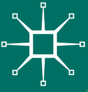

Healthcare Corruption

Causes, Costs, Consequences and Criminal Justice

Graham Brooks

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1
Introduction

This inspiration for this book is academic and personal. The academic interests are the causes, costs and consequences of healthcare corruption. The cost of global healthcare expenditure has reached 9 trillion (US dollars) (WHO, 2022) of which some is lost to corruption. Funds lost to corruption are only one cost, the consequences of corruption in the broad church of healthcare services condemn some around the world to illness and/or a slow, painful death as access to healthcare is limited and/or blocked via some type of corruption. Healthcare is one constant aspect of life and ill-health is inevitable in life—earlier for some than others—but access to healthcare, or lack of it, impacts on us and those who care for us—doctors, nurses and those beyond the medical profession, mothers/husbands/siblings. Healthcare or lack of it, can, depending on the treatment and level of care therefore alter a life course in immeasurable ways.

My personal interest in healthcare is both positive and negative. My father was ill for 30 years of my adult life; in his lifetime he had three heart attacks, one major heart operation, a defibrillator implant, a stroke, prostate cancer and 'trouble' with his eyes, one ear, teeth, bladder, to name a few 'mild' aliments. My mother, for the majority of these

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30 years, was the equivalent of a voluntary nurse, and as such her life was spent caring for her husband. The impact of his ill-health on my mother was immeasurable. My mother, in the later stages of her life, suffered from dementia and was placed into a 'care home' but subject to abuse. My mother entered a care home with no bruises and within days had a number of them on her head, arms and other limbs. We—the family—removed my mother within a number of days to another care home. We then, at a later date, had a safeguarding meeting with social services, the police and Care and Quality Commission (CQC)—the CQC is the body that is supposed to prevent and conduct investigations into poor treatment/care and abuse in England and Wales. All public services—social services, the police and CQC—closed ranks with the private 'care home' and defended what we saw as abuse and presented it as 'poor healthcare' instead. This later example is a corruption of care, as far as I am concerned, but I am aware that poor healthcare treatment, neglect and abuse can sometimes blur. As a family, however, in trying to deal with this abuse, we were placed into a position for which we were neither prepared for nor able to sometimes deal with, and as such members of my family encountered illness too beyond the victim (my mother) which has to some extent made an impact on how I view part of the healthcare sector.

I admire, respect and will always be in debt to those that work in the healthcare sector. This book is not a criticism of all of those that care for us at the lowest moments in life; it is a criticism of those that cause pain, illness, disease and death via corruption. It is also in recognition of those who care for us—family members—that are a 'voluntary adjunct' to the medical profession.

In Article 25 of the United Nations Universal Declaration of Human Rights (1948) access to healthcare is considered a human right. Most nations that are part of the OECD have universal, or as near as possible universal coverage—public or private—for health services. There are differences in how these are delivered, however, with healthcare delivered by state healthcare systems or a combination of public and private provision. Referred to as a healthcare system, though, it is doubtful this is what it achieves: instead, for a number of jurisdictions it is a system that

deals with sickness; it is established to cure rather than prevent. Furthermore, our health or lack of it is subject to factors beyond healthcare. Lack of suitable accommodation, poor accommodation, i.e., infested with insects/rats/mould on walls, etc., limited social welfare, poor diets, lack of employment and psychological issues all impact on health and subsequent rehabilitation and ability to recover from illness.

However, as we make progress and eradicate some diseases because of sustained national vaccination campaigns and access to clean water, we have much to still achieve if the United Nations Universal Declaration of Human Rights and sustainable 'world' development is achieved. The application of equipment, medical knowledge and sophisticated trials to test if a medical intervention 'works' are incredible breakthroughs but will mean little if corruption thwarts and/or blocks access to healthcare where patients are unable to access health services because of some hidden or known act of corruption. Such corruption, though, is no different from other businesses, but healthcare systems and those that work in them are vested with the power to alter the shape of an individual's current familial and future life. In addition, healthcare corruption is an international issue; diseases seek hosts and are not subject to borders or discrimination, as the recent pandemic showed borders offer little protection to disease.

Corruption then is embedded in healthcare systems. It is far more pronounced in some nations than others, but all—public and private—suffer corruption of healthcare services to some extent. National and international health systems are susceptible to corruption because of the complex nature of providing healthcare to a range of people with different needs. The Organisation for Economic Co-operation and Development (OECD) (2017) estimates that more than 140,000 children per annum are dying due to corruption. This, of course, is distributed unequally around the world, but these data underestimate the costs and consequences of corruption, and unless addressed, these numbers will increase. As of 2018 the World Health Organization (2023) estimates that the cost of corruption to healthcare worldwide equates to 455 billion (US dollars), which is more than the estimated 370 billion (US dollars) needed per annum to achieve the United Nations Universal Health Coverage (Garcia, 2019). This 'lost' 455 billion (US dollars)

is out of nine trillion (US dollars) (WHO, 2022) spent on healthcare around the world. The level of funds spent are, however, unequal, as is access to healthcare around the world. The more we spend on healthcare, regardless of the type of healthcare provision—public and/or private—a percentage is lost to national crime and international organized crime but also via white-collar crime in the healthcare sector via doctors, nurses, healthcare/hospital administrators, etc.

The impact of corruption *in and on* healthcare systems is a matter of life and death. This might sound sensational but consider for a moment limited, blocked access to healthcare around the world. Corruption has severe consequences: access to healthcare, quality of healthcare, equity (e.g., no access and/or refused access unless paying for services that should be provided), and efficacy of health (how many billions of dollars are spent on healthcare and/or lost to corruption). To state the obvious, as we spend more on healthcare, we attract corruption. This is within and across different jurisdictions but corruption and disease are transnational in nature, and we to some extent, with or without knowledge might be subject to healthcare corruption.

This book then sets out to examine and highlight the causes, costs and consequences of healthcare corruption and the role criminal justice plays, where possible, in preventing and punishing healthcare corruption. This book is wide-ranging as I want to highlight the reach and impact healthcare has on life beyond the measurement of healthcare corruption and thus see this as a contribution to the debates regarding healthcare corruption. It builds on the literature and, I hope, helps broaden the debates on the reach and extent of corruption and *why* and *how* individuals and organizations engage in healthcare corruption and the potential ways to reduce it. This is not a criticism of the corruption literature of which there are excellent texts available (Brooks, 2016; Dincer & Johnston, 2020; Glynn, 2022; Heidenheimer & Johnston, 2017; Heywood, 2015; Mauro, 2017; Petkov & Cohen, 2016; Rose-Ackerman & Palifka, 2016), to name a few, it is an attempt to view corruption beyond a single discipline, and in particular encourage academics studying criminology that this subject is one that we should contribute to beyond the current level of research.

I therefore hope I deliver a text that is useful and broad in thought, but also accessible for those with knowledge of healthcare corruption but limited knowledge of criminology and those with knowledge of criminology but limited knowledge of healthcare corruption.

Definitions and Terminology

As in all social sciences the use of language and how we operationalize concepts, define an issue or problem is contested and debated. This is a major problem for disciplines that analyse corruption as a concept, its causes, its measurement and location, its impact and how to prevent it (Brooks, 2016; Heidenheimer & Johnston, 2017; Heywood, 2015; Hough, 2015; Johnston, 2005; Rose-Ackerman & Palifka, 2016).

Furthermore, corruption is often a 'hidden crime' or discovered after the event, and whilst some types of corruption are seen as non-violent crimes, its impact is violent, e.g., no access to healthcare medication and subsequent slow and painful death for some people in parts of the world. Drawing a direct cause and effect of corruption, however, is always difficult and thus it is difficult to assess the amount of corruption that occurs (Heywood, 2015) and also the number of victims. Perhaps what we can state is that current estimates are, as with all unethical acts and hidden crimes i.e., domestic violence, under-recorded. There are common elements of corruption such as the misuse of power, but an attempt to offer a cast-iron view of corruption is compounded by social, cultural and legal attitudes towards it which define it across jurisdictions. Even with a clear definition, which would be difficult, if not impossible, the measurement (Sampford et al., 2006) and secretive nature of corruption is difficult to prevent. This is more the case at the cross-border international level as corruption is not anchored in a fixed place and has no respect for international borders. The complex nature of these acts and differences in social, cultural and political developments only 'muddy the waters' of what corruption *is* and who has jurisdictional control. This, however, is no reason to abandon attempt to measure corruption.

It is perhaps instead best to view corruption as a continuum: it can range from legal acts that are morally condemned to highly illegal and criminal acts that involve the public or private sector, working alone or in concert with one another (Brooks, 2016). I do, however, use the term 'criminal corruption' to indicate that a criminal act has occurred rather than one that falls under some moral code. I only refer to healthcare error and waste where relevant, even though substantial funds are lost to waste and error in the healthcare services (OECD, 2017) I consider these different from corruption. Waste and error, however, still impact on the healthcare we can offer.

Trying to define healthcare corruption or the corruption of healthcare is thus problematic. Cases of corruption surface around the world that discredit healthcare systems but this book will highlight healthcare systems that include hospitals, specialized clinics, hospices, doctors' clinics, private practice, dentists, nurses, care homes, specialized mental health institutions, healthcare equipment specialists, a built and/or online pharmacy/chemist, private health insurance sector, dispensing healthcare aid in an emergency and/or part of an ongoing charitable sector commitment and the provision of healthcare services in prison(s). Analysis of the pharmaceutical sector is absent here, though, the reason is that the volume of texts on this sector are available elsewhere, and I have instead attempted to address other aspects of the corruption of healthcare around the world.

The range of acts that could fall under healthcare corruption are wide-ranging: discretion in dispensing medication, medicines and equipment that is stolen, services/equipment defrauded via a system of procurement, submission of inflated or non-existence healthcare services and/or treatment, medicine and equipment, bribes and/or extortion to secure and/or refuse access to healthcare, private healthcare insurance fraud, absenteeism, counterfeit medicine, etc. What I will state with some conviction is that corruption hits the poorest the hardest, but all of us are victimized as funds set aside for healthcare are lost or stolen for individual personal profit and/or organized crime to fund other criminal acts.

Trying to define corruption then, and its reach is problematic, but so is how we define healthcare. However, where relevant I will explicitly state

that different types of corruption impact on the provision of healthcare, and sometimes lead to criminal corruption. These are:

Unethical corruption—an unethical but still legal act or one that is on the cusp of illegality but presented as an 'error' or 'mistake', e.g., neglect in a care home (see Chapter 9).

Corruption of process/procedure—where 'standards of manufacture' (see Chapter 6) are breached and medical practitioners fail to follow a set process and hide poor to corrupt practice behind a white wall of silence (see Chapters 7 and 10).

Corruption of an ideal—where those that work in the healthcare profession engage in unethical and criminal corrupt acts for personal benefit, e.g., inflated claims (see Chapter 3 and 5), extortion (see Chapter 4), peddling substandard medication (see Chapter 5), the corruption of care (see Chapter 9) and the silence of institutions in protecting corrupt individuals and/or practice (see Chapter 10).

In an attempt to resolve confusion in this book, I have offered a clarification of 'terms' I have used. These are a product of my social and cultural background. These are:

Jurisdiction—I use jurisdiction instead of state most of the time in the text. The reason for this is that, we still have, even now, landmass and islands that are beyond the physical boundary of a state but under its jurisdiction to some extent. In addition, federalized states might have slightly different laws regarding healthcare, e.g., licences to conduct medical practice.

Doctor and/or physician—Both, as far as I am concerned, refer to medical practitioners prescribing medication and healthcare advice and work in individual clinics and/or hospitals. Doctors and/or physicians, however, are different from surgeons that have a different skill set and work in operating theatres in hospitals. In addition nurses are members of the medical profession and are different from nurse's aids; whilst trained, nurse's aids assist nurses, and have some knowledge of patient care, e.g., the ability to measure/read a patient's vital signs, but is a different role to that of a nurse. Therefore, where possible I explicitly state the role I refer to but sometimes the distinction between these roles is blurred.

Care homes—I use the term care home to cover all institutions/homes for children, the elderly and residents/patients in mental health institutions. Even though the needs of the residents/patients might differ, all are in an institution/home and that all institutions, *should care* for those under its supervision, hence 'care home'. I also refer to people in a care home as a resident and/or patient. Permanently placed, or placed in a care home for a period of time, I consider someone a resident but also a patient because of medical needs and often use the terms resident/patient together.

Neglect and abuse—I also distinguish between neglect and abuse. Neglect consists of a range of acts that harm patients. Neglect can be intentional and unintentional; unintentional neglect stems from either inexperience or incapacity to deliver appropriate levels of care. Intentional neglect is where a deliberate act fails to fulfil the level of care expected, and harms the patient. Neglect and abuse can blur, though (see Chapter 9). Abuse, is however, *verbal* and *physical* such as the use of abusive language, slapping and hitting a resident/patient; *psychological abuse* is verbal or nonverbal insults, humiliation, isolation, abandonment and infantilization; *sexual abuse* is rape, sexual acts without the residents/patients' consent, or the resident/patients are unable to consent (Myhre et al., 2020); and *financial abuse* is theft or misuse of property and/or possessions. All of these acts are committed by nurses, nurse's aids, supervisors, management, residents and familial members/visitors in care homes.

Pharmacy and chemist—I use pharmacy and chemist together in the text instead of apothecary and/or druggist. I see 'pharmacists/chemists' both as a brick-built edifice or online website as a place where knowledgeable and highly trained individuals can dispense advice on some medical issues and, depending on the jurisdiction, *only* dispense specific medication once sanctioned via doctors/physicians.

Outline of the Book

The book is broken down into sections and chapters. Chapter one highlights the need for such a book. It offers clarification on some of the definitions (see above) and language used and a breakdown of each chapter.

In Part I: *Definition, Types, Measurement and Costs of Healthcare Corruption*, Chapters 2, 3 and 4 will all examine the problem of how to define healthcare corruption in the public and private sectors and what it should entail, the obstacles in trying to measure the volume and value of funds lost to healthcare corruption, and the costs and harm caused.

In Part II: Chapters 5–7: *Avenues of Healthcare Corruption*, I examine how telemedicine can exacerbate online corruption, and how counterfeit and substandard medicine impact on the quality of patient healthcare within and across jurisdictions and how the practice of 'defensive' medicine allows corrupt practitioners to hide behind a veil of medical knowledge, but are also blocked via Non-Disclosure Agreements (NDA) (also known as 'gagging orders') to prevent exposing internal corruption.

In Part III: Chapters 8–9: *Healthcare as a System of Exclusion and Control*, the healthcare sector is viewed as a potential problem. Instead of presenting the healthcare sector as a victim of corruption alone, I emphasize how it is party to corruption and how it could be seen as part of a carceral system where vulnerable individuals—children, adults, senior citizens and prisoners are subject to poor and/or corrupt healthcare.

In Part IV: Chapters 11–12: *Reducing Health Care Corruption*, I examine how rational choice and behavioural economics help our understanding of healthcare corruption. Rational choice is a well-known theoretical approach in criminology, but behavioural economics and nudging is a much under-researched field in criminology. By combining these two approaches I will offer a novel analysis of why some acts of corruption occur in the healthcare sector and how we can reduce them.

In Chapter 13: *Reflections and Conclusion* I reflect on the key contributions of all the previous chapters' debates.

Chapter Synopsis

In Chapter 2: *Healthcare Corruption: An Interdisciplinary Problem*, I draw on a range of disciplines to highlight the need for an interdisciplinary approach to healthcare corruption. In this chapter, I therefore critically examine the uses and obstacles to an interdisciplinary 'working definition' of healthcare corruption and note that the different disciplines, whilst useful, can sometimes make the prevention of corruption a complex problem to understand. I also consider the concept of consensual legitimacy, which is dialogic (Bottoms & Tankebe, 2012) and where we, the public, confer legitimacy on the individual and/or institutions to act for us 'in our best interests'. I examine how the dual and interactive character of legitimacy has the potential to lead to a 'white coat wall of silence' (Huq & McAdams, 2016) where obfuscation can hide corruption in the medical profession. This chapter therefore draws on a range of literature which highlights the complex nature of what 'corruption' is and the different ways in which it is defined by different disciplines in the public and private healthcare sectors.

In Chapter 3: *Types of Healthcare Corruption and the Problem of Measurement*, I highlight the quantitative and qualitative techniques that yield data on corruption and the subsequent analysis of the data on which we draw inferences. There are, of course, common approaches here, i.e., surveys (Khodamoradi et al., 2017), and interviews but this chapter also considers the use of audits as a tool for prevention (Busch, 2012), loss measurement exercises (Gee & Button, 2014), investigative reporting (Vian, 2020), where relevant, and statistical analysis of claims (Ekin, 2019). I then consider the advantages and disadvantages of *volume, velocity, variety* and *veracity* of healthcare data and how it is a doubled-edged sword in that it might exacerbate and/or reduce corruption. In the final section of this chapter, I examine how the public and private healthcare sectors are interconnected but the approach to the same problem is sometimes different. By downplaying or redefining an act, the private insurance healthcare sector precipitates and participates in its own victimization (Brooks & Steirnstedt, 2021; Stenström, 2020) and under-records acts of corruption which are known but not recorded as a crime/act of corruption.

In Chapter 4: *The Costs and Impacts of Healthcare Corruption*, I highlight the attempts to assess the cost of crime and healthcare corruption. There have been attempts in criminology to assess the cost of crime and the impact this has on individual victims, family members and the CJS (Cohen, 2020). In healthcare, however, the analysis is often on funds lost to different types of corruption and how these impact on healthcare provision. Both are admirable. But what is missing is a combination of these, particularly for healthcare where criminal corruption has occurred that can impact on victims and family members as a physical cost (temporary and/or permanent need for care), financial cost (lost income) and emotional cost (e.g., anxiety/trauma), or a combination of all three. Furthermore, emotional stress, potential illness, lack of faith and distrust of the medical profession (as can occur with victims of crime and the CJS) also occur which harms the integrity of the healthcare profession.

In Chapter 5: *Telemedicine: HealthCare and the Online Pharmacy Sector: Healthcare at a Distance and Avenues of Corruption*, I consider the development of telemedicine—the use of technology and information systems that includes remote medical evaluation(s) of patients' conditions, video consultations with specialists and the transmission of medical imaging, as an avenue of potential corruption. In addition I consider the development of pharmacy/chemists online and the problem of regulation and control; as with all online systems laws often stop at jurisdictional borders but access to 'medicine' (counterfeit or authentic) and medical devices is borderless. This chapter will address these threats and how best to reduce the avenues of corruption as jurisdictions offer 'health care at a distance'.

In Chapter 6: *Counterfeit and Substandard Healthcare Medicine and Products: An International Problem,* I examine the proliferation of counterfeit, substandard and unlicensed medicines. Counterfeit medicine and/or products are where the character and/or composition and source of the medicine is oblique, but it is also where claims of healthcare benefits are made where there is none. Substandard medicines fail to fulfil the specifications or the standard of quality, or both, but it is often difficult to pinpoint if substandard medicine is knowingly counterfeit or simply part of a poor process of production in one or more jurisdictions. Unlicensed

medical medicine and/or products are manufactured, sold or distributed without authorization from the respective regulatory body, in a country or region (Rahman et al., 2018). All three, however, are a threat to healthcare services and avenues of corruption. The reach of the internet and proliferation of counterfeit, substandard and unlicensed medicines and products, e.g., medical equipment, is a major international healthcare issue (Fittler et al., 2018; Hamilton et al., 2016; Mackey & Nayyar, 2016, 2017; Nayyar et al., 2019) that needs international collaboration.

In Chapter 7: *Defensive Healthcare Practice: An Environment for Corruption,* I examine 'defensive medicine', which is where medical practitioners' perform needless and/or excessive diagnostic tests 'just-in-case' and thus increase cost of healthcare provision in both the public and private sectors. This kind of defensive practice is also mirrored in the CJS that leads to the imposition of sanctions on individuals that are neither a threat to the public or commensurable with the crime committed. However, I also consider the gagging of healthcare professionals and threats in the public and private sectors preventing public exposure of corruption, with investigations held in private by peers (e.g., members of the Medical Associations or Nursing Councils). In this chapter then we see that both patients and medical professionals that challenge poor practice, maltreatment, abuse, and corruption, are excluded, threatened and victimized by the healthcare sector.

In Chapter 8: *Is the Healthcare Sector part of a Carceral State?* In this chapter I take a different approach to most of the literature on healthcare corruption. There are aspects of the healthcare sector that could be seen as part of a public and/or private carceral state that reaches beyond walls and institutions. I highlight the links between medicalization and crime, and how the carceral state is part of a system of health inequality that controls and contains people with mental or physical illness and shapes and impacts access to health services within and beyond institutional walls.

In Chapter 9*: Uncaring Homes: The Corruption of Care and the Control and Exclusion of Residents and Patients*, I highlight how those most in need often encounter obstacles and exclusion and victimization in care homes. Often uncovered years after the 'event,' we unearth poor treatment, neglect and abuse where individuals or institutional 'practice' is

cruel and callous. Due to mental, emotional and physical needs, people in need of care are often excluded from leading a full life and instead subject to control and exclusion due to dependence and powerlessness. This is not the case for all care homes, but all too often scandals occur with poor practice, poor supervision of care home assistants/nurses, and lack of regulatory oversight. This chapter therefore highlights how those most in need are often neglected and encounter obstacles and exclusion and victimization.

In Chapter 10: *Rational Choice and Behavioural Economics*, I examine and assess to what extent corruption in the healthcare sector is a rational choice based on a calculated cost–benefit analysis. In addition, I also assess the usefulness and application of behavioural economics, a much under-researched field in criminology. This is perhaps because it is primarily a psychological study of cognitive, emotional, cultural and social choices and judgements made by individuals and institutions. This approach, however, moves beyond rational choice and highlights how a change in practice in healthcare could counteract corruption in this sector.

In Chapter 11*: A Nudge in the Right Direction: Persuading People to Change*, I show how we can affect behaviour with positive reinforcement and indirect suggestions to influence choices and judgements. Depending on the context and jurisdiction a negative and/or positive nudge can reap substantial rewards (i.e., increase in vaccination rates) and reduce corruption in the healthcare sector. This chapter will use healthcare nudge examples to highlight how it could contribute to the reduction in crime and healthcare abuse and corruption, with a slight change in practice and attitude but also highlight that a nudge(s) are only part of a toolkit to reduce corruption.

In Chapter 12: *Reflections and Conclusion*, I reflect on the key contributions of all the previous chapters' debates and contemporary issues that assist in understanding healthcare corruption and applying relevant approaches and strategies to prevent it.

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Part I

Definition, Types, Measurement and Costs of Healthcare Corruption