviews with researchers, experts and government officials in both countries as well as content analysis of the print media. The research was conducted in a triangular manner in that it combined a number of methodologies, methods and data collection techniques.

During the duration of the research, it was ensured that the participants from non-governmental organisations, the private sector, government, and academia possessed adequate knowledge and expertise of the countries' health care sector. This type of sampling selection method is referred to as the 'judgemental' type. The interviews with these groups that took place in their respective countries covered corruption in general, different types thereof including extensive organisational, sociological and politically motivated issues.

The interviews were wide ranging and included processes to detect prevention of corruption; instances of personal experiences of gratification including the involvement of private sector suppliers; administrators or politicians; supply chain and procurement mismanagement leading to corruption and the repercussions in the delivery of health-care. The data was coded and categorised after transcription according to the identified themes and commonalities. The content analysis of print media concentrated on the core issue of the research, that is, the health care terrain searching for a wide variety of concepts such as 'political corruption', 'administrative corruption', 'fraud', 'gratification', 'suppliers' legal persons' and the 'private sector'. The key words being 'health' and 'healthcare'.

The research utilised a wide range of variables including private and public sectors, provinces or regions, type of facility/establishments, type of actors involved (businesses, administrators, politicians, companies, medical staff, and healthcare staff).

FINDINGS

The findings are presented below.

India

The country's expenditure on healthcare 2016 was 1.3 per cent of the GDP which was much lower than that of South Africa and this represented both the central and state governments combined. This implied that the shortage of more than 3 000 doctors at primary health care centres in rural areas would remain unchanged (Budget in Parliament 2017). Such statistics become abysmal when dissecting the findings of the present research that revealed health care as the most corrupt service sector in India throughout the years (Interview with researcher from Centre for the Study of Law and Governance, Jawaharlal Nehru University, 20 November 2015).

The key findings are summarised as follows:

There has been an intense debate for years that one of the root causes of corruption lies in the fact that the country's health terrain is possibly the most reliant on the private sector in the world and very expensive for the entire population, more so the poor, including the over 800 million of the so called 'underclass' (Dutta 2012). Health care in the private sector can be described as highly advanced for those who can afford it but no access to the poor and the lower middle classes (Jilani *et al.* 2009:130–132; Bagcchi 2009).



This reality is exacerbated by corruption at all levels.

The doctor-patient relationship: India's doctors and hospitals operate openly in a clandestine way in a cycle of 'referrals and kickbacks' that line their pockets and alienates their patients (Interview with researcher Centre for the Study of Law and Governance, Jawaharlal Nehru University, 20/11/2015)

The doctor-pharmaceutical collusion conundrum: The rampant corruption in the pharmaceutical industry operates through medical doctors' collusion and bribery to prescribe particular drugs. Such corrupt practices are also evident in the direct collaboration between pharmaceuticals and hospital senior managers who collude in signing contracts prescribing specific medicines (Interview with senior researcher Jindal University 19/11/2015).

The pharmacist-patient relationship: The reported restraint and lack of trust of middle class and poor people by medical doctors in the private and public sectors has resulted in large numbers turning to pharmacists. The end result is that scores of pharmacy clients are sold inappropriate drugs over the counter at highly inflated prices (Dutta 2012).

Corruption in medical schools: Despite widespread poverty, there is a proliferation of private medical schools throughout the country that offer postgraduate training schemes at exorbitant fees that place students in profound personal and family debts and obligation (D'Silva 2015). These realities force them directly into the private sector, thus neglecting rural health for immediate and generous private profit through corruption (*Times of India* 2012). This is the only avenue out of poverty and 'return on investment'. As it is almost impossible to get into government colleges, private colleges ask for once-off "capitation fees", which are illegal and may exceed Rs10m (£100 000; ₹30 000; \$150 000) (IBN Live 2013).

Facing these corruption challenges, the government has introduced the Uniform Code of Pharmaceutical Marketing Practices that bans pharmaceutical companies from offering doctors gifts, expensive cars and overseas trips and vacations (BMJ 2014). In the public sector, corruption has been so severe that the embezzlement of hundreds of millions of Rupees has in at least four states, especially Uttar Pradesh, on how the organised looting of government funds, has crippled the National Rural Health Mission (NRHM). The NRHM is a central State initiative launched in 2005 aspiring to improve the health of India's downtrodden poorest citizens specialising in 18 states with weak public health indicators or infrastructure. Its key objectives have been to reduce the infant mortality rate and maternal mortality ratio (Dutta 2014). The country's Central

Bureau of Investigation (CBI) has revealed that \$2bn allotted to Uttar Pradesh was siphoned by successive state governments through corruption and never reached the people whom it targeted. Corruption has also all but obliterated the Indian drug regulator, the Central Drugs Standard Control Organization (CDSCO) that has been known to champion a wide range of vested interests because of its involvement in a web of corrupt systems and processes within the public and the private sectors (BMJ 2014).

The dominance of the private sector has led to a relentless cycle of corruption such as faulty drug prescriptions, sink test and kickbacks for referrals for doctors. The proliferation of the so-called 'public-private partnership' (PPP) is perceived as an escape to mediocrity and corruption but lead to a complete commodification of healthcare, leading to a deterioration of the public health terrain (Economic Times 2014).

Recently these realities have made world headlines in the international press, newspapers and magazines such as the *New York Times* and the *Wall Street Journal* including a wide variety of printed and electronic media (*Times of India* 2015). One of the key issues that point to the root cause of corruption has been the complete dominance of a vast privatised healthcare system that 'pushed 39 million people into poverty every year from medical expenses' (*The Hindu* 2010). The unregulated nature of the system, legal weaknesses and gaps and the fact that the corrupt elements are very rarely punished was presented as key elements of the perpetuation of corruption (BMJ 2014).

The newspaper content analysis in respect of the public sector revealed that corruption was described or perceived as the foundation of the lack of access to medicines (45%), shortage of other basic healthcare facilities for poor patients and shoddy conditions at hospitals and clinics (24%), unqualified and inefficient doctors (18%), spread of and no control of infectious diseases (8%), and incomplete treatment of patients (5%).

In terms of the private sector, corruption was covered in respect of healthcare professionals (primarily doctors) in unethical practices (fraud, bribes, referrals, nepotism) and huge medical bills, (55%), bribes by pharmaceutical companies, circulation of fake or inappropriate drugs, goods and equipment in the market (21%), corruption and greed in private medical schools (16%) and unnecessary medical tests (8%).

South Africa

Corruption in the sector takes different forms and a wide array of professionals, administrators, politicians and sales people have been involved throughout the world: nurses, medical doctors, pharmaceutical sales-people and procurement middle managers, the empirical list is almost endless. Moreover, corruption also costs lives



when fake or adulterated medication is sold to health services, hospitals and clinics (WHO 2000:28–30; WHO 2007; World Bank 2010:19–20). The South African health expenditure has reached 8.93% of the Gross Domestic Product. More than half of this amount is spent in the private health care, which implies that over 85% of the rest of the population rely on a corrupt-ridden and under-resourced public sector characterised by poor returns on health investment (Trading Economics 2016; Health Policy Project 2016)

The seminal research by Rispel *et al.* (2016) utilised a number of methodologies in the effort to explore corruption in South Africa, but the utilisation of statistics in a non-contextual manner proved unable to delve deeper into key issues of the problem. The researchers categorised and analysed the statistical realities carefully of combined provincial departments of health expenditures including unauthorised, irregular, fruitless and wasteful resources as described in the Auditor-General's Reports. These are fundamental in abetting and amplifying corruption but the root causes evident in these reports were left untouched. The researchers present their findings with a conceptual and content analysis of the Auditor-General's Reports that identify the root of corrupt behaviour, coalesced with existing scientific research.

This is fundamental as a Report by the World Health Organisation (2012:7–8) identifies that the lack of efficiency and effectiveness in today's complex, interlinked, rapidly changing environment leads to corruption. This implies that governments need to build capacity to operate effectively in complex, interdependent networks of organisations and systems in the public, private and not-for-profit sectors to co-produce public value (Greer *et al.* 2016:16–17).

There has been empirical research conducted in South Africa and Africa which generally deals with a wide array of governance, financial risk management and concerns including the devastating effects of corruption the negative effects thereof on the provision of health services (Mantzaris 2014a: 68–69; Mantzaris 2014b:82–83; Mantzaris and Pillay 2014:17–18).

The findings from the Auditor-General Reports revealed a worsening trend in audit outcomes with marked variation across the nine provinces. Key-informants indicated that corruption has a negative effect on patient care and the morale of healthcare workers. The majority of the print media reported on corruption was concerned with the public health sector (63%) and implicated provincial health departments (45%). The characteristics and complexity of the public health sector may increase its vulnerability to corruption, but the private-public binary constitutes a false dichotomy because corruption often includes agents from both sectors (Morris 2009:1353).

Notwithstanding the lack of global validated indicators to measure corruption, international findings have revealed serious problems in South Africa's healthcare sector. Corruption is influenced by adverse agent selection, lack of organisational mechanisms to detect corruption and a failure to sanction those involved in corrupt activities (Vian 2008:85–86; WHO 2000; WHO 2007; World Bank 2010:23). The South African Auditor-General's latest Reports on the National and Provincial Health Departments (Auditor-General 2016) describe a number of key issues that are instrumental in perpetrating a corruption cycle:

- *Inadequate governance systems* with less than functional institutional capacity and inept personal competencies of governance, policy and implementation, role-players operating within and across institutions.
- *Blockages* as a result of complicated policies as well as inadequate or inappropriate compliance systems.
- *Lack of proper political oversight* realities in the sector and the relationship of state institutions and the private sector.
- *Lack of coordination of anti-corruption policies and agencies and their operations.*
- *Existing relationships between sectors and state-led health services organisational efficiencies, deficiencies, financial and risk management systems.*
- *Conflict/s of interest and nepotism are factors,* which influence corruption.
- *Serious fraud, collusion and corruption in most instances occur amongst senior politicians and/or administrators.*

These findings, that are political, sociological and organisational identify anti-corruption necessities that start with the political will to run corruption-free health services, effective government to enforce laws, appropriate systems, and citizen involvement and advocacy to hold public officials accountable (Integrated Support Teams 2009; Holmberg & Rothstein 2011:530–32).

Furthermore, the South African Treasury generally publishes detailed health budgets and financial information that it is difficult to understand not only for the citizens, but also the administrators themselves. This reality has immense consequences for corruption, especially in terms of financial systems operations, Supply Chain Management (SCM) and procurement and internal audits (Rispel & Moorman 2013:243–4).

In the private sector, corruption is rooted on a number of fundamentals that point to corrupt practices which need urgent attention. In most instances, South Africa as well as internationally private sector corruption is inextricably linked with the public sector. The private sector in the vast majority of cases are suppliers and service providers



are implicated in corruption in the public sector. This implies that the private–public sectors ‘collaboration’ of a corrupt nature is based on a combination of factors such as the political or administration connection, those in ‘advisory roles’, the collusion of dynamics and financial rewards (Woods & Mantzaris 2012).

There is evidence that the private sector health care operators (hospitals, clinics, doctors etc.) determine the prices patients should be charged and this reality became public knowledge including questions such as what factors contribute to pricing. This reality was unmasked following the Competition Commission’s summonses to the massive *Netcare* Healthcare Group in the context of launching a market inquiry into the private health sector. In the process it appointed KPMG as an expert. Immediately, the Healthcare Group proceeded legally in a High Court case to protect its confidential information from being disclosed by the auditing firm to the Competition Commission (Interview with senior member of the Competition Commission).

It has become a corrupt practice by private doctors and hospitals to submit inflated bills and/or false claims for treatment or tests to insurance schemes and medical aid companies to maximise their income. Nevertheless, certain respondents held that there is less corruption in the private sector because the health facilities are smaller and more manageable; there are more robust systems in place to detect corruption; and checks and balances have been implemented to monitor daily operations (Rispel *et al.* 2016:243). There have been many cases of healthcare providers (doctors, paramedics, and physiotherapists) charging patients and clients for services not rendered.

Suppliers of medical equipment, technology or pharmaceuticals may influence provider behaviour by creating perverse incentives such as gifts or financial kickbacks. Funders, suppliers and providers may offer bribes to regulators to overlook failures in meeting statutory or contractual obligations or quality standards and specifications. Consumers could collude with providers to misuse private insurance funds (Woods & Mantzaris 2012; Rispel *et al.* 2016:240–241).

CONCLUSION

There are both similarities and differences in the healthcare corruption in South Africa and India. In both cases, this corruption is related to ‘cooperation’ of collusion between the public and the private sectors.

Corruption is deeply rooted on human power relationships as well as organisational, political and social realities that ultimately lead to lack of accountability, transparency,

fairness and commitment to the welfare of all citizens of the countries, especially the most vulnerable sections.

As these similarities and differences are evident in the article, it is understood that the wide variety of present corrupt practices are founded on political, historical, cultural, social and economic realities that need a thorough dissection if corruption is to be fought decisively at all levels. For the fight against corruption to become successful existing comprehensive legislation can only be implemented by an independent justice system, active civil society, and public trust on the prevailing political system and regime. Even these advantages are not enough if there is a lack of continuous communication between the State and the whole population. Corruption in health care is a direct violation of the human rights of billions of people as it has direct negative effects on infant mortality and especially under-five mortality rate negatively. While millions of children die because of corruption, political and business elites and sections of the middle classes in South Africa, India, BRICS, and the whole world are directly or indirectly involved in bribing, collusion, extortion, fraud, violation of procurement regulations.

There is no end of this vicious cycle is in sight.

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