Healthcare Corruption: Causes, Costs, Consequences and Criminal Justice

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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

2

Healthcare Corruption: An Interdisciplinary Problem

Introduction

This chapter will draw on a range of disciplines: economic, political, legal and criminological to highlight the need for an interdisciplinary approach to understanding healthcare corruption. In this chapter, I critically examine the uses and obstacles to an interdisciplinary definition of healthcare corruption and note that the diversity of and responses to corruption, whilst useful, can sometimes make the prevention of corruption a complex problem to understand. This is due to competing approaches that emphasize their own discipline at the expense of others.

In particular, though, I emphasize the breadth and depth of the broad church of different criminological approaches in helping understand healthcare corruption, and, of course, the limitations of these different theoretical approaches. These are presented in a historical, chronological order, where I have highlighted the most relevant approaches to healthcare corruption, but as with all 'explanations' of crime/corruption there are elements of a previous approach in the ensuing explanation. In combination then, different approaches offer an opportunity to combine different elements that help explain healthcare corruption.

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In the final section of the chapter, I consider the concept of legitimacy afforded to the medical profession to advise, counsel and advocate a course of medical treatment. To have the power to advocate a course of medical treatment, consensual legitimacy is often needed. This consensual legitimacy, which is dialogic (Bottoms & Tankebe, 2012) is where we, the public, confer legitimacy on the individual and/or institutions to act for us 'in our best interests'. I thus examine how the dual and interactive character of legitimacy has the potential to lead to a 'white coat wall of silence' (Huq & McAdams, 2016; Starystach & Holy, 2021) where obfuscation can hide corruption in the medical profession.

Healthcare Corruption and the Corruption of Healthcare: Theoretical Approaches

In attempting to define any concept, act or term and articulate it in such a way that it is understood, particularly beyond those familiar with the 'field of study', is a difficult task. This is particularly so with corruption (Heywood, 2015). Any definition, as noted by Philp (2015) can have two elements; it can articulate the import and use of a word and also act as a tool to help construct an explanation; the social sciences are primarily concerned with the latter as I am here. Understood as a tool, a definition aims to establish a set of criteria that suggests necessary and sufficient conditions for an act to occur. These, however, differ depending on the theoretical approach, object of study and actual circumstances.

Keeping in mind that corruption can be viewed as unethical but legal to illegal and a civil and/or criminal breach of law(s) (Brooks, 2016) how corruption is defined in healthcare and the role(s) criminal justice systems play in preventing and punishing 'criminal acts' of corruption, is problematic. The recurring problem we encounter in trying to construct a consistent and unambiguous definition of corruption is that political, social and cultural factors undermine attempts to have a definitive version of corruption. As a result, an unequivocal definition of corruption remains elusive. Corruption should therefore be viewed as a complex and multifaceted phenomenon with a multiplicity of causes and effects,

as it exhibits different forms and functions in diverse contexts (Heywood, 2015).

Exactly what counts as corruption is perhaps relative, but our understanding of it is rooted in social, political and cultural systems. Corruption is a product of its environment and social development as are healthcare and criminal justice systems. We therefore fall into a trap, unless careful, whereby we define corruption as a technical problem (Granados & Nicolás-Carlock, 2021; Luna-Pla & Nicolás-Carlock, 2020) that can be dealt with by changing processes to deter and block corruption regardless of the wide-ranging and diverse acts of corruption. It is also sometimes viewed as an illustration of moral decline: however, attention on moral decline alone is also flawed as it does little to assist those in the social sciences in explaining corruption, with an emphasis instead on behavioural indicators, and its potential manifestations.

The causes of corruption and subsequent solutions primarily fall under three broad approaches; these are the rational economic, political science and legal approaches. In criminology we have yet to establish a clear theoretical body of knowledge on the matter of corruption. This, however, is perhaps because of its own competing approaches, which I address later in this chapter.

Rational, Economic Corruption

An economic approach to corruption assumes that individuals, organizations and states simply act in rational self-interest. This view has dominated much of the debate about corruption and often proposes that the best way to reduce corruption is to reduce incentives to break rules by increasing the chances of apprehension and reducing avenues for corruption (see Chapter 11 on behavioural economics and Chapter 12 on nudges).

If we view human behaviour as self-interested at the exclusion of other motivations our view of human conduct is that corruption occurs if we assess the outcome as a cost–benefit analysis. But if an individual only acts in self-interest to secure an advantage it is impossible to establish profitable, reciprocal corrupt relationships, that in some cases is the

bedrock of corruption. Reciprocal relationships or reciprocal corruption then, might mean a compromise to secure an advantage. There is still the potential for an economic advantage here but a lack of compliance with rules is neither a statement that the individual or organization is, or is not corrupt. Such decision(s)—local, national or international—are conducted within a moral, legal and political framework and as such we are left with changes to the political and social structure or small adaptations to them (Philp, 2015) if we rely on a rational, economic model that often fails to prevent corruption.

Ultimately self-interest is the desire to acquire an appropriate promotion, power, financial rewards, etc. How this is achieved, however, is where we enter the often opaque world of corruption. Economic self-interest, depending on personal views, is either part of the problem in that capitalism is based on competition that leads to corruption or that personal self-interest seduces us into acts of corruption and we act in our own financial interests. Regardless of the view above, we either break a 'moral code' or laws and/or engage in illegal corruption.

Legal to Illegal Corruption

A legal approach suggests that the causes of corruption are public sector vested interests' desire to prevent and thwart enforcement of legal and/or regulatory rules, and laws where breaches occur. This is an indictment of the public sector, and was popular in the 1980s (and still is with some) that the privatization of services will eliminate corruption. This, as we have seen, is incorrect (Heywood, 2015) as corruption occurs alone or in concert in the public and private sectors.

The problem with this legal approach, though, is trying to explain how those in positions of power shape the creation, and operation of rules and 'working practice' that can result in justifying inertia in challenging and/or changing practice that conflicts with their own interests (Brooks, 2016). In light of this, corrupt acts are viewed as an inappropriate yardstick; instead, they are more useful as measures of the influence of power than corruption (Brooks et al., 2013). In fact, it is often those that are supposed to uphold the standards that abuse the political and legal

system for personal benefit, or for familial members and/or 'close business contacts' (Johnston, 2005) that commit acts of corruption. Personal benefit, however, is often defended as a case of 'everybody was doing it' (which is also a technique of neutralization) (Sykes & Matza, 1957) or actively seeking out corrupt avenues to secure some kind of profit.

A lack of resources—people, lack of legal power and application of evidence, or lack of it, —is often cited as the cause of regulatory lapses regardless of the sector (Dincer & Johnston, 2020; Heidenheimer et al., 2017). Oversight of the healthcare sector is no different from other sectors (Garcia, 2019) here. But regardless of the sector a lack of oversight and limited enforcement of sanctions is a significant problem in trying to prevent and reduce corruption.

This legal approach is also somewhat vague, particularly when trying to define and explain transnational corruption with the involvement of more than one jurisdiction. Using legal definitions, without an international established definition, simply increases the problem of undertaking operational measures and developing anti-corruption strategies (those that work anyway). A legal definition also requires, by its own very definition, that the corrupt behaviour should violate a principle of legality. However, not all corrupt behaviour is illegal (Dincer & Johnston, 2020). It would be a misconception to confuse what is corrupt with what is illegal. To define corruption as a simple breach of law(s) reduces what is considered corrupt to a narrow breach of a legal rule. Corruption is far more than a breach of some rule; corruption is legal but immoral to illegal (Brooks, 2016) and in the context of healthcare, in the USA, organizations are able to screen for patients' 'legal' status via questionnaires and 'assess' patients' criminal status/records, immigration status and welfare payments prior to, or even access to, healthcare (vest et al., 2023). This later example, however, could prevent unacceptable claims to healthcare but also excluded those entitled to it.

Political Corruption

A tentative definition of political corruption is: where a public official (A) violates the rules and/or expectations of office, to the disadvantage of the public (B), (B) should benefit from this office but instead (A) benefits and a third party (C) who rewards or otherwise incentivizes them to secure access to products and/or services they would not otherwise obtain (Philp, 2015: 22). This definition does not assume that A, however, must break the law, and that corrupt acts do not need to always harm, or directly harm B (the public). The point here is that corruption is not defined solely by its consequences but more a combination of its intentions and distortion of process (Brooks, 2016). Furthermore, if committing a corrupt act(s) to secure personal interests it is seen as corruption, but if rules are broken to secure wide public interest it can be seen as acceptable, depending on the act.

All political, bureaucratic and healthcare systems are under threat of poor and corrupt leadership—hence the refrain 'the fish rots from the head' but also from political leaders that can undermine healthcare provision via bribes, lobbying and blackmail. These distinctions help recognize corruption as syndromes of corruption (Johnston, 2005) where corruption is initiated from either A or C above and often betrays victims of healthcare crime(s) (Hampton, 2021). These economic and political views emphasize human agency and incentives, often with emphasis on a corrupt bureaucratic structure and the existence of systems that are vulnerable to corruption because of a lack of checks and balances to counter a monopoly, despite 'so-called' regulatory balances within the system (Philp, 2015).

Furthermore, political corruption is often explained by what is known as the PA model. This model, however, also helps explain economic corruption. The P stands for *(principal)* and the A *(agent)*. Corruption is seen as a departure between the principal (those employing and/or with the power to direct) the agent (such as an employee). Once A betrays the principal interest (public service) in pursuit of self-interest (Heywood, 2015) corruption has occurred. This view of corruption emphasizes the conditions under which corruption occurs where an individual and/or organization has a monopoly of resources, and the system in place,

if any, fails to hold the individual and/or organization to account. As such, we seek to design incentives or disincentives to make and/or encourage people to act in the appropriate way to prevent corruption (see Chapter 11 on behavioural economics and Chapter 12 on nudges). These incentives or disincentives are the absence of monopoly, e.g., one is unable to abuse a position of power if there is little or no competition and oversight, and *should* (though not always) be held to account. This, however, as with have seen, is an 'ideal' state of affairs and subject to manipulation.

All of these definitions of human behaviour, which are popular in the corruption literature, are limited, as so much depends on the structure and expectations that frame a relationship. Whilst the above sections considered rational economic, legal and political approaches to corruption, I now reflect on the contribution criminology offers and its explanatory power in helping understand healthcare corruption.

Healthcare Corruption: The Broad Church of Criminology

Criminology is a discipline that has crime as its object of study, with some interest in healthcare corruption. This book, as I made clear in chapter one, is to build on this interest. Criminology, as a discipline, is often seen as a hybrid or eclectic approach in explaining crime and criminal justice (Dignan & Cavadino, 2017; Feeley, 2019; King, 2023). Its roots are based in sociology, but it also draws on a range of disciplines to explain *why* and *how* crime occurs but also *what* we should do with offenders and how to prevent crime. The *why, how* and *what* are of course contested. However, such a 'discipline' if it is seen as one, can help explain healthcare corruption because of its broad base and use of different disciplines. This section of this chapter then reviews criminological explanations for healthcare corruption in the clearest chronological order possible but as with all theoretical approaches political and external ideologies impact on how we should punish and/treat offenders and are subject to criticism, revision and resurrection.

Often dismissed as 'empty ruminations', theoretical thoughts and explanations for crime have future consequences for how we treat, punish and deter offenders (Lilly et al., 2015) and potential offenders. A brief scan of criminal justice policy illustrates that theoretical approaches affect which laws and techniques are implemented and therefore theoretical approaches are a core element of preventing crime and criminal corruption (Brooks, 2016). This is where the usefulness of criminology comes into play. It has a history of explaining the breaking of rules and moral codes and criminal acts which is important regarding all crime.

There is also a critical tradition of challenging conventional mainstream concepts of crime (Friedrichs, 2015) and what was and is considered crime and how it was defined within the broad church of criminology. Crime, however, was, and is often defined by the 'powerful' (Whyte, 2020), and for some (Hillyard et al., 2004) crime itself is so limited that it should be abandoned in favour of 'social harm' instead. 'Social harm' (also known as 'zeminology' or the study of harm) has some relevance here since harm is caused if healthcare is withheld, withdrawn and/or blocked by a medical professionals and/or organizations. Such acts, of course, might fall somewhere on the continuum of corruption (Brooks, 2016) but also caused by a lack of public and/or private healthcare coverage. Bands of healthcare insurance coverage are available, and so limited healthcare is available for some, depending on the jurisdiction, but even if entitled to healthcare a doctor(s)/physicians can refuse to treat a patient(s) unless additional payment is made and/or prescribing effective but addictive (Evans et al., 2019) or ineffective 'medication' via a 'kickback' or compensation from a pharmaceutical company (Kurtti et al., 2022).

Since the definition of crime is contested, the notion of 'the powerful' needs some attention too before I progress. 'Power' in all its manifestations—physical, financial, knowledge, bureaucratic, legal, etc.—is part of human interaction. However, we must exercise caution here; 'the powerful' is an elastic term. It can be stretched to encompass the unambiguously powerful but also those that have a degree of power (Friedrichs, 2015) in an organization. An organization has power as do individuals, embedded in a structure or power that is situational or circumstantial. Those in the medical profession have power; but this is dependent on

a number of factors. Doctors/physicians have power (e.g., knowledge and status) and exercise expertise, but this can depend on circumstances, e.g., able to recommend a course of treatment in a hospital, but a hospital administrator, with no medical knowledge might have the power (bureaucratic) to block treatment based on cost. Doctors/physicians, in a hospital, are seen as more powerful than nurses, but nurses still have power (situational) over a patient. This is one example of the application of power and potential avenues for corruption to manifest itself.

We can thus have hierarchical power (Friedrichs, 2015) where power is situational and circumstantial (Barak, 1991; Chambliss, 1989; Chambliss et al., 2010). A structural positional abuse of power leads to harmful consequences, though. Here, an inflexible application of 'rules', or manipulation of set rules, or the satisfaction, for some, of having the power to control others offers vicarious pleasure. Forcing compliance and/or subjecting people to pleading for help and/or sextortion (Feigenblatt, 2020; Hagglund & Khan, 2023) is a form of situational power, as is demanding 'extra' payment to access healthcare that a patient is already entitled to.

In criminology, the 'powerful' and those that administer it have situational, circumstantial and conditional power. Mainstream criminology—see below—is biased in favour of definitions that lend themselves to operationalization (Friedrichs, 2015). Even though the approaches below explain the *why* and *how* we research crime, which is expected, the majority of the research had narrow parameters—e.g., research on young men. However, these theoretical approaches were, and still are, often a response to political and social criminal justice issues at the time (Lilly et al., 2015).

White-collar crime, committed by 'the powerful' and or protected by others that are powerful (Manjoo, 2021) and members of the upper socio-economic class stimulated an interest in why people in positions of power and affluence commit crime(s). Sutherland (1945) suggested that there are nine key tenets that explain why people in white-collar positions commit crimes; whilst it is not possible to review all of them here the key elements of this approach are that criminality is learned through interaction with others in a process of communication—known as differential association. This process of communication is learned via

the techniques, motives, drives, rationalizations and attitudes towards set criminal actions or what are referred to as definitions favourable to violation of law(s). For a person to commit criminal acts there needs to be a culture of dominant attitudes that justify and rationalize such acts as an acceptable way to behave. Sutherland (1945) was convinced that the criminal law was unable or unwilling to address all forms of white-collar crime (i.e., bribery and environmental damage) and the harm it caused as such acts were settled outside the criminal court under civil law procedures or disciplinary rules, as many still are. Given that the crimes of the powerful are often undetected, and if detected seldom prosecuted, and if prosecuted often avoid conviction, the amount of criminal convictions for white-collar crime is far below the real population of white-collar criminals (Slapper & Tombs, 1999) and thus harm caused.

The problem with this approach, however, was how to explain that people in white-collar positions commit criminal acts and yet continue to function. This is explained by developing a positive self-concept that is a combination of institutionalization, rationalization and socialization (Ashforth & Anand, 2003). The combination of these elements are that *institutionalization* is where an initial act becomes embedded in structures and processes (e.g., legal rules replaced with illegal working practice(s), and *rationalization* as acceptable (e.g., the justification for the crime) and *socialization* whereby new employees are induced or seduced into the view that corruption is permissible. In this sense, a new trainee doctor(s)/ physicians might encounter corrupt 'working practice' and challenge, leave or succumb to corruption as established doctors/ physicians highlight 'this is how we work here'.

Here then, corruption is learned; but is it also caused by some kind of 'strain', too? The notion of strain is where a lack of legitimate openings for 'success'—often seen as the pursuit of wealth—is limited and/ or blocked for social and cultural reasons. Institutional Anomie Theory (IAT), (Newburn, 2017) suggests that American culture places exaggerated importance on economic success and thus leads to a willingness to 'cheat' and in turn this behaviour weakens social control. If unable to attain 'expected' and/or desired success then we might consider an illegitimate route (Agnew, 1992) or alternative lifestyle. A common criticism of 'strain' is that there is an assumption that there is a consensus

regarding 'success' and how people interact with one another to establish meaning and understand the context of life. It fails to recognize pluralism, ethnic and otherwise, and is therefore too broad a description of cultural attitudes. Limited in explaining white-collar crimes, this theoretical approach, however, helps explain how affluent and powerful people might engage in criminal acts (Brooks, 2016). This approach contributes to the debate on healthcare corruption; we all encounter some level of strain at some time in life, regardless of our social position and status. Highly skilled and educated medical practitioners might engage in some act of corruption, as they assess their success, or lack of it, in reference to the position they hold in an organization as a justification for corruption.

However, how can those working in a 'caring profession' commit crimes and still deliver the service(s) expected of them? Sykes and Matza (1957) explain that part of the process of learning social behaviour consists of learning excuses, or what are called 'techniques of neutralization'. This approach has some resonance and value as it can explain that individuals and crowds of people might momentarily suspend or neutralize their commitment to expected behaviour and laws. There are a number of 'techniques' but a few should suffice here to help explain healthcare corruption. There is *passing the blame* or *disbursement of blame*, which is where an individual/small number of people are caught engaging in a corrupt or illegal act (e.g., peddling substandard medicine (see Chapter 6) or medical 'hardware' such as a prosthetic), but claim the company was well aware of the acts, and/or fostered such behaviour or pointedly failed to prevent it, whilst profits were made. There is also an *appeal to loyalty* where unethical and/or illegal acts are presented as a benefit of the organization—hospital—or individual—patient—in an attempt to maintain moral integrity. Supporting these techniques of neutralization is the work of Dittenhofer and Zeiltin (2001) and the syndrome of injustice and dissatisfaction. Behaviour here is justified as a sense of injustice, e.g., blocked promotion; however, as Coleman (1987) pointed out, neutralization techniques are not only post hoc rationalizations of white-collar crime but can also precede them and expedite non-compliance. These techniques should not be seen in isolation; they can and do combine to create a 'wall of justification', particularly if

offenders are caught, in order to diminish the impact and seriousness of the offence committed. A rationalization is not an after-the-fact excuse that an offender uses to justify his or her behaviour, but an integral part of the motivation to act. These techniques, though, fail to offer a proper explanation for violent behaviour and those individuals and/or organizations that commit serious offences, and the role that resistance plays in acts of corruption.

This leads us on to the notion of control, and why we conform rather than commit acts of corruption. These theoretical approaches suggest that crime is to be expected unless sociocultural controls—family, teachers and police—work effectively to prevent crime (Reiss 1952 in Lilly et al., 2015). Delinquency and crime then are caused by the lack of internalized control or a 'moral compass'. The problem here is that our choice to act is considered primarily rational. There is no scope for trying to understand how we make sense of the world in which inhabit. There is also the possibility that delinquency leads to a weakening of social bonds rather than weak bonds leading to delinquency. Furthermore, these approaches assume that 'decent parents' should teach middle class values (however, these are defined) to children. However, morals are variable rather than fixed and immutable, and as such keeping 'poor company' can have an influence—i.e., a corrupt doctor/physician affects the moral compass of trainees.

Social/bio-psychological approaches and those that fall under the umbrella of rational choice (see rational, economic corruption section above and Chapter 11) consider the causes of crime as lying within individuals rather than the social structure. Individual responsibility was, and still is, a central tenant of this approach with the criminal law defined by the state as non-problematic (Wilson & Herrnstein, 1985). For these authors, human behaviour included three elements: constitutional factors, the presence and/or absence of reinforcement, and the nature of conscience. The majority of crime was, and is, as far as they were concerned, committed by young urban males and it is the constitutional and social origins of maleness and youthfulness, and the biological status of young people and factors such as sex, age, intelligence, body type and personality that explains criminal behaviour, with reference to permissiveness and dependency on welfare benefits. This approach,

however, is not solely rooted in explaining crime from a biological point of view, it simply accepts that such above factors are 'facts' rather than the direct causes of acts, particularly of criminal acts. They suggest, however, that these 'facts' can account for a predisposition towards crime. This approach proposes that the individual learns how to behave in the social world based on what type of behaviour is rewarded and under what circumstances, and that our conscience is an internalized set of attitudes. This approach, however, emphasizes specific types of crimes such as visible street crime and associates criminal disposition with the poorest sections of society, and therefore frames crime as embedded in human nature (or that of the poorest) rather than the environment. As such, it sees offenders as 'beyond reform' and in need of punitive control. It thus portrays crime as a very simple phenomenon which can be dealt with using simple solutions (Brooks, 2016).

As part of this 'conservative' view of people as rational actors (see rational, economic corruption section above and Chapter 11), (Cohen and Felson 1979; Cornish and Clarke 2014) suggest that crime is routine and that crime is the product of three factors that combine in time and place: a motivated offender(s), a potential victim(s), and the absence of a 'capable' person that can/will prevent crime. It is important to note that this approach offers suggestions about the probability of criminal behaviour rather than making definite claims about when crime will occur. The presence of a motivated offender(s), a suitable victim or item owned by a victim, and the lack of a 'capable' person to prevent/deter potential offenders makes no claim that crime is inevitable. Instead, this theoretical approach suggests that the likelihood of crime increases or decreases based on the existence of these three elements. Much of this is about 'lifestyle', what we do, where we live, who we interact with, but these elements also describe a workplace environment, e.g., hospital. The hallmark of this approach is its lack of emphasis on the offender and its focus on what the victim and 'capable' person/people ought to do to prevent victimization. Such an approach claims it seeks no explanation for the motivation for crime (even though it states that a motivated offender(s) is needed), nor does it offer an explanation of the social context, or why some people help prevent crime more than others. Neither does it endeavour to really

explain why some individual behaviour renders them more susceptible to victimization. It can, however, offer a pause for thought; that workplace culture and environment can influence attitudes towards crime and acts of corruption.

All of these theoretical approaches assist us in understanding why people might commit acts of corruption, but seem to include at least three elements. These are: pressure on the individual; the opportunity to commit a crime; and the ability to rationalize crime. These are all part of what is known as the Fraud Triangle (Kassem & Higson, 2012). However, although opportunity is necessary it is not a sufficient condition for 'upperworld' criminal offences; instead of rationalizations to commit a crime, it is perhaps the culture of the company and an internal voice (or lack of one) that inhibits or rationalizes crime and acts of corruption.

All theoretical approaches in this chapter, however, are limited and indeed at times contradictory, dependent on a particular view of 'human nature'. They are, however, useful: as mentioned earlier, a brief scan of criminal justice policy illustrates that theoretical approaches affect which laws and techniques are implemented and therefore theoretical approaches are a core element of crime prevention and anti-corruption. All approaches have a history of explaining deviance, violation of rules and moral codes and also criminal acts. As such, a theoretical framework is a useful template on which to place debates on corruption and the power to commit different types of corruption in the healthcare sector.

The different types of corruption committed, though, in the healthcare sector are, as mentioned above, often situational and circumstantial where the power to treat people is seen as legitimate. Legitimacy, however, is dialogic (Bottoms & Tankebe, 2012) and consent is needed, but this legitimacy also allows corrupt medical practitioners to block, prevent and deter investigation into poor practice, neglect and corruption, to which we now turn.

The Power to Heal and Power to Steal: The Power of Consensual Legitimacy

As noted in the introduction to this chapter corruption can range from legal but ethically questionable to illegal and criminal acts. Whilst we might disagree on what corruption is and how it can be defined, if at all, the exercise of situational and circumstantial power is not in doubt. How power is conceptualized and defined can vary depending on the discipline; definitions range from the capacity to direct and/or influence others or the course of events or resources; political and/or social power (Rothe & Kauzlarich, 2016: 4); or in possessing the power to order, control and act that has been delegated to individuals in organizations.

The range of power(s) is often exercised via the notion of some level of legitimacy. But what is meant by legitimacy? It is concerned with recognition of the moral rightness of claims to exercise power. The main theoretical approach to legitimacy is that of procedural justice (Tyler, 1990) where we have instrumental and normative obedience to law(s); the normative obedience is subdivided into personal integrity (e.g. a set of principles on which we act) and legitimacy (our views as to whether 'practitioners' have the credibility and power to exercise). To appropriate Tyler's (2003) work that helps explain our compliance with the law(s) not because of a fear of punishment but because we see law enforcement (or some of us)as legitimate (Tyler & Wakslak, 2004) has relevance for the esteem in which some medical specialists are held. If criminal justice is seen as procedurally fair it can lead to acceptance of the decision/outcome of a case and thus initial ascription of legitimacy. If healthcare treatment is seen as appropriate, particularly *for* and *by* patients' healthcare professionals as seen to have legitimacy.

Since Weber (1978) is central to legitimacy, his work is a platform on which to base the debate regarding legitimacy. For Weber, the modern state and use of force is regarded as legitimate only so far as it is either permitted by the state or prescribed by it. Furthermore, it can explain the delegation of power of some private practice, as they are under some kind of state regulation. If a state contracts out healthcare provision it still continues to claim the right to determine under what circumstances practice should occur. The examination of the legitimacy of

healthcare practitioners is then of vital significance. We defer to medical practitioners to make judgement on our healthcare needs. Backed by a scientific body of knowledge a doctor/nurse has the legitimacy to administer a course of treatment.

This deference and thus obedience stems from (1) material motives (such as self-interest), or in this case physical as we wish to deal with an illness (2) an emotional (affectual) empathy with doctors/nurses or (3) ideal motives (such a philosophical or religious views (Bottoms & Tankebe, 2012: 128) regarding healthcare. Securing legitimacy then is an ongoing process. However, by applying resources at their disposal, such as the power to control the discourse of a problem or event, the medical profession has the ability to reaffirm and reproduce itself. These mechanisms of power then produce 'knowledge' that reinforces the exercise of that power (Rothe & Kauzlarich, 2016: 49). This is particularly noticeable regarding discourse; here the powerful can define the problem, or dismiss it as one. Once defined, rules, set parameters of how the 'problem' is/can be discussed, in turn frames the 'truth' about the subject (Foucault, 1980).

Beetham (1991) suggested that those that hold power are only legitimate to the extent that the rules of power are justified and shared by prevailing and subordinate elements within a community/society/nation. To be legitimate three 'tests' need to be passed: (1) to exercise power it must come from a valid source of legitimate power/authority (2) the power should be exercised in a manner that is considered justified in the context in which it is used and (3) the exercise of power must be seen to serve a recognizable public interest, rather than simply the interests of those that hold power. The healthcare profession appears to fulfil all three criteria.

Raz (2009) claimed that consent, if willing, is pre-emptive. This is where the public agree in advance to treat laws and orders of that state and/or institution as superseding and replacing personal judgement. Furthermore, an act of real consent alters the situation between those that hold power and those that are subjected to it. Pre-emptive and normative consent is not a 'one-off act of identification' (Bottoms & Tankebe, 2012: 135). Rather it is an additional reason to respect authoritative directives and affects all encounters with individual and institutional 'power'.

However, not all members of the public engage with institutional power, as such power is challenged rather than accepted as legitimate, as it was with the recent pandemic (Lavorgna & Myles, 2022).

People with 'power' thus attempt to converse with audiences in an ongoing relationship since legitimacy must appear dialogic and relational in character (Bottoms & Tankebe, 2012: 129). A dialogic response, however, is not a single transaction but an ongoing search for legitimacy. It therefore follows that it is possible for the medical profession to be seen as legitimate and yet also corrupt and prejudiced.

Those in a position of power, though, must convince themselves that the exercise of power is acceptable and justified too. Legitimacy is important for the stability and effectiveness of power since unless those who exercise power are convinced that there is an adequate moral justification for continuation in office and/or practice, it is doubtful they will be effective. A loss of 'internal legitimacy' and doubt can lead to disorganization of behaviour and an inability to perform. In addition, legitimacy can be regarded as a precondition for successful audience legitimacy; that is, it is necessary for those that hold power to cultivate credibility in the moral rightness of their own legitimacy prior to making claims to others to be legitimate. This dialogic framework highlights that legitimacy is constantly in flux and claims to legitimacy contested and revised.

The medical profession is subject to challenge; anti-abortionists have threatened and murdered doctors and abused patients (Ellis, 2020); vocal individuals claim the coronavirus pandemic was a hoax (Lavorgna & Myles, 2022), to name a few. However, in the main, those in the medical profession are highly respected and hold consensual power, depending on the jurisdiction. This legitimate power, though, is what corrupt medical practitioners hide behind (see Chapter 7). Divergence from expected practice is hidden and/or covered by fellow colleagues or blocked by the institution. We therefore have two types of legitimacy; (1) legitimacy of the official legal system (practice as laid down in a body of knowledge) and (2) legitimacy of the practice (actual conduct and attempts to present such conduct as acceptable). It is this later practice where acts of corruption in the medical profession occur hidden behind a 'white wall' of public legitimacy.

Conclusion

This chapter started by highlighting that healthcare corruption is an interdisciplinary problem with a brief review of rational, economic, legal and political theoretical explanations as to why people are and/or commit corrupt acts. This was followed by an explanation of how criminology is useful in helping us understand healthcare corruption. Of course, there are limitations to all theoretical approaches but as was mentioned in this chapter theoretical thoughts have future consequences (Lilly et al., 2015). Furthermore, I considered the concept of power and how the notion of legitimacy, often used to explain law enforcement in democratic nations, is dialogic. This notion of legitimacy, however, is useful in helping understand how the medical profession is highly respected but that this level of consensual legitimacy is abused by some corrupt medical practitioners.

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3

Healthcare Corruption and the Problem of Measurement

Introduction

Methods used to measure and assess corruption vary, but within the social sciences a combination of methods is often used. One major challenge in the measurement of corruption, however, is the problem of definition (see Chapter 2). Regardless of this problem all measurement tools should take account of what is achievable and contribute to the understanding of *why* and *how* people engage in corruption beyond the measurement of it. Therefore, it is useful to have a measurement chain. This includes (i) recognizing the best measurement tool available (ii) adapting it to the local conditions, (iii) implementing it, (iv) processing it, and then the communication of its results and (v) evaluation of the impact (Galtung, 2006; Sampford et al., 2006) of the approach to reduce and/or prevent corruption.

I start the chapter with a brief review of the types of corruption the healthcare sector is subjected to. This is to highlight the breadth and depth and reach of healthcare corruption and the complex and multi-faceted challenges to measure local, national and international healthcare corruption.

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I then consider the different techniques that are used to measure corruption in the healthcare sector (Ceschel et al., 2022; Sampford et al., 2006; Simpser, 2020; Sulitzeanu-Kenan et al., 2022; Olsen et al., 2019). I highlight the range of techniques that yield data on corruption and the subsequent analysis of the data on which we draw inferences. Corruption reaches into every aspect of life, but in healthcare it can mean a matter of life and death. It can have serious consequences for access, equity and effectiveness of healthcare. Measurement of healthcare corruption is paramount but the health sector is characterized by a high degree of asymmetry of information (information is not equally available to all in the health sector) leading to significant corruption (Hussman, 2011) and contributing to the problem of measurement.

In the next section of the chapter I consider the impact of the volume, velocity, variety and veracity of data in the prevention and reduction of corruption in the health service. The healthcare sector has always (and will always) harvest incredible amounts of data and these data streams (depending on the jurisdiction), in hard copy and/or online, are subject to misuse via cybersecurity breaches and corruption.

In the final section of the chapter, I examine how the public and private healthcare sectors are interconnected but the approach to the same problem is sometimes different. An act of corruption, depending on the sums lost and the offender(s) is *sometimes* defined as abuse instead of corruption in the private healthcare insurance sector (Stenström, 2020). By downplaying or redefining the act, the private insurance healthcare sector precipitates and participates in its own victimization (Brooks & Stiernstedt, 2022) and under-records corruption on purpose.

Types of Healthcare Corruption

Corruption is a complex and multifaceted challenge and thus sometimes difficult to measure (Galtung, 2006). This, however, is no excuse not to measure corruption. The are 'common' types of corruption within and across the public and private healthcare sectors. Regardless of the

type of provision—public and/or private—or mixed with the enrolment of people on either a mandatory and/or voluntary scheme, or a combination of them all encounter corruption. These are:

- *Improper coding* is where invoices for healthcare procedures do not match the actual procedure provided.
- *Upcoding* is where claims are submitted for healthcare services/procedures above and beyond the actual healthcare service, e.g., putting in a claim for more expensive treatment than was delivered.
- *Unbundling* is where claims are submitted for each step of a service/procedure as if it was distinct and a separate part of the service that increases costs.
- *Multiple claims* is where a healthcare service puts in the same claim multiple times or corrupt networks use a single patient's personal records to claim across multiple healthcare providers.
- *Phantom (ghost) claims* is where claims are made for services that have not been provided or for medicine/medical devices ordered but fail to arrive.
- *Unnecessary medical intervention/tests* are diagnostic tests, x-rays, etc., conducted to increase insurance payments claims.
- *Misrepresentation* is where medical professionals and patients collude by claiming cosmetic surgery as necessary medical intervention and treatment.
- *Fraud* is where we can alter all or part of patients' records to claim for a medical intervention and treatment that was unfulfilled.
- *Identity Fraud* similar to above, but worth expanding; we are unaware that our personal details have been used to claim for medical treatment, patients misrepresent information or use another person's coverage or insurance card to claim benefits.
- *Kickback schemes* are where medical professionals recommend a medicine (even if inappropriate for a patient) from a pharmaceutical company knowing a payment is based on volume of prescriptions written.
- *Self-referrals* is where a medical professional refers patients to a specific hospital or healthcare service even if needless for personal financial reward.

- *Prescription fraud* is a specific type of fraud that has serious societal ramifications. For example, 'doctor shopping' is where individuals and/or criminal networks obtain prescriptions from multiple sources and redirect medication for illegal profit. This can involve kick-back payments to doctors/physicians for signing a prescription for dispensing powerful but prescribed medication, i.e., oxycontin (Evans et al., 2019; Hampton, 2021).

It is possible to engage in these acts for years depending on the type of corrupt approach. For example, 'hit and run' (Ekin, 2019) techniques where a high volume of claims is submitted within a jurisdiction and/or across state-lines employing stolen or counterfeit patient details. Once payment is made, the healthcare service 'company' disappears. These are often discovered, but too late, and the funds set aside for healthcare are lost. An alternate approach is the 'dripping-tap' or 'steal a little but often' approach. Those in the medical profession or interconnected sectors, i.e., insurance encounter this problem where an individual or organization submits claims below the online systems threshold that are established to detect frauds and/or errors; this type of corruption can continue for years.

The Measurement of Healthcare Corruption: The Breadth of Techniques

As a discipline, criminology has debated the usefulness and limitations of crime data and the problem of recording and measuring crime. The literature (Bowers et al., 2004; Coleman & Moynihan, 1996; Maguire & McVie, 2017; Tomson et al., 2015) explains how crime is recorded and becomes a statistic but also the reason(s) why we under-record the volume of crime. Regardless of the nature of the criminal justice system—adversarial or prosecutorial—similar issues arise; lack of confidence in the police, no insurance, crime committed whilst victimized, items stolen of little personal value, and so on that impact on the measurement of crime.

However, if we consider these data for what they are and are aware of their limitations, they serve a purpose and are of use. For all its limitations, recorded crime is a corrective to inaccurate views of crime and reveals how the police work or those in counter-fraud and anti-corruption units, and offers an insight into how different types of crime, e.g., rape, and criminal corruption are viewed. Some of this is down to the policing body tasked with investigating different crimes, though, narcotic offences and/or corruption, in different sectors such as the financial sector or healthcare sector, the lack of funds, personnel and equipment to reduce crime and corruption.

As with all crime data, it is useful to reflect on whether the measurement of corruption and acts of criminal corruption—those that violated a criminal law rather than civil law—is worthwhile. I suggest that it is more than worthwhile; it is necessary (Brooks, 2016, Brooks et al., 2013). Whilst all data can be flawed, and some of the approaches in preventing corruption (see Button et al., 2023) this is no reason to abandon the exercise. Any policy or strategy will need to be based on some indication of the size of the problem to put in place a system of prevention, and as such the measurement of corruption and the development of more sophisticated approaches can increase our knowledge of the problem and, in turn, the level of victimization. This is particularly important for all crime but as we attempt to continue to deliver high-quality healthcare to expanding populations, funds lost to corruption (see Chapter 1) affect our ability to safeguard the most vulnerable in need of healthcare.

How then *can* and *should* we measure healthcare corruption? It is heterogeneous and thus multiple measures are needed. Corruption is measured via surveys of attitudes and personal knowledge, practice and experience (Habibov & Cheung, 2017; Khodamoradi et al., 2017; Miller, 2006). A survey, if consistent in its questions and/or statements and application and analysis can show a trend(s) across a number of years. These could include a change in public perception in corruption regarding healthcare services or a particular type of service/treatment, payment for an informal service (Stepurko et al., 2015) and increase or decrease in private insurance fraud (Brooks & Stiernstedt, 2022; Button et al., 2017; Jung & Kim, 2021), numbers of ghost workers (Vian,

2020) on a payroll, the level of absenteeism (Obodoechi et al., 2021), and medical practitioners engaged in dual practice (Vian, 2020), loss of regular and emergency aid (Button et al., 2015) and estimates of counterfeit and/or substandard medicines and location of them around the world. The effectiveness of some of these approaches, however, is doubtful for some (see Button et al., 2023).

Of course, the survey method here suffers from the same issues of corruption as elsewhere. However, a survey affords us some useful data within and across national attitudes towards healthcare corruption and attempts to reduce it. Broad, international surveys offer a useful overview of types of corruption, e.g., informal payments. The problem, though, is that little research has been conducted on the different types of payments for treatment or medicines bought by and for whom and where, e.g., in hospital, specialized clinic, etc. Far more detailed research is needed within and across nations on this issue. Broad surveys on informal payments miss this important context and local detail that informal payments are a barrier, a wall that blocks patients' access to healthcare. Furthermore, methodological differences (e.g. recall periods), definition of informal payments, and use of language are important in research, and response rates which are affected by reticence, or participant's willingness to disclose an informal payment (Mejsner & Karlsson, 2017) impact on the quality of data.

In order to attempt to overcome such a problem of either the subjective or objective approaches to measurement, aggregate indicators (that combine several forms of both objective and subjective indicators) have now become far more common. Kaufmann et al. (1999) suggested that such indices provide a more sophisticated approach to assessment and referred to them as composite indicators (Arndt & Oman, 2006). Aggregate indicators have become influential and offer a broad national coverage and combine a wide array of individual indicators that allows us to draw on data sets and reduce margins of error and bias that occur in individual measures, and calculate explicit margins of error.

It should be highlighted, though, that many of these indices possess ambiguous relationships with corruption. Whilst presented as sound economic sense, there has been a politicization of perception indices and the management of an organization might be reluctant to respond to

what they consider to be sensitive questions, particularly if seeking to enter or expand into a market. This reluctance can be social, political and economic with limited and/or false statements to minimize legal and political repercussions (Jensen et al., 2010). The breadth of scope of surveys, whilst useful, often lack sufficient local detail. Small scale, local research, is important for understanding the level and reality of corruption (Heywood, 2015) regardless of the sector. But measurement of corruption, or attempted measurement can also prompt responses that can undermine the reduction and prevention of corruption. Depending on the jurisdiction participants responses have the potential to be of limited value and those that engage in corruption adjust their behaviour ('displacement' in criminology terms) by developing ways to circumvent a new system or seek out different types of corruption.

Furthermore, academia is also part of the problem as we often use data without detailed examination of its provenance. There is widespread use of aggregate data by academics. Urra (2007) pinpointed three issues with aggregate data; these were the perception, error and utility problem. For Urra the perception problem is the margin of error when subjective indicators are used to produce complex statistical constructions that can produce an illusion of quantitative sophistication; the error problem is the internal margins of error already contained within the different sources of corruption data, and sampling errors (part of any social science research) and utility problem where the gap between measurement and solutions are difficult if not impossible to turn into actual anti-corruption initiatives. This criticism, however, does not mean that we should abandon all attempts to measure corruption. It is imperfect, particularly with all types of crime, as those familiar with crime data are aware, but those acts and crimes that are hidden add that extra complication of assessment.

Moving beyond surveys and the perception of corruption there is the problem of ghost workers, i.e., a person added to the payroll that is non-existent but has an income that is claimed by an individual or others. This type of corruption affects places that have poor healthcare infrastructure. We can measure the number of ghost workers on a payroll, but only estimate the impact this has on healthcare provision. One technique to measure the manipulation of a payroll is Fraud Loss Measurement

(FLM) exercises (Gee & Button, 2014). A sample of transactions within a payroll system or procurement payment is reviewed. FLM is based on the principle that in a number of transactions, a few cases of fraud and/or error will be detected, with some cases undetected and a high number of correct transactions. There are, however, some issues which need to be considered. Substantial sample sizes are needed for an accurate assessment and this exercise is suited to organizations where records are automated, orderly, coherent, perhaps online, and accessible. Automated systems, however, are often standalone (Ekin, 2019) instead of part of an internal and/or external interconnected system. FLM exercises are suited to substantial numbers of similar transactions within a specified population rather than the total transactions in an organization or sector unless they are broken down into small chunks of similar transactions. An FLM exercise is of use, then, if there are sufficient numbers that examine a type of payment in a specific sector or specific profession such as dentists, opticians, doctors and hospital consultants, external contractors, who exploit the healthcare services.

Audits are also a useful tool, but an auditor will see the data an organization wishes to present rather than all the data. There is a debate here on what is the role of the auditor, particularly as well-known organizations Price Waterhouse Copper, KPMG, etc. (Ariail et al., 2019; McKenna et al., 2023). have published accounts and claimed an organization that is in debt is solvent. Furthermore, few organizations have the capability to audit major organizations and so with little competition, collusion is possible where an auditor(s) suspects or is aware of creative and/or omitted data in accounts but fails to act, as it is in the interest of the auditor(s) and the company they represent to keep quiet to keep the contract. Poor or corrupt accounts impact on the services a hospital and/or specialized clinic can offer. The impact is thus substantial as services are delayed or withdrawn.

The impact on healthcare provision is also substantial if there are high rates of absenteeism. This is where a person is legitimately on the payroll but chronically absent without approved reason (Belita et al., 2013). I suggest, however, that even an approved reason needs consideration here. For example, absence is approved by whom? Internal management (that might be corrupt), and is the reason put forward by those

absent authentic? Yet again, context is important. Levels of absenteeism differ depending on the nation. Low income and poor work conditions lead to healthcare workers seeking work elsewhere (Kline & Lewis, 2019). Research can show how often a person is absent but often fails to highlight what reasons *they are* absent for.

Dual practice is another version of absenteeism (Obodoechi, 2021). Doctors that hold a public sector position can also engage in private practice, in some jurisdictions, e.g., United Kingdom, and whilst this dual practice is acceptable it offers avenues of corruption. Doctors/physicians could redirect medicines, equipment, vehicles and fuel, funds and patients from the public sector to private practice in which they have personal or familial financial interest (ECORYS, 2017). Dual practice could thus reduce the quality of services in the public sector, and exacerbate inequalities in patient access and healthcare workers distribution. It can also increase informal payments (Abera et al., 2017) as people seek healthcare and engage in 'queue jumping'. How, though can we measure patients, that can exercise a choice (if affordable) paying for private sector healthcare and have confidence in the data? After all, patients pay for healthcare in different systems, as a choice and/or via extortion (see Chapter 5).

Further corruption of healthcare services is the use of counterfeit and substandard medicine and medical products (see Chapter 7). These enter markets for a number of reasons: poor national regulation and state collusion. The impact of counterfeit and substandard medicine and medical products, though, is felt everywhere: no nation is exempt. However, the distribution of this impact is unequal, particularly with specific types of medicines; e.g., anti-malarial medicines, and location, e.g., Saharan Africa and victims, e.g., children (Vian, 2020). Here, though, we have partial data of recorded tests of medicine that have reached and/or failed to reach the required threshold of a standard medicine. Data is recorded in-the-field with a spectrometer that analyses specific medicines that are subject to corruption. These are often antibiotics such as ciprofloxacin (this treats a number of bacterial infections, i.e., abdominal, respiratory, typhoid and urinary infection) and as above affect specific continents such as Africa and central and southern America.

All of the above methods in this chapter, sometimes use aggregated and/or disaggregated data or a combination of both. By disaggregated data I mean numerical or non-numerical information that has been (1) collected from multiple sources and/or on multiple measures, variables, or individuals; (2) compiled into aggregate data (a summary of data) for the purposes of public reporting or statistical analysis. Combined these data offer the clearest picture of corruption we can obtain.

We know that many types of healthcare corruption flourish where some people can exercise power over access to services that others need (e.g., licences, health services) or where legal power is invested in individuals and institutions (law enforcement, court proceedings, and judges). More qualitative, local healthcare analyses that collect disaggregated data are therefore useful in unpacking the impacts of corruption on specific populations, e.g., young children, women, etc.

We can also view corruption as a static or dynamic factor. *Static analysis*—scores, survey data, rankings and indices—are a *snapshot of what is*, whether that is perceptions, laws, institutional context or reported experience of corruption. As such, static data is used to compare the performance or characteristics of a country, sector and/or institution to another one (e.g., indicators on child mortality per annum or at a different point in time (e.g., mapping the change in mortality rates), (Luna-Pla & Nicolás-Carlock, 2020) provided the methodology is consistent. This makes static analysis useful for the assessment of corruption by analysing the differences and needs in a legal or institutional framework to tackle corruption, monitoring outcomes of a programme and its progress, but is of limited use in helping us understand *why* progress has or has not happened.

If static analysis tells us what is, *dynamic* analysis seeks to highlight *why it is*; and how changes might happen (Accinelli et al., 2017; Fantaye & Birhanu, 2022). A dynamic approach to corruption seeks to uncover the underlying causes of corruption in political settings, and poor management of services, and reforms that might challenge vested powerful interests, implementing change based on the understanding of needs and services in systems and of people and highlights the limitations for meeting service needs in healthcare markets (and thus adjust healthcare services to achieve some success).

Research has shown that high levels of corruption have high rates of infant and child mortality (Vian, 2020). Poor regulation is often cited as a major cause of infant and child deaths, and the UN recognizes corruption as an 'enormous obstacle to the realization of all human rights', and advocates transparent and meaningful participation as an effective way to reduce corruption. It also suggests that those that engage in corruption should be held to account and that corruption harms and destabilizes healthcare systems. Furthermore, it suggests access to Universal Healthcare Coverage (UHC) services is essential and affordable. All of this is admirable. But is this possible? Even in industrialized democratic nations healthcare is sometimes out of financial reach for some citizens, in systems that encounter 'manageable' corruption.

The problem now and in the future, however, is not the different types of corruption I have highlighted here or the measurement of them; it is the v*olume, velocity, variety and veracity of data* that, depending on how we use it, is able to help reduce and prevent corruption or be a conduit of it.

The Prevention and Reduction of Healthcare Corruption: Volume, Velocity, Variety and Veracity of Data

The healthcare sector has always produced incredible amounts of data such as medical records, doctors, dentists and hospital visits, and compliance and regulatory inspections to name a few. These data streams (depending on the jurisdiction) are in hard copy or online but with the development of artificial intelligence there is a rapid digitization of volumes of data (Davies, 2021). Electronic health data sets are so substantial and complex that it is difficult (or impossible) to administer with traditional software and/or hardware. Data in healthcare is overwhelming because of its volume but also because of the variety of data and the velocity at which hospital administrators, doctors/physicians, dentists have to sometimes make a decision. Healthcare data includes clinical data, doctors/physicians' notes, prescriptions, medical imaging,

test results, pharmacy data, private and public health insurance, patient electronic data, patient records, machine/sensory data (e.g., monitoring vital signs of medication), etc. The *volume, velocity, variety* and *veracity* of healthcare data is thus a problem but also useful, depending on how it is used, to measure healthcare corruption.

Data mining is one technique that allows automatic scanning of a high volume of healthcare data (García, 2019; Joudaki et al., 2016; Nichols, 2020; Puaschunder, 2020). The use of such systems in healthcare enables the management of medical knowledge and its secure exchange (as secure as possible) within the healthcare sector. The essence of this approach is to recognise relationships, patterns and models which support predictions. These predictive models are used in hospital information systems (see point above, though, about standalone systems). Data mining, however, is one step in a process. What is needed is (1) selection, (2) pre-processing, (3) sub-sampling and transformation and (4) application of mining methods with (5) evaluation of the collected data to extract subsets of data (EHFCN, 2019) in reducing and prevention of potential corruption.

Data mining offers healthcare services the chance to secure descriptive and/or predictive data (Kudyba, 2018). Descriptive data sets have a number of uses: it can attempt to highlight patterns, or *associations*, between elements in data sets; it can c*luster analysis,* grouping similar types of data) in the same cluster and/or different clusters and *link analysis to* form networks of analysis that examine associations. Predictive data works with predefined objectives (including the creation of models) and helps to predict data, or dependent variable(s) (e.g., that which is analysed from a set of variables (which can be controlled). In medical research, however, data mining starts with the hypothesis and results are adjusted accordingly; this is different from standard data mining practice that begins with a set of data without an obvious hypothesis and is concerned more with the description of data than explaining the patterns and trends of the data.

For the healthcare sector, there is, in the vast amount of healthcare and non-healthcare data (e.g., social media postings) an array of data, which has the potential to reduce corruption (Davies, 2021). By discovering *associations* and patterns and trends, there is the potential to enhance the

level of care to patients but also reduce costs caused by error, and waste, but most of all corruption. Data analytics can move beyond clinically cost effective and appropriate treatments in helping to predict and minimize corruption implementing advanced analytic systems that check how accurate the data is, and how consistent healthcare insurance claims are (Joudaki et al., 2016).

The *volume* of data, both 'medical' and personal (e.g., social postings), but with the development of technical medical advances such as 3D imaging and biometric readings, has produced 'new' data streams. Advances in data management, virtualization and cloud computing, help the development of platforms that can capture, store and assess volumes of data. By digitizing data records it has the potential to detect healthcare corruption. Of course, the problem with such a volume of data is that the more complex and wide-ranging it is, the opportunity to commit corruption increases. Data analysis, therefore, on its own is limited; it can highlight a problem but a strategy is needed to prevent corruption since corruption is often 'hidden' and data analysis alone is unable to claim it has 'discovered' corruption in a hospital, clinic, etc. The private sector, however, is capable of analysing volumes of data but the public sector (depending on jurisdiction) has limited capacity to analyse healthcare records (Ballantyne & Stewart, 2019).

The *velocity* at which data is collected presents new challenges, too. Just as the *volume* and *variety* (see below) of data that is now collected has changed (paper to online), so too has the *velocity* at which it is created and evaluated within and across data streams. Most healthcare data has (and still is in some jurisdictions) static (e.g., paper file systems) but healthcare technical, medical systems secure real-time data and measurements (e.g., home blood pressure readings sent directly to a database), medical (e.g., operating room monitors for anaesthesia, heart monitors, etc.). This type of data and measurement can help with highlighting potential healthcare issues such as a hospital, clinic or unit or individual doctors/physicians' prescribing excessive amounts of medication, and the unnecessary use of highly specialised equipment and subsequent claims for such use, but at the same time detailed 'correct' analysis of data (Davies, 2021; Ranchal et al., 2020) can advance an anti-corruption healthcare strategy.

A problem with trying to measure the *variety* of healthcare data is that it is *structured*—instrument readings, patient medical records, treatment and reimbursement codes, and *unstructured* data—handwritten nurse and doctor/physician notes, hospital admission and discharge records, paper prescriptions, and *new data streams*—fitness devices, social media postings, that makes the measurement of healthcare data challenging but not insurmountable (Tiwari & Agarwal, 2022). Analytic techniques have adjusted to the complex healthcare market, and sophisticated analytic techniques are now used to deal with the volume of data, at *velocity* and in a *variety* of different data sets. The problem here is that, whilst useful in helping reduce corruption, i.e., excessive use of medicines, the *variety* of data does not always lend itself to useful analysis.

This leads on to the *veracity* of data. Here we seek 'data assurance' or quality of data, where data analytics and outcomes are considered credible. Data quality issues are of acute concern in healthcare; clinical judgements affect the health, life or death of a patient. These judgements are based on the quality of healthcare data. The problem is that unstructured data, if used, is all too often incorrect (e.g., inaccurate translations of handwriting on prescriptions) and 'traditional' data management assumes that 'warehoused' data is factual, clean and precise but is often incomplete and incorrect. This can, of course, lead to error and waste (OECD, 2017), but also corruption. Quality data can help with the design and development of an anti-corruption strategy but poor or 'incorrect' data leads to poor data collection which is of little or no use in developing an anti-corruption programme. Time spent on reading and rejecting poor quality of data is time lost to proper anti-corruption analysis (EHFCN, 2019).

The private healthcare sector is, however, perhaps more advanced in dealing with *volume, velocity, variety* and *veracity* of healthcare data than the public sector. The private sector, however, has an interest in protecting its profits; it is to this notion of profit and how the private sector deals with corruption to which I now turn.

The Private Sector: The Power to Define Healthcare Corruption

The private insurance sector, or those that work in it have the power to define what is a risk and threat (O'Malley, 2019). Risks and threats are handled, however, without always engaging state law enforcement (Meerts, 2020) where the 'architecture' of organizational, sectoral and state control (Wilcock, 2019; Stenström, 2020) impacts on how organizations deal with risks. Acts of corruption are seldom disclosed (Ericson et al., 2003) or defined as a problem in the private sector. Instead, and placed in a Foucauldian framework, Stenström (2020) highlights how the technologies of power shape the plurality of policing (Bowling et al., 2019; Button, 2016; Nokleberg, 2020) and the private healthcare insurance sectors' approach to corruption.

Primarily concerned with statistical analysis of events rather that disciplining individuals (Headworth, 2021) the private insurance sector works to secure profit. Wilcock (2019) and (Stenström, 2020) highlight that the insurance sector is engaged in promoting a 'system' that allows individuals to 'cheat' within a set 'bandwidth' of desirable and undesirable behaviours (Foucault, 2009: 6) and financial margins where profit is maintained (Ericson, 2007). Private insurance then considers customer satisfaction and convenience of service important, placing controls, and a boundary on investigations to prevent threats to organizational profit.

There are thus different methods to determine the truth of an act (Ericson & Doyle, 2004; O'Malley & Valverde, 2014) in the public and private sectors, and types of control—discipline of bodies (Headworth, 2021) or financial risks and thus measurement of corruption. This is a crude distinction yet the work cited here emphasizes the need to move beyond research on the characteristics of corruption and understand how power is exercised in the private healthcare insurance sector to shape definitions of what is considered acceptable and unacceptable levels of risk (Wilcock, 2019) and measurement of corruption. This is part of the plurality of policing, a network of state and private sectors that exercises power to shape practice and thus sanctions in the context of responsibilization (Garland, 1996). With the power to shape a bandwidth of acceptable and unacceptable levels of behaviour then, is private

healthcare insurance sector precipitating and participating in its own victimization?

The private insurance sector is not seen as an ideal victim of crime (Duggan, 2018); it is seen as acceptable to defraud (Button & Brooks, 2016; Button et al., 2017; Gill & Randall, 2015). An insurance company is able to withstand partial loss—as a victim of a crime—and still function. It has no need to pursue all potential cases of financial loss, instead it has to appear that it is 'tough on crime' and acts of corruption (Stenström, 2020) but instead accepts a tolerable level of losses. In this sense, I suggest that the insurance sector is precipitating and participating in its own victimization (Cross, 2013, 2020; Petherick, 2017). Accepting losses will embolden some offenders to commit such acts, unless the act is committed inside the organization. Framed within its own responsibilization (Garland, 2001) the organizational pursuit of profit downplays its victimization and thus measurement of corruption, whilst precipitating in its victimization and participating in company losses to crime/corruption.

Conclusion

This chapter has shown that trying to measure a crime, corruption or criminal corruption (Brooks, 2016) is difficult. As a 'hidden crime' or unethical act its impact, particularly for healthcare is to condemn people to a slow death sentence in some cases. Healthcare corruption will often have a delayed impact instead of immediate, and the number of people—women and children in the poorest parts of the world—are often the victims. All the platitudes, and aims for universal healthcare are thus still a 'wish list'.

Furthermore, by emphasizing the public sector as a cause or conduit of crime the social sciences have for years been trying to explain a range of behaviours at the individual, organizational and state levels that are considered corrupt. This is limited. With the increase in the privatization of public services, in some jurisdictions, the distinction between the public and private spheres of influence and power is becoming blurred. There are, however, significant differences within states—democratic,

autocratic and across sectors—on how healthcare services are delivered and the impact of transnational and cross-border corruption. All of these issues make the measurement of a 'hidden act' difficult, but with a substantial loss of life due to corruption, we *should* and *must* continue to measure what is a cold, callous and sometimes indifference to human life. Data is a benchmark, a foundation on which we can build. Corruption blocks access to healthcare and harms the legitimacy and subsequent faith in healthcare institutions. The measurement of healthcare corruption is about people; it is about the services blocked, withdrawn and/or that we are excluded from which makes the measurement of data a valuable and worthwhile exercise.

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4

The Costs and Impacts of Healthcare Corruption

Introduction

In 2020 global healthcare expenditure reached nine trillion (US dollars) (WHO, 2022). This expenditure is partly down to the increase in the global population and demands for services, but also funds lost to corruption, abuse, waste and error. Whilst waste and error are a problem, these can be reduced with careful planning and execution (Dalton & Byrne, 2017; Ekin, 2019; Ramori et al., 2019) to some extent; however, in this chapter I primarily consider healthcare funds lost to corruption and abuse.

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). This chapter draws on the cost of crime literature (Albertson & Fox, 2012; Czabanski, 2008; Wickramasekera et al., 2015), and particularly the work of Cohen (2020) to highlight the breadth and depth of costs beyond the obvious impact on direct victims of crime.

Building on this literature, I then highlight the debates we should/can have on the breadth and depth of healthcare corruption costs. I suggest that we need to move beyond obvious direct costs of healthcare corruption and consider indirect and societal costs in cases of proven

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healthcare corruption. Some jurisdictions already consider a range of impacts, e.g., USA, in a legal context of negligence court cases and/or jury awards. In other jurisdictions, such as Japan (Suzuki & Otani, 2017) and the United Kingdon there are criminal compensation awards for victims with caveats, of course. The advantages and disadvantages between these schemes and subsequent 'awards' are available elsewhere (Miers, 2019); here, I consider the cost of direct and indirect victims and societal costs of healthcare corruption, and what we should perhaps count as a cost in the future as we attempt to measure (see chapter three) healthcare corruption. In the next section of the chapter, I reflect on the problem distinguishing between paying a bribe and/or extortion in the healthcare sector. Finally, I consider that some healthcare costs are due to the systems in place. A combination of pre-payment and post-payment systems, particularly post-payment have the potential to lead to corruption. Trying to secure payment after a service has been rendered and treatment dispensed is problematic and is an avenue for healthcare corruption.

The Costs of Crime: Money as the Currency Of Justice?

I understand that there is, for some of us, neither a moral nor adequate level where we can put a financial value on tangible (actual medical costs) and, in particular intangible costs such as physical and emotional pain and lost quality of life as a victim of crime. However, payment for victimization and subsequent physical and emotional pain is part of all criminal justice systems. In one shape or form, 'money justice' (Daly & Davis, 2021) is part of civil and criminal justice systems across different jurisdictions and cultures and has antecedents in archaic legal sources where mutilation and payment for victimization is/was customary practice. Revenge systems—payment in place of mutilation or ransom for a limb in place of payment—were replaced by state justice and compensation, in some jurisdictions. Liability and subsequent punishment and civil and criminal justice, such as payment in lieu of other punishment(s) (Geistfeld, 2016), however, still echo in democratic systems we have now.

These residue elements, and in particular payment, are presented as restitution, reparation and compensation. However, in socio-legal and criminology/criminal justice discourse these terms are often used interchangeably and the core meaning of each term is also subject to its historical antecedents. For example, *restitution* could mean the return of stolen or seized land but *reparation* is payment in lieu of land/objects/works of art that individuals/organizations/nations cannot return. In the later instance 'cannot return' (Daly & Davis, 2021) could be a tactic or excuse that we 'cannot return at this moment in time' due to political circumstances, e.g., unpopular to return some artefact with the electorate.

To complicate matters *reparation* is to restore some historical injustice that might include the payment of money similar to *compensation* (Torpey, 2006), whilst de Grieff (2006) uses reparation as an umbrella concept for transitional justice. The United Nations (2005) also use *reparation* as an umbrella term for *restitution*, a return to the status quo, *compensation* as a type of money payment, *rehabilitation* medical, legal or psychological care, and *satisfaction* where we seek the 'truth' and an apology and/or preventing a repeat of some injustice. Drawing on these descriptions, it is possible to see how victims of medical harm seek compensation, rehabilitation and satisfaction.

For some, money is, however, the only 'justice' on offer for this type of healthcare corruption, and thus the only form of justice available. Money is, therefore, in some circumstances, the *currency of justice.* 'Money justice' as the currency of justice is what is offered to victims in the aftermath of 'wrongs' committed by individuals and organizations (state or non-state) and nations. Payments can be civil justice awards and out-of-court settlements for personal injury. However, 'money justice' also examines the procedures and techniques and outcomes of payments to victims in a broad range of settings where payments are intended *as a form of justice.* (Daly & Davis, 2021: 61–62). It is a form of corrective justice where liability should 'correct' the injustice. The key elements of this approach are that only wrongful losses should lead to a duty to repair, and an individual or organization depending on the healthcare system has a duty to repair the harm caused. Payment is due if intentional and/or negligence is proven (Daly & Davis, 2021; Daly & Holder,

2019; Renaud, 2018). Some patients, however, that have suffered the most egregious medical acts, depending on the jurisdiction, struggle to establish a threshold of negligence.

Money and litigation is referred to justice for victims of crime but often compensation in the case of healthcare negligence or corruption. This can, of course, depend on the case. Money is one part of a panoply of outcomes individuals and family members seek. Non-monetary objectives such as holding people to account, an apology, accepting responsibility for an act or actions and revealing the 'truth' of *what* caused the problem and *why* it happened and *how* to prevent it from happening to others (Hensler, 2003) is highlighted in the literature (Daly & Davis, 2021).

These outcomes above are what some victims seek beyond 'money justice'. Money justice is all that is sometimes on offer, though, and all the legal system can deliver, but this alone hardly makes it justice; instead a value is put on physical pain and emotional trauma. In addition some institutions and individuals prevent external investigation, if possible (see Chapter 7) into potential corruption and challenge payments to victims. This can cause additional disappointment and is exacerbated where an institution has the funds but offers 'compensation' under specific circumstances, e.g., a set time period that will expire unless payment is accepted, under constant negotiation to reduce amount awarded and/or withdraw only to be under negotiation once more where different people secure different level of payments.

Furthermore state payments/compensation are decided in conjunction with notions and aim(s) of justice. In addition, public opinion ranking the seriousness of crime and/or length and type of prison sentence for crime often expresses subjective punitiveness rather than level of harm caused. The problem here is that democratic systems of justice are more of a hybrid system. There is often no dominant philosophy of punishment and/or treatment of offenders. This is reflected in how we sentence offenders and seek to reduce the cost of criminal justice by developing alternative systems of crime control. For example, crime prevention schemes, community policing, intensive probation; all have a cost, and often debates occur on what is the most cost effective (Brooks, 2016, 2019; Eisen, 2017). The term cost effective, however, is often contested;

the cost of a private prison system and public state prison system have different costs but are often presented as comparable (Centre for the Advancement of Public Integrity, 2016).

The economic costs of crime literature, however, has traditionally distinguished between three costs. These are those caused by (1) the offender(s), (2) societal response to prevent and/or deter future crime via retribution and rehabilitation and (3) costs incurred as offenders engage in crime instead of some other productive economic endeavour.

Estimating the Costs of Crime

Estimating the cost of crime is highly problematic, as seen above. Some costs are incurred by an individual and/or familial members whilst others are a societal response to crime. Social costs are a normative concept based on a subjective evaluation on whether an act is harmful (Cohen, 2020), and to what extent there is social consideration of the victims of crime.

Some costs are tangible, e.g., financial compensation is awarded whilst others are intangible. The distinction is often blurred regarding the costs of crime between these *tangible and intangible costs*. Tangible costs are those that involved some kind of monetary payment—which is calculated—such as medical costs, cost of a prison cell and police expenditure. These costs are presented as total funds spent and include estimates of aggregates. Intangible costs, however, are nonmonetary costs such as fear, pain and loss of quality of life. Crime victims incur physical pain and emotional trauma as a victim of crime. Potential victims fear crime, out of proportion to the potential victimization (Noble et al., 2020) and such behaviour manifests itself in psychological 'fear' and changing of habits to contain the real or considered threats, which might incur costs.

There are different ways to measure the costs of crime but these broadly fall under *direct* or *indirect* costs. Direct costs of crime are those inflicted on a victim(s) via an offender(s) acts and/or actions. For example, property is stolen, or medical costs incurred as a victim of violence. Even if medical costs are covered via insurance or some kind of

private or state benefit, there is still a societal cost borne via private insurance and criminal (and civil) cases processed by criminal/civil courts. In addition, a high-crime rate (or perception of one) could inhibit economic development as employers seek to invest elsewhere. This could in turn impact on employment and 'social ills' linked to insecure/temporary employment, poor accommodation and ill-health.

State compensation schemes around the world for victims of crime (see United Kingdom (Miers, 2019) and Japan (Suzuki & Otani, 2017) as examples), help with employment and state sick leave to some extent, and claims on personal private insurance and subsequent increase in premium payments, and potential pressure on employers to hire temporary help to cover a role and/or paying overtime to current employees to cover absent workers. These, however, are total out-of-pocket costs in excess of property losses, medical costs and lost income.

Direct methods of counting costs use primary sources such as information published by a central and/or state administration depending on the type of political structure, e.g., a federalized system. In addition, we can estimate costs of crime via victim surveys (MacDonald, 2017; Lugo et al., 2019; Reep-van den Bergh & Junger, 2018) and/or jury awards as a bench mark for compensation. This later example, however, might set a threshold, depending on the system of law, e.g., adversarial, but precedent in court cases is unable to offer complete assurance of success.

Tangible costs such as medical costs or loss or reduction in income are obtained via direct methods such surveying and/or reviewing the official records of victims or healthcare services, if accessible. But intangible costs such as pain and loss of quality of life are estimated by drawing on '*revealed preference* market based' estimates such as a willingness to pay for a safe neighborhood' and thus high property price for a 'modest' home, with a stated preference approach employing surveys to elicit a willingness to pay for crime reduction (Cohen, 2020).

Then, we have indirect costs: due to victimization, depending on the crime and the victim, some people might alter their behaviour. For example, using a different route to work that could incur extra travel time and costs, purchasing personal protection devices, personal alarms, and/or carrying an illegal or legal weapon, in some jurisdictions. These are all indirect costs that are often visible, but a temporary or permanent

injury—physical and/or mental—affects victims and others in different ways. For example, a victim is unable to engage in housework, and a family member or hired help is needed. In addition, a school age victim might miss a significant amount of school, with the potential that a limited education impacts on future career choice and income (Cohen, 2020). Of course, this can depend on the income or wealth a family can draw on in such circumstances. One of the potential major costs, however, is with crime victims' physical and mental health costs. Both impact on the quality of life not only of the victim but also those that care for them.

Then there are what we call societal costs. For example, police investigations, prosecutors' costs, court costs, probation supervision, incarceration costs—on remand or prison, victim compensation and treatment/therapy costs. In addition, a victim is a witness to a crime but so are others that were present but not victimized; as witnesses, and/or on jury service we all incur costs, too. The impact of crime also leads to a fear of crime for those directly and indirectly victimized, i.e., the victim and family member(s). This leads to individual but also a societal response such as campaigns to warn people of types of crimes.

There are also those costs that perhaps secure the least sympathy and these are costs the offenders' family incurs. If employed and then arrested and sentenced to prison, the family has lost an income. Regardless of whether these costs are included there is an economic cost in lost productivity, and also no doubt future employment as offenders find it difficult to secure employment and accommodation post release (Cherney & Fitzgerald, 2016; Oswald, 2022; Zakaria et al., 2018). There is also the intangible cost as children suffer if a father/mother is subject to a custodial sentence. This intangible cost, though, is difficult to assess: if a child is subject to parental abuse and this individual/couple are sentenced, a child or children might live with another family member or placed in a care home (see Chapter 9) and/or adopted or become homeless.

There is often a delay (in democratic states) between victimization and cases reaching court and potential sanctions in Australia (Thorburn & Weatherburn, 2018); USA and Canada (Anevich, 2019) and England and Wales (Godfrey et al., 2022); and Europe (Kalliris & Alysandratos, 2023). If we accept that this is the case in some jurisdictions then *when*

should we count a 'crime cost? If we count a cost as defined during a year (this could be calendar year or tax year) this is a *prevalence based* cost. If imposed in this year but not realized until years later this is an *incidence based* cost. Cost based on prevalence counts all the costs of the injury that incurred in a year, regardless of when the injury or multiple injuries occurred. Incidence based costs count present and future costs in which the injury cost stream commenced. For illnesses that are acute (less than one year's duration) incidence and prevalence based costs are roughly the same (Cohen, 2020) but prevalence base costs exceed those of incidence for serious injury. Incidence based estimates indicate how much could be saved by preventing future incidents whilst prevalence based estimates could be used for insights into attainable cost savings through enhanced treatment of injuries, and of interest to public health and the estimation of medical care/treatment needs.

Finally other collateral costs could include a refusal to report crime to the police due to a range of factors such as discrimination, previous record, lack of faith in the criminal justice system to dispense punishment, etc. Then, we have miscarriages of justice around the world that are a cost to the individual and family members and impact on the legitimacy of criminal justice systems. There is, however, no clear consensus on what to measure as the costs of crime, and how it should be done, but what is indisputable is that the costs are real and reach beyond those which we can simply count.

The Costs of Healthcare Corruption

In the above section I briefly highlighted the range of issues to consider when estimating the cost of crime. Before we progress here, though, a note of caution is needed. There is a conceptual difference between 'pain' and 'lost quality of life' costs to victims. These can blur but consider that 'pain' is the monetized value of physical and mental *pain and anguish* endured by the victim (Cohen, 2020) whilst quality of life costs is the monetization of *enjoyable 'lifestyle'* the victim is unable to engage in as a result of the victimization/injury.

How, then, can we assess the costs of healthcare corruption? This is highly problematic: some costs are incurred by an individual, public and private insurance schemes/company, but ultimately all of us and healthcare services are funded out of taxation and/or personal private contributions. Some are tangible, e.g., payment as settlement for negligence—but even if medical costs are covered via insurance or some kind of private or state benefit, there is still a societal cost borne by private insurance and criminal (and civil) cases processed by criminal/civil courts (if they reach court).

The literature on the cost of crime on victims covers direct costs such as medical bills (Cullen, 2009) time lost for work—paid employment and housework—and indirect costs such relocation, if possible, purchasing alarms—personal and household (Cohen, 2020). A complete characterization of the crime costs is helpful in that it shows the reach and impact crime has on individuals, family members, etc., but also how best to allocate limited resources to tackle crime.

The poor state of healthcare provision in many healthcare systems around the world impacts on the kind of service it could and should offer its citizens but is often harmed by collusion and corruption. Regardless of the type of nation—democratic or 'non-democratic—none are exempt from corruption, though. All suffer the impact of corruption, but this can depend on a number of factors such as collusion, abuse of power, etc., that makes the health sector vulnerable to corruption. This problem plagues all nations one way or another.

Victims of healthcare corruption in the past and now are often those that have suffered some kind of injury—psychological, emotional trauma or permanent physical harm and/or death. Pain, however, impacts on different levels where different people—the victim and family members suffer some kind of loss. This loss can be substantial: the consequences are significant; loss of mobility, personal independence to loss of life. In medical practice mistakes are made; some poor practice, some negligent and some with criminal intent (See Chapter 3). The difference between poor practice and negligence can blur but the intentional removal of organs (Ambagtsheer & Balen, 2019; Ambagtsheer et al., 2013; Columb, 2015) without patients' permission or trade in them or needless invasive surgery impact on the victim and familial life.

The distinction is often blurred regarding the tangible and intangible costs of healthcare corruption. In healthcare, however, analysis is primarily on funds lost to different types of corruption and how these impact on healthcare provision (Ekin, 2019). This is 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. For example, disabled by needless invasive surgery, and/or poor practice leading to reduced hours of work, complete loss of income, dependent on medication, or need of prosthetic limbs, or modifications to accommodation. Family costs also occur—the type of employment and number of hours a family member(s) can work are reduced to take care of a victim(s) of poor practice and/or corruption. 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 with the medical profession.

The distinction is often blurred regarding the tangible and intangible costs of healthcare corruption, though. There are, however, myriad victims of healthcare corruption: some incur physical pain and emotional trauma as a victim of invasive surgery; some a reduction/deferral in service. The boundary can blur here; a person in pain (intangible) might seek private healthcare (a cost and tangible) because of quality of life e/g. in pain and limited mobility.

The difference between crime and healthcare corruption, however, is that if victimized by violent offenders we might require some medical attention and seek 'criminal justice'. If victimized by a member of the medical profession, we require help from others in a profession that has abused us. There is little or no choice. Some victims of crime also have little choice, but we all turn, apart from those where religion excludes healthcare or fear of a healthcare conspiracy (e.g., pandemic) access to healthcare.

As with crime there are far more costs we could/should count when we estimate the cost of harmful acts and victimization. This is a problematic exercise but one cost—informal payments in healthcare is an international issue. Informal payments, though, are either a bribe or extortion.

These two are different: both are a cost to the individual, family and have a societal impact. It is this which we explore in the next section.

The Cost of Healthcare: Informal Payments, Bribes and Extortion

In cases of corruption it can be difficult to distinguish between paying a bribe and/or extortion. It is useful, however, to distinguish between procedure and substance (Ayers, 1997). A crude distinction is to state that paying a bribe is initiated by a patient(s) or family member(s) of close personal acquaintance on behalf of the patient(s) whilst extortion is initiated by a medical practitioner(s), e.g., doctor, nurse, etc., and/or hospital administrator.

However, if it is known that a doctor/physician, nurse, etc., is receptive to a bribe patients could consider an informal payment and initiate contact. For such a patient(s), a bribe should increase access to needed healthcare, but extortion, unless payment is made, increases exclusion from needed healthcare. Extortion thus consists of paying to prevent, if possible, unfair treatment.

This then is the threat/offer central to the philosophical discussion of coercion. This is the moral desert (Miller, 2017): a doctor, nurse, or administrator agreeing to a bribe when access to healthcare is entitled is morally corrupt regardless of whether an understanding is based on extortion or a bribe. However, if patients have no option and are unable to access healthcare without pre-payment, even though entitled to healthcare, this is extortion. I suggest that we need to review the informal system of payments in healthcare and refer to them as extortion instead of a bribe. The reason for this is that patients often have no choice other than paying to access healthcare even when entitled to healthcare, and as such this is extortion.

However, instead of paying a bribe or subject to extortion it could be a combination of both. If a doctor demands payment for access to healthcare, and the patient is knowingly subjected to 'poor/substandard'

healthcare perhaps we should see this primary and secondary victimization. This is also a cost: pre-payment for access to healthcare, which is then substandard care.

A corrupt doctor/physician can therefore prevent access, demand payment for access, and/or demand payment for specialized surgical operation(s) which are then performed by subordinate, unsupervised assistants (Yoon, 2022). The costs—physical and emotional—to patients keeps rising, and thus excludes those that are unable to afford the cost of such healthcare. But will extortion reduce the individual/organization's moral culpability since patients engage in extortion or a combination of bribes and extortion as it is 'common practice'? I am aware people will engage in informal payments as with healthcare we have no choice if the system of informal payments has reached the stage where the provision of healthcare is a combination of institutionalization—where corruption is embedded in structures and processes of healthcare provision, rationalized—a justification for such acts, and socialization—new employees induced or seduced into the view that corruption is permissible (Ashforth & Anand, 2003). The outcome, after payment, however, is still inexact. An informal payment is payment for access, which can be blocked after the payment is made and/or the quality of care poor. Therefore, due to a range of potential outcomes extortion or paying a bribe is a risk rather than an assured outcome.

Furthermore, if extortion or a bribe is seen as 'too high' individuals seek alternative access to medicine, and as such, payment for services declines and the opportunity to extract illicit payments therefore declines. This is when individuals access the 'black market' of healthcare provision and counterfeit and/or substandard medication is bought (see Chapter 6), though. This leads to poor health outcomes and societal costs.

Here we can see both the complex nature of corruption and its consequences. Doctors/nurses, etc., can behave in a corrupt and prejudicial fashion, but to accept a bribe or solicit one, engage in extortion for personal benefit damages the legitimacy that the medical profession claims to have. Furthermore, if exposed as corrupt it calls into doubt all healthcare doctors/nurses provided for patients.

However, whilst informal payments are made the reason(s) vary: in some 'systems' it is because corruption is institutionalized; in others it is cultural expectation. For example, 'gifts', rather than informal payments, are part of paying homage to maintain custom and tradition (Akerstrom, 2017). In such cultures there is little distinction between a gift and a bribe and these gestures are extended to public office holders and influential individuals. Gifts are often presented, but without prior deals attached. This is still a cost, but one that is custom rather than corruption.

Healthcare Systems as a Cost: Preventing or Contributing to Costly Corruption?

The majority of healthcare pre-payment and post-payment claims in advance democratic nations are submitted online. Pre-payment is where payment is made—all or some of the cost—of the medical procedure prior to healthcare; post-payment is where all or some of the cost is paid after the medical consultation/intervention.

It is advisable to have a pre-payment process in place, as this will reduce the costs for healthcare now rather than chase the payment later (Ekin, 2019). The benefits of pre-payment analytics can help reduce corruption, abuse, error and waste (OECD, 2017), reduce investigative, legal and administrative costs trying to recover cost from individuals/organizations, and potentially shape behaviour by blocking claims that lack sufficient patients details and/or course of medication recommended by medical practitioner(s). This pre-payment approach has the potential to also build awareness of prepayment measures, strengthen relationships with ethical partnerships, and assessment of trends, e.g., cosmetic surgery presented as medical need (Brooks & Steirnstedt, 2021). None of this, however, can completely prevent corruption, at best only reduce it.

It is useful to consider the context in which healthcare systems might work, though. There is the Fee-For Service (FFS) model where healthcare services secure a set payment for the healthcare service(s). These claims are often, but not always considered valid, unless opposing evidence is discovered. This type of 'framework', however, has the potential to

induce medical practitioners to maximize the number of services to maximize profit. For example, engage in pointless consultations and/or tests and claim a fee.

An alternate system is called Managed Care Organizations (MCO) (Ekin, 2019). These are based on a contract with a public agency, e.g., a Dept of Health or local federalized state, depending on the jurisdiction, where an MCO is renumerated each month for a set number(s) of members in exchange for providing core services. Such a system of payment, however, is not immune to corruption. For example, an MCO could simply refuse treatment to some patients, deliver substandard care or engage in charging a patient more than the co-payment for the prepaid services. These types of frameworks, of course, vary, depending on the jurisdiction, but these types of payment for services are used with national or local caveats (see USA).

Both public and private healthcare pre- and post-payment systems, however, cost a substantial amount to procure, implement and maintain. As will the employment of a range of people with different skills—doctors, nurses, data analysts, police and counter fraud specialists—to prevent, and if required, conduct an investigation into potential cases of deception.

A problem here is that whilst prescribed medicine and medical practice is considered to be based on scientific, objective principles there is room for medical subjectivity (Ryan, 2017). This is needed as doctors make a judgement based on patient data and information but it is difficult to always judge the appropriate level of healthcare to heal patients. This should *not* lead to blanket criticism of the healthcare profession, but recognition that it is difficult to challenge a medical professional's judgement. Subjectivity, however, also allows doctors to claim a procedure is essential, but could engage in excessive blood tests, X-rays, etc. (see Chapter 7).

Measuring the costs of healthcare corruption then, is complicated. We need to consider the funds lost to corruption, the cost of trying to prevent corruption via computer packages/systems, the employment of people to examine claims, costs of data analysts and potential investigation and court costs. Few cases of corruption reach court (victims of corrupt healthcare mirrors victims of the CJS) as corruption is hidden,

whilst the medical profession uses cultural capital and power to downplay, dismiss, prevent and block examination of corruption and poor practice. Cases that reach civil or criminal courts are often exposed years after the harm has occurred (e.g., unwarranted removal of organs or neglect and deaths of children in hospital) and the costs of actual healthcare (e.g., medication/transplants) has changed too in the period of elapsed time.

Conclusion

This chapter has shown that trying to assess the costs of crime and corruption in the healthcare sector is difficult. There are different ways to assess the costs—direct and indirect and tangible and intangible—but all impact on an individual, nuclear or extended familial members. Furthermore, I highlighted the societal costs of healthcare corruption and the harm and impact of healthcare corruption beyond the obvious, e.g., known medical costs. Healthcare corruption, though, will often have a delayed impact instead of immediate, and how and what we count such as a *prevalence-based* cost (a cost as defined as a calendar year or tax year) or *incidence-based* cost (a cost not realized until years later) affected present and future costs of healthcare.

I then considered how informal payments are a cost; here, I emphasized the difference between a bribe and extortion. There is an important difference: a bribe is offered whilst extortion is a demand for payment, a block to access healthcare unless payment, in the form of a cash payment, but sometimes sextortion (Feigenblatt, 2020) is made. This is a cost that individuals and/or familial members incur, but also a cost in that those that need healthcare but are unable to afford it are excluded. Therefore, those that are excluded seek 'black-market' medicine or suffer, and disease reaches beyond locales and national borders.

These above costs, however, effect individuals/familial members and also have a societal impact. But costs incurred via online payment systems are also a potential conduit of corruption, and thus another cost of healthcare provision. It is perhaps fair to state that the current and future

costs of healthcare as estimated by WHO are similar to the estimates of the costs of crime: under-recorded and understated.

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Part II

Avenues of Healthcare Corruption

5

Telemedicine and the Online Pharmacy Sector: Healthcare at a Distance and Avenues of Corruption

Introduction

The development and application of scientific and technical knowledge and equipment in the healthcare sector is one of continuous progress. However, with scientific and technical developments come the potential for corruption. Telemedicine is one such development. It includes remote medical evaluation(s) of patients' conditions, video consultations with specialists and digital transmission of medical imaging. There are other terms to describe online healthcare—telehealth—which is a broad all-encompassing description of health education, remote monitoring of blood pressure, and e-prescriptions and practitioner(s) and patient(s) consultations and—telecare—which is the use of digital systems that test and record patients 'conditions' whilst patients remain at home (Christensen et al., 2017; Collins, 2020; Henderson et al., 2014; Wachter, 2015).

In this chapter, I start with a definition of telemedicine. Even though, the term is contested some grasp of the characteristics of telemedicine is needed. Then I consider the impact of the online healthcare sector on national borders and the technical, social infrastructure to reach patients (or customers). As with all technical advances corruption is close behind.

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This leads on to the types and reach of corruption via a system of telemedicine. Here, I draw on the extensive system in the USA, and explain how the Dept. of Justice attempts to reduce and prevent corruption via regulation and sanctions (Copeland, 2022). I then review the role of online pharmacy/chemist's in dispensing medicine and as the last line of control in preventing use/abuse and/or addiction of medicines. Of course, legislation is passed, depending on the jurisdiction to protect patients and safeguards are in place in medical practice. But laws often stop at jurisdictional borders and access to 'medicine' (legal, counterfeit or substandard) and medical devices is borderless. Telemedicine and the online pharmacy market is thus an international problem that is open to corruption and a threat to the provision of legitimate healthcare services. This chapter will address these threats and how best to reduce the avenues of corruption as jurisdictions offer 'healthcare at a distance'.

Telemedicine

There is no single definition for telemedicine; it is one term that is often used with or in place of telehealth. To compound matters other descriptions are used: non-face-to-face treatment, u-health, e-health and virtual treatment. Although the above terms describe 'medical advice at a distance', there are also differences, and the aim of each term is different.

Telemedicine is where a doctor**/**physician dispenses medical advice and clinical services such as an examination and/or treatment and a medical judgement via some form of telecommunication. Telemedicine thus refers specifically to 'the practice of medicine' via technical communication system(s) at a distance. *Telehealth*, often used interchangeably with telemedicine, is seen as a broad service beyond telemedicine as it's 'as a broad scope of remote services' (Copeland, 2022: 75). A live link between a patient and doctor/physician is telemedicine but a patient's use of an online patient portal to view medical records is telehealth.

Telemedicine also has several characteristics that are different from traditional medical practices and legal issues to contend with (Nittari et al., 2020). These characteristics are the use of telecommunications that include equipment such as telephones and video calls to the use

of professional medical equipment such as telemedicine examination devices and dissemination of patients' records for diagnostic purposes; image compression of data; image processing (Thanki & Borra, 2019) for diagnostic purposes; digital transmission of medical images; electronic control of medical equipment; real-time transmission of video images for patient consultations; transmission of medical data to hospitals from medical devices and 'data mining' of databases of patient records for use in medical education, and dynamic control of medical hardware (Chen, 2017; Copeland, 2022).

There are thus different types of telemedicine provision. There are real-time, *synchronous* visits where information and data are transferred live. This type of visit is where communication is via video calls and/or telephones between a patient and a doctor/physician, but it could also include the live transmission of ultrasounds or the streaming of medical procedures in an operating room, depending on the quality and sophistication of the equipment and patient access. An *asynchronous* service is where pre-recorded medical information, such as patient X-rays, are transmitted to a healthcare company to assess or treat an issue. In addition there is the use of personal health technologies to record, process and transmit information via the patient to the doctor/physician via home devices, such as heart rate or blood pressure monitors that are used in chronic disease management.

However, all the different types of 'telemedicine' mentioned above are limited to some extent. Touch and smell are blocked, and the capacity to hear and see are limited (Dongkyu, 2021) in consultations. In addition, as patients' familial members or a 'close acquaintance' conduct a 'test' e.g., recording temperature and/or pulse rate precision is perhaps sacrificed for convenience. Furthermore, medical practitioners and patients authentication is needed for an online exchange to occur. Doctors/physicians *should have* a license, and patients' medical insurance and identification for 'tests' to proceed. Authentication, though, as with all the other issues above is done online, and is, unless careful, open to manipulation and thus corruption.

Healthcare Online: The Potential for Corruption

There is, even in affluent nations, concern about a dearth of healthcare services in rural, and/or economic disadvantaged, and underserved districts (Ashwood et al., 2017). Telemedicine is often promoted as a way to increase access to healthcare in these underserved locales and districts. Prior to the pandemic and subsequent expansion of telemedicine Medicare coverage in the USA, however, was permitted only if: (1) the recipient was located in a rural or health professional shortage region (2) services were delivered in an interactive audio and video telecommunication system; and (3) the recipient was in a doctors/physician's office or dedicated medical office for the telemedicine visit. Waiving these prerequisites permitted people in underserved parts of the country to access care via telemedicine. This allowed people to have telemedicine visits in their own homes. The number of telemedicine visits substantially increased as the healthcare conditions for providing services altered under the pandemic (Copeland, 2022: 71).

There are a range of crimes and types of corruption in health systems around the world as highlighted in Chapter 2. However, the development of telemedicine will no doubt exacerbated these. Telemedicine is a positive development, but it also has the potential to enable old types of crime and corruption in a new format. There are legal studies on telemedicine (Becker et al., 2019; Nittari et al., 2020), but little research on the corruption of telemedicine, with the exception of (Copeland, 2022; Dongkyu, 2021). The application of technical online systems was already in use across a number of jurisdictions to administer healthcare pre-pandemic but this has now altered how 'traditional' medicine is delivered in some jurisdictions.

Due to the pandemic and concern regarding infection, shortage of medical professionals, a shift occurred from primarily face-to-face communication to dispensing medical advice at a distance. For some, living in a rural and/or isolated region, telemedicine is an invaluable form of communication (Dongkyu, 2021). This is understandable, but post-pandemic the use of telemedicine for a range of healthcare services is now a permanent part of healthcare provision.

Rapid technological change, however, can open avenues of corruption, as we adjust to a different way of providing some healthcare services. There are a number of reasons that also highlight the potential entrenchment and use of telemedicine in the future. These are convenience, cost and rapid technological development. In some circumstances a conference call and consultation with a doctor/physician is useful for patients and medical practitioner(s). For patients, and particularly those in rural parts of a country, such a system reduces travel costs and the need to sit in a room with other ill patients. For medical professionals there is the potential to connect with more patients, and for medical institutions to reduce the size and number of buildings it has to construct, heat and maintain. Furthermore, it is possible on most modern phones/watches to obtain information on heart rate, etc. As wearable devices and applications record more information and can send data to other interconnected devices, it is not too much of leap to suggest that telemedicine will reach into the healthcare market beyond its current use. These developments, however, are restricted to those jurisdictions that have the infrastructure to offer such services, and depending on the system of healthcare, its costs and access. Therefore, telemedicine reflects the current distribution of international healthcare services: it is available in those nations that have the infrastructure.

The Corruption of Telemedicine

Due to the pandemic telemedicine has increased in those jurisdictions that have the infrastructure to offer such services e.g., South Korea (Dongkyu, 2021). Seen primarily as a benefit, however, a range of corrupt acts can still occur; a brief sample of these are inflated medical payment claims; corruption of patient data and the upcoding and unbundling of claims (Canady, 2020; Leonard, 2022; Sparrow, 2000). In addition there are potential threats to traditional medical practitioners as individuals and/or organized crime advertise herbal supplements as medicine or manufacture medical devices that are sold to vulnerable individuals. Harris and Goldwater (2023), however, have claimed there is little evidence to substantiate a rise in healthcare corruption via

telemedicine in the USA, but others seem to have a different view (Copeland, 2022).

Based on the current state of medical corruption, however, it is possible to suggest what types of corruption will occur with telemedicine. Reflecting on the characteristics of telemedicine and the corruption and manipulation of other online services, the healthcare sector is a potential avenue for abuse (Tett, 2020). The corruption of online medical payments and claims was highlighted in Chapter 2. With telemedicine, the volume of claims and payments online, particularly in a pandemic will increase which could lead to an escalation in potential corrupt claims for services rendered. Both the private and public sectors could thus see an increase in processing data with counterfeit claims; these, though, will come from individual patients, doctors, hospitals and healthcare institutions 'below the radar' of systems highlighting a potential case of corruption. As such the volume and variety of claims (see Chapter 3) that are corrupt impact on the ability of state and/or private insurance to offer the healthcare services to expanding, ageing populations. Furthermore, the more we engage online the more personal data/information is transferred and weaknesses in processing and protecting data are attractive to organized crime (Enfield, 2020).

There is also the potential for accidents to occur. Due to the limitations of telemedicine, it is possible that patients' symptoms—recorded via online systems, patient and/or home-help—are erroneous (Dharmar et al., 2013; Sabiniewicz et al., 2022). It is therefore understandable that the application and use of telemedicine is a contested issue in the medical profession. However, the risk of erroneous conclusions regarding a patient's health is limited because telemedicine, at the moment, is used to assess non-fatal diseases. This, though, is a limited safeguard, as some mistakes online are a matter of life and death.

In addition there is the problem of unlicensed medical practitioners. Different legal rules occur within, and across jurisdictions. For example, there is a difference between USA, EU, China, etc. but also a difference between states in a federalized nation such as the USA. Therefore, what type of practice and whom it licenses 'to practice' differs depending on legal and medical standards (Nittari et al., 2020). Unlicensed online medical institutions are established on the dark web (Fausett et al.,

2021; Kruse et al., 2021; Pointer, 2020) and are difficult to detect and individuals that refuse to visit hospitals, such as criminals, can access these illegal services. Online platforms are thus available and used to access doctors/physicians from other states and nations and unauthorized 'online hospital services'. As telemedicine advances, a range of medical devices can be used online. These devices, as with medical practitioners, need a license. However, there is the potential here to use unauthorized medical devices. Both hardware and software applications are vulnerable to manipulation and corruption.

As telemedicine communication increases so will the volume of data online, and storage of data. Personal health information is a sensitive and important piece of data, and yet medical institutions often have insufficient protection to prevent data breaches (Choi & Johnson, 2021; Gabriel et al., 2018; Lee, 2022; Liu et al., 2015). In addition viruses are released into hospital computer networks with threats to ruin important data, and steal patient records (Meisner, 2017). In some cases extortion is the motive but in others it is to disrupt. In 2017, the NHS in the United Kingdom suffered a ransomware (Ghafur et al., 2019) attack and in the USA more than 500 healthcare organizations suffered ransomware attacks in 2020 (Copeland, 2022) of which we are aware. As such, cyberattacks on medical information will continue. Some institutions are aware of the commercial value of such data, whilst medical professionals might illegally sell or share this information elsewhere, and others might use patients' photos or videos 'inappropriately' for personal pleasure and/or commercial use.

There is then the concern that telemedicine collects, transfers and retains highly sensitive personal medical data such as videos, photos and physical information of patients. As digital information travels across computer networks there is the chance that communications are breached, and personal data appropriated and/or altered. This is a significant threat where online services used for medical therapeutic purposes such as the transmission of confidential information, pathological test results and transmission of intimate images are breached. Although data is encrypted, those with criminal intent are able to breach such defensive measures (Enfield, 2020).

Furthermore, the Internet, in particular, offers a comprehensive and efficient medium for person-to-person communication, and promotion of healthcare products and services. Some advertisements for health products and services are, however, counterfeit, and/or preying on vulnerable individuals. By moving some medical practice online avenues of potential corruption abound. Some examples are:

- Services *not* rendered: putting in an online claim for no service, or one that is knowingly ineffective for the patient(s).
- Upcoding: claims submitted for healthcare services/procedures/ but claimant has exaggerated length of time spent on telemedicine services to increase reimbursement.
- Misrepresenting number and type of services: Medicare (USA) reimburses for several types of virtual interactions, including telemedicine visits, virtual check-ins, telephone visits, and e-visits.
- Kickback schemes: a company makes unsolicited contact with doctors/physicians to prescribe or refer the patient for needless tests, prescriptions and medications, or medical equipment for a fee.

Healthcare service employees that work for a telemedicine company prepare orders and/or manufacture prescriptions for needless tests or Durable Medical Equipment (DME) such as knee braces. The 'patient' might have had some contact with the healthcare service or none at all, though. Claims are then submitted to relevant insurance schemes for reimbursement. A DME company, in this example, pays a telemedicine company for 'patients' information, and the telemedicine company pays the healthcare institution for the orders and prescriptions (Copeland, 2022). This type of corruption is conducted on a considerable scale since in-person medical consultations and visits are not needed. A telemedicine company will sometimes tell a medical practitioner(s) that there is no need to contact the 'patient' or that a telephone conversation is sufficient. In addition, medical practitioners are refused access, or excuses made to access and review the 'supposed' patient's medical records. Furthermore, the telemedicine company could direct medical practitioners to order or prescribe a pre-selected item or service, regardless of medical need or clinical appropriateness. The telemedicine company sells the order or

prescription produced by medical practitioners to other individuals or organizations that then bill the insurance scheme for the needless items and services. A number of schemes uncovered by the DOJ in the USA highlight the size and reach of the problem where DME organizations were paying bribes and kickbacks to medical practitioners employed by telemedicine organizations to order unnecessary back, shoulder, wrist and knee braces for Medicare recipients (Copeland, 2022: 101).

The schemes are often complex where a number of DME shell firms in the names of straw owners are established. The DME claims are submitted across a number of shell organizations to preclude a potential investigation by law enforcement. In the USA, a range of organizations have targeted Medicare recipients and collected personal and medical information and then utilized an internet-based platform to manufacture counterfeit supporting medical practitioners' orders. These orders are signed electronically by medical practitioners in exchange for bribes who have had no contact with the 'patients'. The telemedicine vendor then transmits these DME orders to the actual, real DME organization, and other DME shell organizations. All of these are sent to Medicare requesting payment for what was unnecessary DME equipment (see Copeland, 2022 and FCA violations).

Furthermore, some DME organizations have 'relationships' with marketing organizations. The DME organizations 'reward' these organizations for a set number of completed authorized orders. Marketing organizations contact people in receipt of Medicare to determine if eligible for a service and/or product. If so, these organizations then obtain the needed medical information from Medicare recipients, but leave the prescriptions blank. These blank and unauthorized DME prescriptions, with payment are sent to the telemedicine company where a medical practitioner(s) sign the prescriptions regardless of medical necessity, in the absence of a pre-existing doctor/physician relationship, and without a physical examination. The DME organizations then submit claims to Medicare.

These schemes have become so prevalent that the OIG, in 2022, published a Special Fraud Alert in the USA to warn medical practitioners of the danger of working with a telemedicine company. The Special Fraud Alert had eight 'suspect characteristics'. The primary victims of

telemedicine 'scams' are state and/or federal healthcare services such as Medicare/Medicaid in the USA. Unwanted medical tests, DME and prescriptions, however, harm patients too. In some cases, the harm is financial, in that patients never received the DME, test results, or medications or if delivered the medicine/equipment was inadequate or unusable for both the patients and doctors. In addition the misdirection, sham diagnostic tests mislead and hinder patients' chance to seek appropriate treatment for medical issues (Copeland, 2022: 73). Furthermore, the private healthcare sector increases premiums, depending on the type of healthcare service available, but regardless of the type of provision, costs increase to counter the funds loss to corruption.

Regulatory Oversight of Telemedicine

For legitimate telemedicine services to remain credible it is in their own interest to prevent risks and expose corrupt individuals and sites where possible. Integrity is thus essential. The Special Fraud Alert, produced by the OIG, in the USA, is of some use here. The advice is primarily for medical practitioners, however, but some of the advice is worth consideration here.

Practitioners were informed to be aware/cautious of 'patients' orders or items or services or recruitment via a telemedicine/telemarketing company, call centre, health fair, and/or through the internet, television or social advertisement. In addition, the OIG advocated caution if medical practitioners have limited or no contact with or information from the 'patient' to assess the medical need or the items or services ordered. Likewise, advice was dispensed that medical practitioners should be careful of a telemedicine company that blocks medical practitioners (or another practitioner(s) to engage with the 'patient' or provide them with medical information and talk to the patient and monitor progress, or lack of it, of medical treatment.

In addition, concern was raised regarding the hint and potential promise of compensation based on the volume of items or services ordered or prescribed based on the number of professed medical records that practitioners reviewed. A telemedicine company might only have

one product or a single class of products (e.g., durable medical equipment or prescription creams), and thus restrict a medical practitioner's options to a predetermined course of treatment. These 'cautions' are welcomed, but a quick review of cases (see Copeland, 2022) highlights, as with other types of corruption that the penalty for such corruption, could be considered light (a nurse involved in a $10 million fraud, in the USA, was sentenced to nine months in prison).

Preventing healthcare corruption seems to be more about 'cost containment, not universal access'. There is no question that telemedicine visits can help reinforce relationships between doctors/physicians and patients. Thus, telemedicine appointments can help with the continuity of care. The key question, however, is whether that pre-existing relationship can be established through a telemedicine visit. One of the reasons that corrupt schemes are successful is telemarketers can call people with whom they have no prior association, initiate sham telemedicine visits, direct patients to have unwanted tests, obtain a prescription(s) at a specific online pharmacy, or equipment from particular DME providers. One way to prevent, or at least reduce, this type of corruption is to have a prior patient/doctor/physician relationship where only the doctor/physician can request tests or sanction a prescription for medication or DME. This, though, is counter to the healthcare aim of providing accessible healthcare.

However, regardless of the type of relationship and on what medium it is conducted a potential way forward is to limit reimbursement for telemedicine visits. Instead of a fee-for-service approach, which as we have seen, emboldens overutilization of healthcare services and disincentivizes efficient care, an alternate system based on quality of care instead of quantity of care based on health outcomes and cost reductions is helpful. The Affordable Care Act (2010) in the USA established alternative payment models (APMs) with added incentive payments for quality and cost-efficient care (see Chapter 12 for in-depth consideration of alternate systems of payment) but as of 2023/2024 has limited voluntary uptake of the new systems of payment for political as much as health reasons.

The rapid expansion of the healthcare sector, regardless of the service, is always vulnerable to corruption. Telemedicine is no different. Even

when telemedicine was highly restricted, pre-pandemic, it encountered corruption. The relaxation in regulation and development of the telemedicine market has increased the threat of online corrupt telemedicine schemes. It is perhaps now impossible to return to the past and instead we should now design measures that preserve access to care via telemedicine at the same time as trying to reduce avenues of corruption.

The Online Pharmacy Market and Corruption

As we have seen telemedicine offers patients access to healthcare but is also vulnerable to corruption. However, another noticeable shift in healthcare is the online pharmacy/chemist in some jurisdictions.

As with telemedicine the online pharmacy sector has also embraced healthcare online where it offers and dispenses non-prescribed and prescribed medicines to patients via the internet (Gabay, 2015). Due to the intangible nature of the internet, and depending on the jurisdiction, it is difficult to highlight the size of a national and international online pharmacy market with confidence (Fittler et al., 2015, 2022). However, as with telemedicine, it is anticipated that a number of illegitimate online vendors (Lavorgna, 2015; Miller et al., 2021) engage in this market. It is therefore difficult to determine the number of active online vendors, and the volume of medicines bought and public health impact, as what data is available is limited.

The illegal market, as with all illegal markets, is an uncontrolled environment regarding vendors, consumers and products. Depending on age, we can order some type of legal medication without a prescription, medical supervision or appropriate medical analysis, consequently compromising patient welfare. Globalization regarding e-commerce has enabled the creation of a digital pharmacy/chemist market on an international scale far beyond the legitimate supply chain. Patient safety is potentially compromised by procurement of medicines outside the legitimate supply chain, where questionable sources, poor product quality, inappropriate and inadequate storage of medicines, illegal and/or poor transportation of medicines and counterfeit and/or substandard

medicine abound. Global websites and e-commerce crosses jurisdictions and consequently, the online pharmacy market and purchasing of medications via the internet make regulation problematic. In the case of trans-border trade, the country of operation sets the legal regulations and quality assurance standards, but the physical location of a 'service' could be different to the domain registration. Websites are often reluctant to reveal their real-world location, and online websites are considered a major source of substandard and counterfeit medications in developing and developed nations (Lavorgna, 2015; Miller, 2021) where consumers are expected to understand the regulatory framework under which the website is operating and/or location. Therefore, regulatory oversight is needed.

Regulatory Oversight of the Online Pharmacy Market

Due to the lack of international standardized regulations, the control and law enforcement of medications across borders is open to corruption. Despite the national/international legal differences, some standards exist. These include that prescription medicines be dispensed by a valid doctors/physicians' order, and that a pharmacy/chemist shall adhere to the regulations of the sale of medications to the destination to which the medicine is sent. Further, controlled substances (narcotics, psychotropics) and unauthorized medicines yet to be approved by a national regulatory body cannot be distributed, with the sale of substandard and counterfeit medicines considered a crime (Lavorgna, 2015).

Websites that adhere to national jurisdictions have the potential to trade medications across borders to consumers in other jurisdictions with different domestic laws. However, it is possible that in the country where a consumer is located, the online pharmacy is not registered and/or the medication is not legally sold. In these circumstances, the consumer(s) are engaged in unauthorized and/or illegitimate online sales. Even though the exportation of prescription medication without a valid prescription is a violation of most international regulations (Gabay,

2015), some consumers are unaware they have bought some kind of medication illegally.

But the illegal/rogue online sector is aware of what it is engaged in within and across borders. The most common and noticeable indicator of these online vendors is the sale of prescription only medication without a valid prescription (Gabay, 2015). Verification is thus of key importance. The main issue regarding such systems, though, is that they require consumer awareness, but without knowledge of the dangers of illegal medicines and the existence of verification systems, the impact on protecting patients is low. Unofficial verification or counterfeit verification systems compounded this matter.

Further, parallel to national and international systems of verification maintained by the relevant regulatory body, the private sector, depending on the jurisdiction can also engage in the certification of websites that sell medication. These services differ in certification standard, coverage and certification outcome. Legitimate accredited vendors display website seals as images and links to national or regional bodies. For example, The National Association of Boards of Pharmacy (NABP), in the USA, initiated the Verified Internet Pharmacy Practice Site (VIPPS) programme. Joining this site, however, is a voluntary choice instead of compulsory. USA online services should comply with relevant regulations, authenticate and secure prescription orders, adhere to a quality assurance policy and provide 'meaningful' e.g., actual contact with a patient) consultation with medical professionals (LaCrosse et al., 2019); but the NABPs database as of 2022 has less than 100 members.

In the private sector there is PharmacyChecker; a verification agency established in Canada. It too is voluntary and also has certification fees. The website offers a price comparison of medicinal products, but only with its members. The members are 'supposed' to meet the standards for pharmacy accreditation but a complete list of searchable database members or illegal sites is not available on the company's website.

Valid prescriptions, however, are a useful tool to prevent some corruption. Some online services request valid prescriptions, including e-prescriptions, scanned or written by an independent medical doctor(s) to be submitted. There are, however, currently two forms of online health status evaluation. Prescribing/online consultation requires individuals to

consult with health professionals (physician or pharmacist) employed by or affiliated to an online pharmacy/chemist to obtain medication whilst some internet websites supply medications after the completion of an online questionnaire. This later method could include pre-selected items that restrict personal choice but also patients—by design or default—responding with incorrect/inappropriate data/information.

Legitimate internet services in this sector *should* have a link to an approved pharmacy/chemist. Depending on national regulations, however, this could be a local independent community pharmacy/chemist, a pharmacy/chemist chain or a mail-order company as part of an established 'brick and mortar' service or a standalone service operated under a trade association, distributor(s) or franchise partner(s) that offers online service and also collect in store service.

Conclusion

Telemedicine and online pharmaceutical services have rapidly developed in some jurisdictions due to the pandemic. As with all technological advances, once utilized, it extends its reach. However, with every development there is also the opportunity to commit crimes and acts of corruption. Regulatory frameworks, in national jurisdictions are 'in place' but these are limited beyond national borders. In the case of counterfeit medicines, promoted via online marketing, quality assurance measures supporting medications in the legal supply chain (e.g., audits and analytical measurements) leave openings between the manufacture of products and use.

In addition, public campaigns have limited impact as uninformed consumers are unable to differentiate between legitimate websites from illegitimate services and consumers (patients) lack professional knowledge to establish the efficacy of a specific medication. The illegal internet market utilizes marketing techniques including e-mail spam, manipulation of search engine results and development of corrupt networks to pedal products that contain poisonous and dangerous elements (e.g., diethylene glycol and/or chromium) that result in poisoning or compromise the treatment of chronic diseases and, at worse, contribute to disease

progression and resistance. All of these 'issues' cause and/or lead to the potential international spread of addictions, infectious diseases and death. Ease of access *is not* in the case of healthcare always a sign of progression.

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6

Counterfeit and Substandard Healthcare Medicine and Products: An International Problem

Introduction

Building on the chapter above, I examine the proliferation of counterfeit, substandard and unlicensed 'medicine' and healthcare products. Counterfeit medicines/products are manufactured to disguise the character composition, and/or source of the medicine/product and also claim healthcare benefits where there are none. Substandard medicines, however, fail to fulfil the specifications or the standards of medicine/products, or both. Unlicensed medical products are manufactured, sold or distributed without authorization from the respective regulatory body, in a country or region (Rahman et al., 2018). All three 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).

The chapter starts with the problem of trying to define counterfeit and substandard medicine and healthcare products. Then, I explore the social, economic and health impact of 'poor-quality medicine' and its impact on healthcare. I then highlight this problem, with a case

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study of how 'law enforcement', in Nigeria is trying to reduce the incident and use of counterfeit medicine and the approach(es) used to stem the tide of harmful medication. I then highlight how substandard medicine is a problem for all nations regardless of how sophisticated its internal 'management' of medicines. The chapter concludes with a view that medicine and technical hardware in the healthcare sector is subject to routine corruption across and within borders and as such is an international problem (Attaran et al., 2011).

A Problem of Definition

There is lack of consensus on a common definition of what constitutes counterfeit medicine. Counterfeit medicines violate a national medical body's specifications, but with criminal and deliberate intent (Attaran et al., 2012; Rahman et al., 2018). The World Health Organization (WHO, 2023) has defined counterfeit medicine as one that hides the source or sources of the product. Both counterfeit branded and universal medicine can include some of the correct elements or counterfeit elements, or be without the essential active elements, and/or with an insufficient active element or incorrect packaging to mislead. The term 'counterfeit', however is seen as limited and has been increasingly replaced with 'falsified' which can cover all of the types of counterfeit medicine but also intellectual property and commercial interests.

Substandard medicines, however, are those that, for unintentional reasons, fail to meet the standard and specifications of a medicine such as the correct and active elements. Substandard medicines are thus defective in a number of ways; the use of poor raw materials, poor quality of elements, manufacturing errors and/or poor handling of different organic and/or medical/chemical elements. Expected standards are under—depending on the jurisdiction—the auspices of a national regulatory body. The problem here, though, is that the boundary blurs between counterfeit—a deliberate, calculated act—and a possible deliberate act or one that is a mistake in the production of a medicine.

Unlicensed medicines are those that have yet to, or unable to, secure the national authorization for the manufacture and/or importation of a

medicine for it to be sold within national legal jurisdictions. Unlicensed medicines can, of course, reach market, but more often it is illicit diversion (Fittler et al., 2018; Mackey & Nayyar, 2016) or theft and thus criminal intent to circumvent regulatory approval.

Furthermore, other terminology often used is out of specification (beyond its commercial use), degraded (past its use by date and/or degradation of key active elements in the medicine) and poor quality (below medicinal threshold set). To make this even more problematic counterfeit, falsified and substandard medicines are often used interchangeably (WHO, 2016). Perhaps it is best to follow and refer to them under the umbrella of substandard and falsified medicines (SFM) or substandard and counterfeit medicines (SCM), except where it is evidently a particular type of healthcare corruption.

There is also the nutraceuticals market to consider. I do not dwell on this market in this chapter (see Egea et al., 2022; Daliu et al., 2019; Nounou et al., 2018; Sadgrove, 2022) but nutraceuticals are defined as natural food (or part of a food) that offers medical or health benefits, including the prevention and/or treatment of a disease. Nutraceuticals are promoting 'health', with claims that products are natural with no active pharmaceutical elements augmenting different physical and mental benefits. There is no distinct difference, for some, between 'nutraceuticals', 'functional foods' and 'dietary supplements'. The Federal Drug Administration (FDA), in the USA has highlighted that such claims regarding nutraceuticals are dubious as the mixture of elements might have dangerous side effects as products are adulterated, substandard, falsified, unlicensed and/or counterfeit (El Amrawy et al., 2016). For some, a nutraceutical is *practically* a chimera (Mukherjee, 2019); it moulds food and medication into a single design that is neither a food nor a pharmaceutical product. Instead a nutraceutical is a broad term that includes vitamins, minerals, amino acids, herbs and botanicals.

All medicine and healthcare products then have the potential to be counterfeit, substandard and unlicensed. Regulating a national market is difficult but medicine is manufactured around the world, and in jurisdictions, that have, at best, a weak infrastructure to monitor, maintain and sanction corrupt, wayward and/or poor-quality medicine that reaches the healthcare market.

Social, Economic and Health Impact of 'Poor-Quality Medicine'

Poor-quality medicines present a serious public health problem (Rahman et al., 2018), particularly in emerging, developing nations. Substandard and/or sometimes poisonous medicines harm patients by compromising the treatment of a dangerous and sometimes, life-threatening disease. This impact is exacerbated in parts of the world i.e., Africa, but no nation is exempt from the social, economic and health impact of such corruption (Fantasia & Vooys, 2018). There are no precise statistics on the prevalence of counterfeit/substandard medical products, which is understandable due to the nature of the corruption, but there are estimates that offer an indication of the size of the problem. The WHO (2016) estimates that the rate of counterfeit medicines (and only counterfeit) in 'western markets' is between 1 and 3 per cent, and elsewhere e.g., Africa and southeast Asia is impossible to estimate. A lack of regulation and infrastructure to deal with counterfeit medicine and/or substandard medicine is thus a major part of the problem in some parts of the world.

Counterfeit medicine with no medicinal effect has a significant impact on national populations and is thus an economic burden (Nayyar et al., 2019; Rahman et al., 2018); this is particularly so for those that can least afford it. But substandard medicines because of poor manufacturing and quality-control practices in the production of branded or standard, universal medicine also reach patients, as well as contaminated blood (see McGoogan, 2021 for NHS blood scandal). Different jurisdictions, however, 'treat' poor practice and/or corruption in different ways e.g., in France individuals were subject to criminal convictions (Kazarian, 2019) regarding a case of contaminated blood. Substandard medicines then represent a threat to health (Funestrand et al., 2019; Hauk et al., 2021; Khurelbat et al., 2020; Nayyar et al., 2019; Ozawa et al., 2018; Sakuda et al., 2020) around the world. These can lead to healthcare failures, such as antibiotic resistance and spread of disease(s), as well as death or additional illness in individuals.

Due to the complex nature of trying to define and claim with confidence the cause of ill-health e.g., corruption and/or poor practice, corrupt and/or criminal practice is a problem. Is a medication

that reaches market the product of planned corruption, poor manufacturing, poor storage, lack of equipment, and/or ineffective quality-control measures, etc.? Regardless of how the medicine reaches market though, victims of counterfeit, substandard medicine are often unaware they are victims, similar to other types of corruption. The medical profession will perhaps seek to understand *why* a patient(s) accrue no health benefits via a prescribed system of treatment. This can lead to mistrust in the healthcare profession and in doctors/physicians because it is possible that patients start to question the analysis and medical diagnosis of practitioners. This is exacerbated by diagnosis, and self-assessment of the causes of an illness based on 'information' on the internet (Akbar et al., 2020).

All of this is compounded if the healthcare system is viewed in a negative way for a variety of reasons: corruption, paying bribes to access healthcare and extortion in Europe (Dallera et al., 2022; Sommersguter-Reichmann et al., 2018; Stepurko et al., 2015), in Africa and Asia (Aminu et al., 2017; Binyaruka et al., 2021; Busse et al., 2022; Rajan et al., 2022) where healthcare is seen as corrupt and/or ineffectual. This leads to doubt, for some, that medical practitioners in the healthcare sector lack clinical skills and professional competence. In addition to the lack of available medicines (Akinyandenu, 2013) it is possible that people seek help from elsewhere i.e., the black healthcare market and counterfeit medication and organ trade (Columb, 2015, 2020; Goodwin, 2006).

The trade of counterfeit and substandard medicine can cause social issues such as: (a) encouraging corruption, counterfeiters paying bribes to corrupt officials responsible for regulating the importation and circulation of medicines (b) and with the size of the worldwide market and potential income available it is perhaps understandable that the corruption of healthcare markets attracts criminal enterprises. The sale of counterfeit medicines is then used to acquire ammunition, cause public disorder and influence corrupt officials and (c) these threats left unchecked weaken the political infrastructure of a nation. These combined effects in Africa lead to: (i) loss of revenues for the pharmaceutical sector, (ii) the state in taxation (iii) poor or no investment because of fear of working in a corrupt environment and (iv) job losses where medical practitioners are needed.

The social and economic impact then of 'counterfeit' and substandard medicine impacts on all nations that encounter 'poor-quality medicine' and causes diseases and death. The social and economic impact, however, is felt across the world as counterfeit and substandard medicines reach market where disease has no respect for national borders. To tackle the problem of counterfeit medicines major organizations such as the World Health Organization (WHO), U.S. Pharmacopeia (USP), Interpol, and the U.S. Food and Drug Administration (FDA) developed approaches to counter the extent of illicit medicines that reach the public market (Spink et al., 2016). To understand the problem at a national level, however, I review how one nation, that has a problem with corruption—Nigeria—is trying to prevent the proliferation of counterfeit medicine below.

Counterfeit Medicine: The Case in Nigeria

Counterfeit medicines are a public health risk; counterfeiters are human actors rather than pathogens, and as such corruption is based on the application of intelligence, and stealth, all to maximize profit. This type of corruption is intentional with no concern for public health. The challenge to prevent this type of corruption is consistent with the public health objective to prevent a *disease* rather than treat the *symptoms* (Spink et al., 2016: 1). To emphasize the size of the problem, and what options are available to reduce the threat of counterfeit medicine to public health beyond trademark, patent and intellectual property, the attempts made by The Nigeria National Agency for Food and Drug Administration Control (NAFDAC) to tackle counterfeit medicine in Nigeria but also its 'relationships' with other nations to prevent cross-border corruption is a useful case to consider. The approaches below, however, are not exclusive to Nigeria.

Nigeria is one of the principal economies within Sub-Sahara Africa (primarily due to oil) but has one of the highest recorded counterfeit medicines incidents. This, however, is in part because of the investigations of counterfeit cases that have contributed to a high number of incidents to other markets in Africa (Akinyandenu, 2013; Aminu et al., 2017; Spink et al., 2016). The NAFDAC has developed a multi-layered

approach to reduce corruption in this sector i.e., product authentication, serialized codes, deterrence, state regulation, and these are broken down into individual approaches below, but it is perhaps useful to consider them as a holistic approach.

Product authentication is useful for a regulatory body and/or law enforcement to test products in-the-field in different locations. This is achieved with handheld spectroscopy equipment (Roth et al., 2019). This type of equipment is where a tablet is placed into the port of a spectroscopy device to analyse and authenticate the product. A chemical profile of the product is created and matched, if possible, with a pre-loaded unadulterated product to confirm it is authentic. To support the authentication of the samples, the NAFDAC utilizes and updates the profiles of the products that are authorized and approved for sale in the marketplace (Spink et al., 2016). This approach is useful for customs officials at borders, investigators in a wholesale warehouse, or in a retail marketplace to assess a sample of a batch of medicine.

However, even though this helps enable the determination of a legitimate product from a substandard or counterfeit one, and raises consumer awareness that a product is substandard or counterfeit, it can only examine a sample of a batch of medicine and it is difficult to pinpoint where in the chain of production or substandard or counterfeit acts occurred. As with all technology such an approach has its limitations and in some jurisdictions, and to be admissible in court, results require independent validation. Moreover there is a risk that counterfeit product profiles could be hacked (e.g., unauthorized access) into the database of authorized product profiles resulting in an official test authenticating and approving a counterfeit product.

Serialized codes that consumers can check to authenticate the product are also another way to evidence that a product is authentic. However, serialized codes only authenticate the label on the package and not the actual product, and the public need to understand the significance and relevance of the code and have a telephone/internet connection to check and contact people for advice.

In matters of crime and criminal justice, there are always calls for strengthening enforcement and punishment of offenders (Pratt & Miao,

2023) to deter those already engaged in corruption and those contemplating it. In the case of Nigeria rigorous enforcement appears popular, which could increase consumers' confidence in the supply chain, but at the same time increase fear if egregious cases are publicized and corruption is seen as rampant. Furthermore, even if a prosecution results in the seizure of counterfeit medicine and equipment and the incarceration of criminals, the opportunity to make a profit, fails to deter some. Enforcement resources are also limited, regardless of the nation, and with a lack of political will and cross-border corruption, deterrence is only one part of a toolkit of approaches needed.

Regulating the supply chain also helps control the distribution of authentic medicines. This is an expectation, though, in developed nations, and so the NAFDAC strengthens its wholesale and retail medicine distribution system. It created a central medicine distribution network of warehouses, permitted only licensed outlets to sell medicines and certified pharmacists to dispense products. This, it was hoped, might deter those that knowingly sold counterfeit or substandard products (Spink et al., 2016). The problem here, though, is that there is still demand for low cost products, particularly by people that cannot afford medicines available in the 'primary' supply chain, and much depends on the type of regulation—limited resources and/or underfunded and weak ineffectual regulation—fails to prevent the potential for counterfeit products to enter the market. Public campaigns (see Chapter 11 on nudges) to raise awareness of healthcare issues are also used, but as with all campaigns, and in parts of Nigeria, low levels of literacy rates, limited reach of public campaigns in rural districts and a low level of trust in institutions all dampen the impact of such an approach.

However, as new measures, regardless of the jurisdiction, are implemented, it is wise to assume that individuals and organized criminal enterprises will discover or invent new ways to circumvent the system or seek new avenues of corruption, in this sector or elsewhere. An underlying problem in Nigeria and other African nations is the cost of medicine. The price and margin issues (Bate et al., 2012) of medicine affects what people can afford. For example, socio-economic factors increase the cost of some medications and 'push' poor consumers to access the illegal black market of medicine. The dark market in medicine

(Columb, 2020) is thus, for some, the solitary option available and place to secure medication and hope that it is effective. Product price increases perhaps contribute to the corruption, as with the creation of a shadow market where illegal narcotics and counterfeit and substandard medicine are also available.

Finally, in this section of the chapter, a major concern is: will new measures to tackle corruption always secure political will? If the financial return on the investment for anti-corruption appears to work and reduce corruption, and increase tax revenue and legitimate products increase the development of domestic markets for medicine, it is possible such an approach has a future. However, since counter-corruption measures are permanently needed to reduce corruption, political, economic and social change impacts on the longevity of a sustainable anti-corruption countermeasure, which is a problem that all nations encounter.

'Substandard Medicine': A Problem for All Nations

In cases of substandard medication, which might arise through inadequate production processes, rather than through some act of corruption, all medication could be considered substandard if it has either too much or too little of the appropriate medical elements. Lacking the essential elements and/or incorrect amount, the product has neither the chemical element as part of the medicine nor an excipient (i.e., a substance that is included for long-term stabilization such as a preservative) (Johnston & Holt, 2014). An organic and/or inorganic impurity or residual solvent can alter medication and turn it toxic and the contamination of a product could be a deliberate act as the medicine is manufactured or turns toxic later or under specific conditions such as high temperature, as some medication is unstable and unsuitable for use in tropical conditions. Of course, such issues could occur because of corruption but also poor practice and poor management of process. In addition a small change in an excipient (substance for long-term stabilization) in a standard medicine will affect its shelf-life. Unless bioequivalence is achieved:

that is the same medicinal elements are used within set parameters the medication might fail to have the impact on a disease it should have.

Substandard medicine poses a serious health concern. Counterfeit medicines have perhaps had most of the attention with respect to corruption, but substandard medication also leads to deaths. For example, patients fail to respond to antimalarial treatment because the medication contains less than the required dose of chemical elements. Adverse events also occur due to interactions with contaminants, the presence of excess chemicals and contamination with poisonous substances. Poor-quality antibiotics contribute to resistance and spread of diseases such as tuberculosis (Johnston & Holt, 2014). In the modern interconnected world, localized issues can rapidly become an international issue, and the spread of a disease and our resistance to it are compromised. The potential for the administration of substandard medication to contribute to antimicrobial resistance has been recognized by the WHO (2016) as one of the underlying factors that hasten the emergence and dissemination of antimicrobial resistance. An individual patient then can suffer from substandard medicine, but a batch of substandard medication can impact at a societal level. Clinical outcomes also suffer; substandard medication could result in a loss of confidence in medication and doctors/physicians and patient(s).

Furthermore, clinical and human factors contribute to an increased economic burden, both on a national scale and to individuals. In some developing nations private insurance is the main option to secure access to medicines, and these costs account for a proportion of household income. Paying for replacement or additional medication, or for repeated courses of inadequate ones, imposes a severe economic burden on a household, especially if combined with loss of income due to illness (Johnston & Holt, 2014; Nayyar et al., 2019). At a national level, costs incurred with inadequate or contaminated medication include lost productivity and state healthcare costs, depending on if these are at least in part funded via state taxation.

To tackle such an issue though, some notion of the extent of the problem is needed. This, however, is a problem. The extent of the problem is difficult to assess, but can occur worldwide. The distribution of substandard medicine, though, is particularly prevalent in

southeastern Asia and Africa. This geographical bias reflects the 'poor' regulatory control of antibiotics and antiparasitic medicine. Therefore, whilst attempts have been made to understand the size of the problem, the data is limited or contested. There are perhaps a few key issues to consider that impact on this measurement (see Chapter two for the problem with the measurement of healthcare corruption), or lack of it. Poor regulation within and across different jurisdictions, and the hidden nature of corruption, the problem is discovered 'after or in the course of the event' with the harm already beyond repair.

A lack of resources—human and material—to test the medicinal quality of a product, in some jurisdictions, is thus limited. This has been addressed to some extent—see the case of Nigeria above—but—the evaluation of a medicine or batch is only as reliable as its workforce and technology available and, thus, is vulnerable to flaws and shortcomings in preventing corruption. There are number of levels on which the production of and marketing of medicine is influenced by corruption and leads to substandard products—medicine and/or technical equipment—entering the market. This can occur with the manufacture of medicine, registration or certification, of quality-control checks, site inspections, tests and procurement stage.

Effective medication is available for some of the most prevalent and destructive diseases in the developing world, e.g., tuberculosis, malaria and HIV/AIDS. However, the effectiveness of medication in preventing these diseases, as well as many other illnesses, is compromised by the distribution of substandard medicines. Both branded and common medicines are affected (Johnston & Holt, 2014). Generic medicines offer low-cost options, and substitution of expensive medication is mandatory due to cost, in some jurisdictions, but the quality of these needs regulation. In parallel with the resources invested in tackling the problem of counterfeit medication, and illegal narcotics trade, international effort is required to combat the distribution of low-quality medicines that arise through poor manufacturing processes and poor regulatory oversight.

Empowered and well-funded national bodies are essential, but a failure to fund resources—human and technical—to address substandard medication is also a problem. Diseases do not recognize or consider a geographical or human boundary as it spreads within and across borders.

Failure to address this issue leads is a conduit of corruption (Brooks, 2016); substandard medicine has an enormous economic impact on individuals, families, healthcare provision, and states. Distress, pain and death might not be distributed equally around the world, but we all encounter either physical pain, emotional anguish or financial costs. For some, it is a combination of all three.

The Routine Corruption of Healthcare

As we have seen in this chapter the reach of corruption is substantial and its impact immeasurable. The problem here is that acts of healthcare corruption are committed in different parts of the world (Fittler et al., 2018; Mackey & Nayyar, 2016, 2017) through individuals in different roles, in legal and/or illegal production and organizations in the manufacture of healthcare products. However, practical solutions (see section on Nigeria above) have highlighted that some reduction in corruption is possible. This practical reduction, though, is still based to some extent on theoretical notions of *why, how* and *what* could be done to prevent and reduce the level of corruption. The types of corruption highlighted in this chapter suggest crime as routine: a commonplace act (Sigiura, 2018) in the development and production and distribution of healthcare products.

Crime as routine stems from Hawley's (1950) theory of human ecology, which explored the temporal aspects of human behaviour (Brooks, 2016). Hawley pinpoints three key aspects of collective human actions: rhythm (the normal recurrence of events), tempo (the number of events in a certain period of time) and time (the coordination and intersection of behaviours in the environment). Cohen and Felson (1979) adapted these principles and put forward the view that crime is the product of three factors that combine in time and place: a motivated offender(s), a potential victim(s) and the absence of a person(s) that prevents and/or deters corruption. It is important to note here, though, that this approach offers suggestions about the probability of criminal behaviour rather than definite claims about when it will occur. The presence of these three factors is a context in which crime and corruption

might occur; a crime and act of corruption is not inevitable. It is a likelihood of an increase or decrease in corruption based on the existence of these three elements. This approach is of some use in studying varying levels of corruption but on an individual level what is a suitable avenue of corruption depends on the perceptions and preferences of individual offender(s).

These three factors offer a framework within which corruption occurs. It is assumed that the frequency of crime will decrease if (1) the probability of success is decreased (2) the potential benefits are reduced and (3) the potential costs are increased (Cohen & Felson, 1979) for the offenders or potential offenders. If potential or actual acts of corruption and/or crime are successful and thus avoid detection and punishment, it follows that such acts will continue unabated. The key variable in explaining crime, for this approach, and the subsequent victimization is therefore the scope of social life that sometimes enables acts of corruption as it places individuals in criminogenic situations (Garland, 1999). In economic terms, corruption is the supply side, a consequence of the openings to breach rules and/or commit offences, though it fails to explain the demand side, the desire to commit crimes.

Explaining the situational aspects, this theoretical approach looks to coincide time and space as a crucial function to understand places and/or avenues of crime and/or corruption. The emphasis on situational aspects and location makes corruption a built-in feature of social organization (Garland, 1999). Cohen and Felson (2003) state that, since illegal acts must prey upon other acts, the spatial and temporal structure of routines play an important role in helping establish the location, type and quantity of illegal acts. This is an ecological approach that shows how people interact within an environment and how the incidence of corruption is reduced to the interaction of the three vital elements mentioned above. This 'chemistry of crime' (Felson & Boba, 2010) has some explanatory power in the case of Nigeria above and its approach to reduce healthcare corruption.

Guardianship has the potential to dissuade or prevent crime, even in the presence of a motivated offender(s). A capable presence is, however, an expansive concept that is open to interpretation. Law enforcement, in a broad sense, deters some from crime rather than all (Dau et al.,

2023; Rinehart Kochel & Gau, 2021), depending on the type of crime and jurisdiction. Furthermore, a police presence might delay or displace crime on a transnational (Guerette & Aziani, 2022) or local level (Hatten & Piza, 2022) elsewhere rather than prevent it. Guardianship though is not limited to people: it is also technical, as highlighted by the Nigerian example above.

However, whilst this theoretical approach has some value in explaining opportunity and motivation and prevention, it is limited with victimisation. The hallmark of this approach is its emphasis on the victim and lack of control and/or prevention. Victimization occurs via *exposure* to an offender(s). Direct victimization will occur e.g., doctors/physicians knowingly sell and/or dispenses counterfeit/substandard medicine to a patient, but so much victimization here occurs 'at a distance' from the offender and offence. The offender and the victim must have occasion to intersect in time and space, but this time and space is across time and jurisdictions and sometimes online. As with most corruption the source of the act is at a distance and trying to retrospectively trace the chain of events is problematic. This limitation is no reason to completely reject the approach as types of crime, corruption and victimization are to some extent determined by social structure and situations which contribute to victimization.

It is difficult to police the whole process of development of manufacture and distribution of counterfeit, substandard medicine. The concepts and implications put forward here, however, coincide with a number of other theoretical approaches that seek to minimize criminal openings, deterrence and social control measures in trying to reduce a range of crimes and corruption (Brooks, 2016).

This approach, whilst useful, fails to explain the motivation for crime (even though it states it needs offenders' motivation to act), nor does it offer an explanation as to the social context which might highlight the combination of these. There are a number of issues with this approach, but one is the broad and vague lexicon of its definitions is inconsistent. There is no clear definition of what constitutes a 'potential' offender(s) or how we describe 'vulnerable' or who or what is 'capable' of prevention beyond obvious external 'policing' bodies. These latter bodies, though, are sometimes part of the problem regarding corruption (Brooks, 2019).

Further criticism is possible of this approach (see Brooks, 2016) but its rather crude but practical approach is of use, as control within and across jurisdictions and the development and manufacture and distribution of medicine is, even if known, a complex chain of events, vulnerable to corruption.

Conclusion

Despite some international successes, counterfeit and substandard medicine still poses a serious threat to public health and safety in Africa, Asia and the rest of the world. No country is completely free of the risk, including developed nations with a highly regulated healthcare environment and sophisticated detection equipment. There are nations (and continents), however, that suffer the most. Improving access to healthcare is a step forward, but access is only one issue; providing healthcare is expensive, and regardless of the type of provision—state insurance or private—providing coverage for a population and particularly those most in need, is difficult.

There is some hope here, though, as the advance in detection of counterfeit and substandard medicine, particularly in Africa, has made progress. Providing healthcare is costly and suggestions are put forward to tackle the problem of limited access and treatment. These often include (i) extensive public enlightenment and awareness campaigns (see Chapter 11 for a debate on nudges and campaigns) via education, print and electronic access, use of religious organizations, and health workers' education; (ii) review legislation and laws; (iii) political will to enforce legislation, and 'punishment' for offenders. All of these, though, are more of a wish list instead of an incremental and practical solution to what is an intractable problem due to a lack of resources and international collaboration beyond political soundbites.

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7

Defensive Healthcare Practice: An Environment for Corruption

Introduction

'Defensive medicine' is where healthcare administrators and medical practitioners depart from normal medical practice and perform treatments or procedures that reduce patient accusations of neglect, malpractice (Avraham & Schanzenbach, 2017; Berlin, 2017; Mello et al., 2020), corruption and potential litigation, but increases the cost of healthcare. This is damaging, for a number of reasons, as practitioners perform needless and/or excessive healthcare tests 'just-in-case' (Porter, 2022) and thus increase the cost of healthcare in both the public and private sectors. This kind of defensive practice is also mirrored in the CJS and leads to the imposition of sanctions on individuals that are neither a threat to the public nor commensurable with the crime committed (Colgan, 2018; Harris, 2016; Pattillo & Kirk, 2020). The problem in the healthcare sector is that needless and/or excessive treatment could lead to medical complications that have serious health consequences for patients but can mask and prevent exposure of neglect, malpractice and corruption, too.

One technique I examine, that is used in the healthcare sector, is Non-Disclosure Agreement (NDAs) (known as 'gagging orders'), (Barmes,

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2023; Kalra et al., 2020; Pagan, 2023; Tiitinen, 2020) that can prevent exposure of a range of issues such as poor and/or incorrect treatment of patients, unethical and harmful practice, invasive and unwanted surgery and financial corruption. Whilst some cases of negligent practice and corruption reach the public, it is perhaps, as with all acts of corruption and indeed crime, that only a small percentage are dealt with in a way that reflects the harm caused by egregious acts. Often, however, with corrupt healthcare practice we have no knowledge that we have been a victim and if patients complain NDAs are used in the public and private sectors to block medical practitioners sharing information. The 'management' of healthcare services is, however, only one way to prevent exposing corruption. The medical profession can also precipitate and participate in healthcare corruption. Medical practitioners are often powerful: they can define what the medical problem is, the type of treatment that is needed (see Chapter 2) and the course of treatment required to treat the problem (Ryan, 2017). This power to define, however, is based on the status of the individual and the role held in the institution. In healthcare services, as elsewhere, there is a hierarchy of power; doctors/physicians wield more power than junior doctors and nurses, and are barred from practice whilst senior medical practitioners and 'management' can thwart, block and obfuscate investigation into medical treatment and corrupt behaviour.

In this chapter then I will highlight the types of techniques used to block exposing corruption in the healthcare sector. I then consider if poor regulatory oversight is a conduit of corruption. Finally, I explain how some in the public and private medical profession precipitate and participate in healthcare corruption as a matter of 'practice' because of the individual and institutional power and medical knowledge.

Defensive Practice: Preventing the Exposure of Healthcare Corruption

Regardless of the system—public or private healthcare —funds lost to corruption impact on the quality and level of healthcare provision for its citizens. The medical profession, however, is often seen as a public

benefit with medical practitioners seen as primarily honest. This, of course, is dependent on the jurisdiction, but in a hospital or medical practice we encounter professionals and specialists providing healthcare such as nurses, anesthetists, doctors/physicians and hospital administrators all of which can act in a corrupt manner. There are reasons for engaging in different types of corruption, though: stress due to workloads, lack of resources, lack of medical equipment, the culture of the institution (Starystach & Holy, 2021), bullying (Castronovo et al., 2016; Holm et al., 2023; Johnson & Benham-Hutchins, 2020; Karatuna et al., 2020; Samsudin et al., 2018) and absenteeism that affects healthcare in different parts of the world (de Paiva et al., 2020; Magnavita et al., 2022; Onwujekwe et al., 2019) and different sectors (Agwu et al., 2020; Kisakye et al., 2016) (i.e., social care).

Medical practitioners, however, are individuals providing and practicing healthcare rather than administrators of a hospital that have a non-medical role. However, both can act in a corrupt fashion and/or protect individuals and/or units in a hospital that engage in corruption. Individual medical practitioners might be aware of poor and/or corrupt practice but fail to act for fear of reprisals in some sense of collegial spirt. Hospital administrators might siphon funds meant for healthcare into a personal account. But both medical practitioners and administrators might lead on the internal investigation of poor and/or corrupt practice. Medical and non-medical employees that engage in internal investigations are able to manipulate, or thwart investigations into medical practitioners. It is the role, position of power that can block exposure of corruption in what we broadly call 'western democratic nations' where healthcare corruption is recorded as a rare event. However, as with recorded crime, I suggest that healthcare corruption is far more prevalent that official statistics indicate.

Non-Disclosure Agreements (NDAs) (known as 'gagging orders') are legally binding contracts of employment that are used to prevent employees passing on and sharing sensitive information with others (Barmes, 2023; Pagan, 2023). Others in this sense are the public, patients and colleagues working in a hospital or part of a hospital. Legally binding NDAs are used to prevent damaging information from exposing poor and/or incorrect treatment of patients, unethical and harmful practice,

invasive surgery (Damani, 2017; Lee & Lai, 2018; Walshe & Chambers, 2017) and financial corruption that all impact on the quality of patient care. NDAs prevent investigation of poor to harmful practice reaching the public but also allow and perhaps embolden corrupt individuals to act in a way that is psychologically and physically damaging to patients. NDAs in the United Kingdom have thus encountered much criticism but are still in use (Ashton, 2015; Dyer, 2019; Finch, 2019). The problem for the healthcare sector is once a medical professional raises an internal issue of poor medical practice or failure in healthcare provision or corruption is how it is dealt with.

Internal investigations of poor practice, neglect, abuse and corruption can be used as a tool, mechanism to prevent exposure instead of dealing with the issues raised. It is here where healthcare administrators and medical practitioners, unless corrupt, contribute to the problem. Hospital administrators and medical practitioners might not engage in corruption but still remain silent (see Chapter 11) or actively engage in blocking investigations and thus contribute to the continuation of corruption. It is understandable that a hospital prefers to deal with an issue of poor, negligent and corrupt practice as an internal matter. This is no different to the criminal justice system (Brooks, 2019) and other sectors that offer and deliver a public or private service. All of these 'services', particularly if corrupt, make a substantial impact on the quality of life we lead but knowingly poor, negligent, dangerous treatment can lead to temporary or permanent incapacity and/or early death of a patient(s).

A brief review of healthcare in the United Kingdom highlights the recurring problem of poor, negligent and harmful practice. In the examples below, I suggest that much of what is highlighted is corruption. It is corrupt in that a number of people are aware of the unethical and/or poor practice; it is a hidden, calculated and hospital management and medical practitioners' attempt to block investigation into poor to corrupt practice. Exposed years after the events, as most are, these few examples below highlight how poor, unethical and dangerous healthcare practice is downplayed, dismissed and hidden.

In Alder Hay Hospital, in the United Kingdom (1988–1996) patients' organs were removed without familial consent and authorization and

retained in jars. This scandal, in part, helped establish the Human Tissues Act 2004 which overhauled legislation regarding the use of human tissue in the United Kingdom. There is also the example of 'institutionalized practice' in Gosport War Memorial Hospital (1989–2000) where it is claimed that 800 deaths were due to overdoses of diamorphine and inappropriate application and administration of medication (Bennett, 2020; Darbyshire & Ion, 2019). In Mid-Staffordshire hospital (2005–2009) patients suffered due to inadequate systems of care with the exact number of patients subject to negligence, and some death, impossible to determine due to the number of years in which poor healthcare was commonplace (Brooks, 2016; Brown et al., 2020; Francis, 2013; Smith & Chambers, 2019). Later on in Morcombe Bay Hospital (2004–2013) a 'lethal mix' of failures caused the death of 11 children and one mother. The maternity unit had been 'dysfunctional' with 'substandard care' with employees lacking the relevant skills and knowledge. Even though the public and police raised concern about the quality of care, there was significant organizational failure to address these issues (Goodwin, 2021; Kirkup, 2015; Taylor & Goodwin, 2022). In Shrewsbury and Telford Hospital (2000–2019) there was a repeated failure in maternity care that caused a number of deaths (Brazier et al., 2023). Finally, in the 1970s more than 2000 people contracted HIV and hepatitis C because of infected blood, but it has taken until recently for this to be recognized in England and Wales (McGoogan, 2021).

The above cases are not exhaustive, they simply show that harmful practice keeps recurring. But what is noticeable is that these cases highlight *known* egregious practice.

During these periods of time, it is perhaps safe to state, with some conviction, that poor and corrupt practice was evident. Yet the victims, and I suggest they should be seen as victims, and family members, and in one case above the police, encountered institutional obfuscation.

The danger then in healthcare is that we are dependent on practitioners with medical knowledge far in excess of most of the public. It's logical we place our faith in professional medical judgements and treatment. Mistakes are made in healthcare, which is understandable due to the stresses mentioned above, but preventing exposure exacerbates the problem, particularly once it is exposed. Furthermore, whilst some of

the cases above are 'old' the consequences of these actions impact the present (i.e., NHS blood scandal). They impact on the victims, familial members, and public that lose faith in healthcare.

These cases and others are presented as a problem where a culture characterized by introspection, lack of insight, poor internal management, lack of self-regulation, rejection of internal and external criticism no doubt contributed to and/or was the cause of a number of deaths. It is inconceivable that medical practitioners and management were unaware of some of these practices. In some cases some were no doubt complicit and party to them as part of a culture of institutional practice. This, I suggest, is organizational corruption. To engage and commit an act of corruption such as accepting bribes for healthcare treatment for personal benefit is without doubt corrupt, but to observe and fail to prevent and/or expose such an act(s) could also be seen as an act of omission but also corruption. The problem is that NDAs block people—medical practitioners—from exposing such practice .

To engage in healthcare corruption is for some medical practitioners simply the normalization of deviance (Wright et al., 2021). Poor health care practice, negligence and corruption is often uncovered (as is a substantial amount of corruption) by those on the 'inside'; where medical practitioners encounter a culture of dismissiveness and defensiveness. It is rare, however, that those that fall under the broad and descriptive term 'management and administrators' expose corruption. The normalization of such behaviour provides a counterpoise to individualism, and highlights how signals of potential danger are subject to institutional and thus collective misinterpretation and absorbed into the accepted margins of safe operation. Normalization is an insidious process that is often overlooked minimizing the effectiveness of exposing some kind of poor practice or negligence but most of all corruption. Such a context inevitably leads to a disaster(s), as we have seen above. Attention on individual action eclipses the social, cultural and organizational underpinnings of healthcare failures and fuels a perception that threats to patients result from the actions of a minority of incompetent practitioners. This reinforces a culture of blame and defensiveness (Taylor & Goodwin, 2022).

The normalization of such behaviour, however, helps explain how potential danger is normalized. First, there is a signal of potential danger; second an official act/response of some kind acknowledges the risk; third, an internal review of the evidence is conducted; fourth, there is the official view that the risk is of an acceptable level and fifth, work continues with level of risk accepted as part of working practice (Wright et al., 2021). Formal 'official acts' then acknowledge, and endorse the level of risk as acceptable, signalling that workers should continue to engage in established practice despite an obvious increased risk to patients (Taylor & Goodwin, 2022). This is important to recognize as, often when normalization of poor and/or corrupt behaviour is operationalized in healthcare, the emphasis tends to be on the individual within the culture, whilst others slowly become accustomed to accepting breaches in safety standards and/or corruption adopting and adapting behaviour accordingly.

'Serious untoward incidents' (SUIs) (e.g., the death of a child) can occur due to cycle of incidents that were normalized. An individual that raises an issue of poor practice or potential danger is, depending on status, rapidly dismissed, and seen as an individual matter rather than systemic. Incidents that are interlinked are viewed as unconnected, and thus poor practice spreads within and across different medical units in a hospital. Internal (board level management) and external investigations (a coroner) are sometimes conducted but internal views are shaped by normalization or known failures in healthcare that are dismissed, downplayed and/or hidden, with a compliant or ineffectual external perfunctory review of limited information.

Individual medical practitioners willing to speak out encounter threats, intimidation, demotion and 'gagging orders' to protect the 'reputation' of a hospital. But in doing so this type of practice leads to corrupt practice and a culture of fear that in turn leads to ongoing poor harmful practice. A culture of fear is instilled in an institution slowly but becomes a symptom of ongoing practice. 'Gagging orders' are used as a legal and biding contract to prevent the type of moral and in some cases no doubt criminal corruption from public inquiry and exposure, and unwanted examination of its practices. The organizational structure and culture emasculate attempts—individual or numbers of individuals—to address

the problem. The incidents are thus viewed as 'coincidental rather than evidence of serious dysfunction' (Taylor & Goodwin, 2022: 674).

NDAs or 'gagging orders' are also used in the private sector to hide poor, unethical and harmful practice. In the United Kingdom medical practitioners can work in the NHS and the private sector. Whilst both conduct internal investigations into unethical and corrupt practice, they can and do block, obfuscate and exclude patients from internal investigations and inform them of the outcome of an investigation or disciplinary process. This exclusion damages the credibility and legitimacy that we invest in healthcare professionals. In addition, even if banned from practice in the NHS public sector for negligence, abuse of patients and/or corruption, the private sector can still employ discredited and banned practitioners. This can lead to criminal corruption (Campbell & Topping, 2020) and the abuse and victimization of patients.

These types of practices damage the legitimacy that healthcare professionals hold. This is highly problematic in that legitimacy is dialogic (Bottoms & Tankebe, 2012) which is where claims to legitimacy by those that hold power are accepted or contested by those that are subjected to it (see Chapter 2). Legitimacy is thus interactive between medical practitioners and the public/patients. If, however, we encounter cases that were hidden for years public compliance with medical advice and treatment is challenged, and medical practitioners' credibility suffers. The domino effect in preventing exposure of corruption is thus immeasurable.

Furthermore, such cases impact on the credibility of oversight and the role of professional associations in preventing poor practice, negligence and corruption. Different medical councils and associations around the world represent different medical practitioners and decide on cases of whether a person is 'fit to practice'. These powerful professional bodies, however, can be used to review an individual's medical practice but also used by administrators and fellow medical colleagues to silence criticism. Those that expose poor practice, unethical behaviour and corruption find it is their credibility that is called into doubt (see cases above). This is the corruption of professional codes. A question of professional integrity and practice is thus sometimes dealt with by non-medical administrative and medical colleagues. However, it is noted victims of organizational corruption might also engage in the rationalization of their own victimization

and thus contribute to the problem of corruption (Shepherd & Button, 2019).

If this is the context, for some healthcare sectors, then what is the solution? The solution is complex, but in all the cases mentioned here, a regulatory body that is there to maintain standards of healthcare was absent and/or complicit in its failure to prevent abuse and corruption. It is to this that I now turn.

Regulatory Oversight or Capture: Incompetence or Complicit Corruption?

Part of the problem in preventing corruption is that regulatory oversight is sometimes poor, ineffectual, complicit or a combination of these. There are reasons for this such as lack of resources—available funds, employees and equipment—poor work conditions, poor renumeration, and limited or no legal/law enforcement powers. Furthermore, in some states e.g., Eastern Europe, the healthcare service is subject to state capture; this is where an organization captures a state service via bribes (Hellman et al., 2003) to corrupt officials, in order to secure specific rights to 'offer' a particular service.

In the United Kingdom, however, there is the Care and Quality Commission (CQC) that should hold public and private medical establishments to account in the healthcare sector (Jonker & Fisher, 2018). Its role is to ensure that healthcare services are providing an effective and a high-standard of care for all patients under its care. However, as a regulatory body, it has sometimes failed to reach these aims. For example, it has concealed mistreatment of patients in hospitals (Renton & Master, 2016). In Winterbourne, a private care home, patients were subject to physical and mental abuse. The CQC was made aware of the issues in Winterbourne but failed to conduct a comprehensive investigation. There were similar reports of patient abuse at a CQC-monitored institution—Whorlton Hall—a special care service in North East England (Richards, 2020). The CQC was criticized for prioritizing and protecting its reputation over the safety of patients in their care (O'Dowd, 2019). This criticism is hardly surprising as it was later discovered that patients

complained of abuse, but these were not corroborated by inspectors. It appears that knowledge of the inadequate conditions in the hospital (Renton & Master, 2016) was known but not acted on. An independent review established that CQC inspectors lack relevant skills and understanding of the extent of abuse (Denne et al., 2020; Jonker & Fisher, 2018). As such poor or ineffectual oversight is part of the problem of healthcare corruption. In addition a surgeon in the NHS in England and Wales won a tribunal case after being subject to bullying *from* CQC that appeared to listen only to his hospital at the expense of his highlighting a number of healthcare issues in his hospital from 2015 to 2019 (Greene, 2022).

The above examples highlight that an act of poor practice might not be considered corrupt but the action to dismiss and downplay such practice can lead to the corruption of the administration of practice. This is exacerbated if the acts are corrupt and hidden from the public, and then exposed years later. By engaging in obfuscation a regulatory body, instead of a solution, is part of the problem. Preventing the exposure of unethical and/or corrupt medical practitioners and administrators thus contributes and precipitates and participates in corrupt practice.

The above recurring examples are perhaps due to lack of funds, employing people without the skills and knowledge to conduct an inspection and/or incompetence. It could also, in some jurisdictions, be state regulatory capture. This is where there is collusion between private 'actors' for mutual private benefit (Shah, 2007: 235). In this form of corruption, the private sector 'captures' the state legislative, executive and judicial apparatus for its own purposes. State capture then co-exists with the conventional views of corruption, where public officials extort or otherwise exploit the private sector for personal enrichment and to shape institutions to advance and protect their own 'empires' at the expense of social interest (Hellman et al., 2000). Furthermore, Iwasaki and Suzuki (2007: 396) state that state capture is a kind of 'rent-seeking' where the actions of individuals or organizations have the ability to influence the formation of laws and regulations. In this way the rules of the economic exchange are manipulated to secure personal and/or organizational advantage. Such a description, I suggest is perhaps sufficient for explaining some nations e.g., some in Eastern Europe and/or transitional

economies, it is, however, insufficient in explaining the complex interplay of state capture in democratic western states.

Healthcare corruption or the corruption of healthcare services then is a complex matter to analyse. But what is apparent is that poor, limited, ineffectual state regulation or regulatory capture impact on the healthcare services the public can access. The corruption here, if seen as corruption, is at the level where contracts for services—public and/or private—are submitted and awarded; it is at the organizational level where negotiation of contracts, payment for types of services, standards of care and objectives are reached (or should be reached to secure and maintain the contract) but are sometimes breached by design or failure. The problem here, though, is that the withdrawal and/or privatization of some public services has produced, as was no doubt, intended, openings for the private sector to fill in neoliberal jurisdictions. Such services, though, need and seek external legitimacy via state contracts, and recourse to claim an efficient service and innovation. The claims that reduced costs of such healthcare services are, however, at best sometimes dubious, but with the increased cost of state-delivered healthcare services in jurisdictions with an ageing population providing healthcare under contract is an option in the provision of healthcare services.

The Power of Medical Knowledge

There is a substantial amount of international literature on corruption in the healthcare sector but the majority of this is still on the public sector at the expense of analysing the private sector. But regardless of the sector both attempt to prevent exposure to poor, negligent (Avraham & Schanzenbach, 2017; Berlin, 2017; Mello et al., 2020) and corrupt practice. These acts can blur but systems are in place in different jurisdictions to prevent corruption of healthcare provision from internal sources—doctors, nurses, administrators, etc. and external sources—contractors.

Healthcare administrators and medical practitioners are party to corruption in the public and private sectors as part of everyday working practice. This can range from sextortion (Feigenblatt, 2020) and

promises of promotion or blocking career progress, and/or demanding and accepting bribes to administrative corruption (i.e., illegal and hidden private 'earnings' of a public official) (Štefan et al., 2020; Weißmüller & Zuber, 2023), depending on the jurisdiction. There is a difference between those that engage in corruption for personal benefit, or for a company, and those that are precipitating and participating in corruption as part of everyday working practice, however. The 'management' of healthcare services via legal contracts, institutional inertia, professional codes and associations, as highlighted above are different ways to prevent exposing corruption and thus corrupt the process of preventing current and future abuses and failures in the provision of healthcare. Regardless of the act, the outcome is still one that impacts on the quality of healthcare provision. In this section of the chapter then I explain *how* the medical profession and administrators have the power to engage in unethical and/or corrupt behaviour.

Medical practitioners are often powerful and can define what the medical problem is, the type of treatment that is needed and the course and duration of treatment. This power to define, however, is based on the status of the individual, the role held in the institution. In the healthcare sector there is a hierarchy of power, too. Doctors wield more power that nurses and thus senior medical practitioners and 'management' can thwart, block and obfuscate investigation into medical treatment and corrupt behaviour far more than nurses or trainee medical practitioners.

Medical practitioners are able, in principle, to decide on the course of treatment if the anticipated clinical benefits outweigh harm(s) (Ryan, 2017). This is most noticeable with medical practitioners that can defend a course of medical treatment based on professional education and a body of medical knowledge and scientific practice. Medical practitioners can thus misuse and/or abuse prescribing medication that has little or no effect on the patient's condition and/or engaging in needless surgery for personal profit. All of this increases the costs of healthcare services but is also defended in the name of medical practitioners' professional status and body of scientific knowledge.

In some contexts this precautionary approach is understandable. Litigation can have a dampening effect on healthcare services rather than developing services and protecting patients. The provision of healthcare

services in some jurisdictions i.e., USA created an environment where medical practitioners' insurance has increased and some practitioners are reluctant to perform risky procedures for fear of litigation. This limits healthcare services for all patients. This leads to defensive medicine (Ortashi et al., 2013). This is where medical practitioners depart from normal medical practice as a safeguard to circumvent potential challenges and accusations that treatment was withheld, or a failure to treat within a specific timeframe. It occurs where practitioners perform treatments or procedures that reduce the risk of litigation or accusations of malpractice but increase the cost of healthcare in both the public and private sectors. Defensive medicine and fear of litigation have the potential to lead to excessive treatment , but this could also be part of institutional practice.

Behind a defensible medical practice and claim to scientific body of knowledge and code of professionalism it is possible to hide, suppress and conceal poor practice, negligence and acts of corruption. In such a context it is possible to engage in corruption periodically or as part of a routine everyday practice (see Chapter 6 on routine healthcare corruption). In this way, healthcare is similar to professional practice elsewhere. Corruption is institutionalized when it is stable, withstands challenges to its regimen of treatment and it endures because the individuals involved fail to challenge established corrupt practices. The social cocoon of organizational socialization is a powerful 'force' that seduces individuals into acceptance of corruption or to mute moral awareness (Brooks, 2016). Further, socialization practices can themselves become institutionalized and strongly influence new employees that encounter an 'indoctrination' of set practices and views of 'how we practice medicine here' by established members of the hospital/medical practice.

There can appear to be a contradiction here: on one hand, the medical profession makes claims to professionalism, a body of scientific knowledge and proven practice and regimen of treatment, and yet appears to sometimes prevent challenges to its proven scientific healthcare provision. This, however, is to prevent litigation to public healthcare services and the private insurance sector, but with a defensive wall of NDAs or 'gagging orders', professional medical boards excluded the public from investigations and allow corrupt practice to occur and flourish. Furthermore, non-corrupt acts such as poor practice or negligence once

concealed become part of the process of hiding and preventing exposure that is corrupt. In this way the healthcare sector precipitates and participates in corruption.

The power to control and characterize a contested issue such as poor and/or negligent, corrupt healthcare allows individuals, but particularly institutions, to claim a body of knowledge, facts and 'truth' and prevent exposure. 'Each society has its régime of truth … the types of disclosure which it accepts … the mechanisms and instances which enable one to distinguish … the techniques and procedures accorded value in the acquisition of truth' (Foucault, 1980: 131). Institutional power, in this case, medical knowledge and expertise affords its holders the capacity to define the truth, and knowledge of the truth. The power to be heard is unequally distributed (Becker, 1967) with some versions of the 'truth' possessing more credibility. Furthermore, with the power to control and characterize the 'truth' comes the power to engage in discourses of denial. This can take different forms: in 'classic' discourse there is literal denial (nothing happened); interpretive denial (what happened is really something else) and implicatory denial (what happened is justified). These denials and manipulation of the truth are part of medical discourse by individuals and institutions (Brooks, 2016).

The public and private healthcare sectors then often block access to information and data thus preventing the exposure of corruption. The private and public sectors use similar techniques such as legal binding contracts of employment to silence (gagging) medical practitioners and conduct closed investigations of patients' complaints regarding poor healthcare (e.g., members of the Medical Associations or Nursing Councils) with victims of corruption and abuse often excluded from the investigation. Patients subject to abuse and acts of corruption by medical practitioners are often little more than a repository of information (as is often in criminal justice systems). The capacity to define an act as corrupt, abuse or incompetence is with medical peers, hospital administrators and medical associations but this power to define, however, is also used to block medical professionals and also patients' attempts to expose healthcare corruption.

Conclusion

This chapter highlighted that 'defensive medicine', where healthcare administrators and medical practitioners depart from normal medical practice has the potential to lead to or is in reaction to neglect, malpractice (Avraham & Schanzenbach, 2017; Berlin, 2017; Mello et al., 2020) and acts of corruption. This is damaging, for a number of reasons, as practitioners perform needless and/or excessive healthcare tests, and thus increase the cost of healthcare provision or mask corruption. One technique I examined is how Non-Disclosure Agreements (NDAs) (known as 'gagging orders') prevent a range of issues such as poor and/or incorrect treatment of patients, unethical and harmful practices, invasive unwanted surgery and financial corruption reaching the public. This potential for unethical and/or corrupt acts is compounded by poor, limited regulatory oversight and/or state capture. All, however, impact on the type, cost, quality and access to healthcare. Furthermore, I highlighted how the medical profession can also precipitate and participate in healthcare corruption. Medical practitioners can define what the medical problem is, the type of treatment that is needed. This power to define a medical issue *as a medical issue* based on status and medical knowledge allows medical practitioners to engage in and/or thwart, block and obfuscate investigation into medical treatment and corrupt behaviour.

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Part III

Healthcare as a System of Exclusion and Control

8

Is the Healthcare Sector Part of a Carceral State?

Introduction

In this part of the book and chapter I take a different approach to most of the literature on healthcare corruption. I start by highlighting the links between medicalization and crime. To understand the impact of the healthcare sector's reach, we need to look beyond hospitals, etc. and question how we define and 'treat' those that encounter the criminal justice system and how the prison has supplanted the asylum as the site to contain and control people with mental illness.

The next section of this chapter highlights the conflict between trying to deal with mental health in prison and beyond prison walls. The aim of a prison and carceral state is to control and punish, be it behind institutional walls or beyond them, but the aims of the criminal justice system often clash with the aims of the healthcare sector. Solitary confinement serves carceral needs of control and incapacitation but can cause and/or impact on individuals with mental illness, or exacerbate symptoms of mental illness, and cause new psychiatric symptoms (Herman, 2019). Individuals under a community sanction(s) also encounter restrictions of movement and self-determination and people (ex-offenders) with known mental health illnesses are often required to engage in mental health

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services as a stipulation of probation. A breach of conditions leads to incarceration and a potential downward spiral in the health of millions (as millions of people are incarcerated) who, at a future date, are released with either a mental health issue and/or a physical non-communicable or communicable disease with a need to access healthcare services.

The final section in this chapter reflects on how the criminal justice system shapes and impacts on the inequality of access to health services for offenders and ex-offenders. Offenders encounter challenges with access to healthcare in prison but also once released with access to accommodation, employment and appropriate levels of care (Kirk, 2018; Testa & Jackson, 2019). In prison there is exposure to communicable diseases and infections, which once offenders are released become a health issue beyond institutional walls. Healthcare in prison then is a public health issue that can affect us all as offenders' poor health impacts on healthcare services a state and/or private sector can offer.

Institutional Control: The Medical, Carceral 'Shadow State'

The healthcare sector, where available, is seen as a positive model of a state's success or failure to establish a market for healthcare and deliver services, particularly in a pandemic. However, there are aspects of the healthcare sector that could be seen as part of a public and/or private carceral state (Foucault, 1977). The carceral state, which suggests a broad phalanx of institutions, is a mode of power, a regimen, and leads to subjugation of populations in prison and asylums but also reaches beyond walls and institutions. As mental health institutions sought alternatives to treatment in an institution, the state, in some jurisdictions i.e., USA, built new correctional institutions. As mental hospitals declined, the criminal justice system and prison network has expanded. As mental institutions closed, the prison system has absorbed those with mental health issues (Preston et al., 2022).

There are a number of definitions of medical social control (Conrad, 1979; O'Neill, 1986; Zola, 1972) and all highlight that social control comes from possessing the power and legitimacy to explain specific

behaviours. Medicalization, though, describes the process by which non-medical issues are defined and treated as a medical problem, as an illness or disorder. For Zola (1983: 295) it is a process 'whereby more and more of everyday life has come under medical dominion, influence and supervision'. Defining the problem in medical language, adopting a medical framework to understand the problem and/or employing medical interventions 'to treat' a population is a social-cultural process that could but not always encompass the medical profession (Conrad, 1979).

The medicalization of a problem or problem population can occur on three distinct levels: the conceptual, the institutional and interactional. At the conceptual level medical language is used to define and explain the problem. At the institutional level, organizations adopt a medical approach to treat a particular problem in which the organization specializes. Doctors/physicians can thus exclude or confer legitimacy on organizations that adopt a medical definition. At the interactional level doctors/physicians define a problem as medical (a medical diagnosis) or treat a 'social' problem with a medical form of treatment (e.g., prescribing tranquilizers) (Conrad, 1979). Medicalization then is a broad definitional course that could include the medical profession and treatment, or exclude it, with alternate views that apply, accept or reject and challenge medical definition(s) of a 'social problem'.

Medical issues are thus constructed. However, since social construction assumes knowledge is relative, it is not an independent judge (Bury, 1986) and therefore knowledge is 'discovered' or 'invented'. This is a debate that has occurred elsewhere (Conrad & Barker, 2010) where sociocultural construction of illness determines which illnesses are stigmatized, and which are deemed contestable (i.e., some medical practitioners view the existence of an 'illness' questionable) as opposed to unquestionably recognized in the medical profession.

The organization and structure of the medical profession then has had an important impact on how we 'treat illness'. Professional social respect and public legitimacy (see Chapter 2 on legitimacy) offers medicine the power to decide on what we label a health issue or illness. Once a definition is accepted or a problem is medicalized it extends its reach and expands its own medical reach. This expansion thus extends its reach beyond medical treatment and into a form of social control. This medical

control is institutional and also at a distance beyond asylum and prison walls.

Some types of crime(s) are thus distinguished by types of medical social control: medical ideology or system of thought, in collaboration with others in an institutional context and technical knowledge. Medical views backed by its claim to scientific, objective analysis can impose a medical model on an issue because of its social benefits. These are reinforced in an institutional context with others across a broad medical, scientific spectrum. This in turn is reinforced by the application of technical medical knowledge and use of medication to control individuals and populations under medical surveillance (Foucault, 1977). This is where specific conditions and behaviours are viewed as a medical issue or as a problematic one.

Social control, however, is rarely an either or situation. It is cyclical and subject to change as 'new' medical techniques appear or a definition of a problem is challenged. Furthermore, as with approaches to criminal justice earlier modes of social control remain is some shape or form, and are used for different reasons. The 'prison' is a useful example here as it has remained as a physical structure but its aim(s) alter due to political, economic and social issues (Levy et al., 2018).

The prison has primarily supplanted the asylum as the site to contain and control people with mental illness. Prison, though, has replaced rather than created the punitive nature of state control where asylums and the prison system was, if anything operating in different bureaucratic silos. State power is marshalled towards control with a prison as a locus of power. Prison populations, though, increase or decrease depending on the prevailing political views on types of crime (Pratt, 2008) and 'offenders'. The legal system has thus *criminalized* mental illness with disorders—real or fictional, often punishable with a prison sentence. Asylums were (and still are) part of the carceral state but instead of deinstitutionalization the move is one where a prison is part of a sector of *re*-institutionalization, of which the medical profession in some form has played its part (Sim, 1990). As mental health institutions sought alternatives to mental hospitals, the state built new correctional institutions; as mental hospitals declined, the criminal justice system and prison network expanded. As mental institutions closed, the prison system has absorbed

those with mental health issues with the application of medical technical control. This is the carceral state where the public and private sectors, under contract, control offenders and ex-offenders' behaviour and access to healthcare.

Mental Health and the Carceral State

Building on the above section, in some jurisdictions i.e., USA mental healthcare has increasingly become a carceral endeavour. Jails and the prison system have replaced mental hospitals as the de-facto mental healthcare 'option' for incarcerated individuals. Furthermore, practices like mandated mental healthcare (Dowling et al., 2018) for specific types of offenders in prison and/or under supervision beyond secure walls have trapped offenders and ex-offenders with mental health issues within the criminal justice system (Bradshaw et al., 2017; Human Rights Watch, 2018; NICE, 2017; Preston et al., 2022).

Individuals with mental illness are over-represented in jails/prison systems and under supervision beyond secure walls. The aim of a prison, and carceral state, however, is one of control and punishment, rather than a therapeutic environment (Sim, 1990). In the absence of sufficient help and services to meet the burgeoning need for intensive outpatient psychiatric treatment, people released after completing a sentence or on probation have to contend with a lack of available services. As such a mental health issue manifests into inappropriate and/or criminal behaviour, and police encounters, arrests, and incarceration (Preston et al., 2022).

In the context of an expanding carceral system and a limited social safety net, in the USA, 'correctional services' have become the de-facto 'bottom-line' mental health service. There is thus a shift to the 'criminalization of mental illness'. Fisher et al. (2006) define this 'criminalization' as 'a process where behaviours once considered legal become illegal,' and subject to criminal sanctions. As some jurisdictions adopt a legal response to non-normative behaviour, the behaviour itself is conceptualized as criminal (Preston et al., 2022). Some types of behaviour are thus defined within a legal, rather than a psychiatric framework. Here,

then, police and judges, impose a criminal, rather than psychiatric definition on individual behaviour that falls outside social standards. As the carceral state expands to assume control over the healthcare of millions, mental health treatment suffers the effects of an under-equipped system, with significant resource limitations and a dearth of available clinicians, limited budgets, logistical challenges and inadequate numbers of employees (Gaston, 2018; Herman, 2019).

There is perhaps little public concern regarding this matter whilst offenders are behind bars. But, in democratic nations, the majority of offenders are released. As such people with known mental health illnesses are often required to engage in mental health services as a stipulation of probation. This is presented as a benefit for the individual, but linking legal supervision to treatment conveys a complex message to individuals—that mental illness constitutes a moral failure punishable by the criminal justice system (Preston et al., 2022). Furthermore, compliance with a regime of treatment is prerequisite, in some instances, to access other services i.e., accommodation. Access, though, might also be dependent on the individual's completion of their mandated treatment. This contingency also conveys moralizing undertones, implying to the individual that their access to and worthiness of public services is dependent on their compliance with court-mandated mental health treatment.

These demands also put pressure on individuals, as in some jurisdictions i.e., USA offenders must also pay for the costs of treatment. These include paying for mandated treatment if it is not covered by the state, completing mandated medication regimens regardless of side effects, and navigating the logistical challenges and completion of a course of treatment. In this context, the carceral state comes to encompass a broad swath of people's lives, and access to accommodation, livelihood and healthcare.

The criminal justice system thus labels individuals with mental illness. Diagnosis of mental health, however, appears to suggest that Black American—men and women are under some kind of custodial or community supervision more than White American—men and women and also incarcerated with—and perhaps for—symptoms of mental illness. A number of structural factors in public health and the prison system play a part here with implicit racial prejudice of some in law enforcement

policing Black neighbourhoods, the mental health effects of structural racism and inequities in the quality of mental healthcare (Appel et al., 2020).

Furthermore, as carceral institutions encounter a rise in an incarcerated population with mental health issues there is an inescapable conflict between aims of incarceration and effective mental health services. Goals of mental health treatment are diverse and depend on the type of treatment, institution, patient and available services. Mental health language emphasizes a strengths-based, patient approach promoting empowering relationships. These are, however, difficult to achieve in a carceral environment where punishment, rather than care is the main aim. This, of course, depends on the jurisdiction (e.g., the USA and Norway/Sweden use a prison as a type of punishment but the aim and ethos are different).

Systems of mental healthcare face a number of challenges, and the absence of carceral influence is in no way an assurance of effective, compassionate patient care. A carceral environment, however, is an extra challenge in implementing patient-orientated care, as its environment is built on principles of control, retribution and deterrence, which stand in contrast to therapeutic ideals. Prisons/jails/ secure units' primary aim (depending on the jurisdiction) is incapacitation and deterrence with rehabilitation as a hopeful outcome.

It is suggested that the carceral state, in the USA, is a pattern of 'racial capitalism' (Story, 2019) with the creation and enforcement of economic and social exclusion. In this way, the carceral state creates socio-economic barriers for whomever it happens to ensnare; but also suppresses and maintains a racial/class-delineated economic and social underclass. For all of these reasons, the criminal justice system is viewed as a system for the punishment and 'rehabilitation' of the individual, but also to protect and uphold certain structures of power and influence. In this way, mental health, care and treatment become intertwined with correctional aims of custody and control (Preston et al., 2022).

Bringing mental healthcare within the carceral state, an individuals' healthcare needs are seen as requiring control. Healthcare here and in particular mental health is controlled via threats e.g., withdraw what help is available unless completing a specific course of action. Furthermore, such courses of which some require consumption of medication without

a patient's consent have the potential to lead to a narcotic habit. Dependent on others to access services and 'medication' carceral mental healthcare can overemphasize individual factors of mental health, downplaying the importance of environment, relationships and social context, with 'treatment plans' relying on pharmacotherapy or psychotherapy, rather than employing a holistic approach to address criminalized behaviour. A caveat here, though, is that overmedication and oversimplification of mental illness and treatment are by no means exclusive to carceral mental health care (Preston et al., 2022).

The carceral state then is a cause or conduit to mental illness that it claims it treats in incarcerated individuals. In pathologizing criminalized behaviour and situating both the cause of and the solution within the individual, the carceral system absolves itself of any blame as a cause or conduit that exacerbates mental health, as well as responsibility to remediate its negative societal effects. It is these unequal effects which are considered in the next section of this chapter.

Criminal Justice and Health Inequality

As we saw in Chapter four, crime leads to healthcare costs beyond those we currently measure. Here, though, we consider how and if the criminal justice system is a cause of healthcare costs. Encounters with the criminal justice system are stressful for victims, witnesses and offenders. It is also stressful for those that work within the criminal justice system—police, probation and prison officers, prosecutors, etc.—because of violent encounters with members of the public, and prosecuting cases of child abuse, sex offenders and violence, and 'managing' offenders on probation. Criminal justice then is a cause or conduit of poor health outcomes. But it appears that it is particularly 'bad' for some e.g., black population in the USA and elsewhere (Appel et al., 2020). This section of the chapter examines the links between health outcomes and encounters with a criminal justice system and subsequent healthcare costs of crime and incarceration.

Incarceration in an institution is linked to both mental and physical harm, but a decline in mental health is particularly acute for individuals subject to extensive periods of incarceration. The criminal justice system, then, shapes and impacts on the physical and mental health of some offenders. The majority of these offenders, depending on the jurisdiction, are released. It is possible that some have a range of mental health issues prior to incarceration and/or exacerbated after a period in prison. Incarceration is thus a primary and secondary form of stress and includes the loss of independence, physical and emotional isolation, and threats of violence (Appel et al., 2020; Porter, 2014). Acts of violence, however, are committed by inmates on inmates, prison officers on inmates, inmates on prison officers (also see Chapter 10 for abuse and violence in an institution).

The stress of incarceration also extends beyond release, where ex-offenders encounter challenges with accommodation, employment and stigma (Kirk, 2018; Testa & Jackson, 2019). Therefore, a lack of employment, financial independence, limited access to food, shelter (Kirk, 2018; Testa & Jackson, 2019) and the erosion of individuals' social contacts and exposure to communicable diseases and infections in prison are a problem for healthcare services beyond institutional walls.

Research increasingly links criminal justice contacts to health risks from a host of causes (Boen, 2020; Geller et al., 2014; Lee & Wildeman, 2013; McFarland et al., 2018; Porter & Novisky, 2017; Sugie & Turney, 2017). These 'causes' have implications for individuals, family members and national populations. There is, of course, unequal access to healthcare for individuals that have no involvement with a criminal justice system. But with mass incarceration in some jurisdictions, contacts along the criminal justice continuum (Boen, 2020)—police stops and search, arrests (Payne-James et al., 2010), convictions, and incarceration—impact on individuals' health and contribute to racial health inequality (Appel et al., 2020). The majority of the research on health and contact with a criminal justice system, though, is the relationship between incarceration, particularly long term, and health outcomes. Incarcerated individuals have high rates of illness and an array of conditions such as hypertension, and sexual infections/diseases (Boen, 2020).

Prison populations—men, women and young offenders—encounter 'poor' healthcare services. However, a note of caution is needed here. In some jurisdictions i.e., USA access to healthcare is unequal, but the same might apply in the United Kingdom even though it has a national health service. Regardless of the system access and quality of services on offer differ. There is, however, regardless of most jurisdictions, a difference in access and quality of care in and outside of a prison (Blackaby et al., 2023; Sridhar et al., 2018). The differences in service provision have the potential to contribute to illness and disease in prison, but also on release. Therefore, medical invention(s) in prison are in the interests of patients in prison but also the public once an offender is released.

Multiple social and economic disadvantages contribute to long-term health conditions, communicable diseases, mental illness and narcotic use/misuse/abuse in prison (Kinner & Young, 2018; Stürup-Toft et al., 2018). This is exacerbated with the demographics towards an ageing incarcerated population placing demands on a healthcare system (Wang et al., 2017) in some jurisdictions. Life in prison appears to accelerate the ageing process, although trying to determine who is 'old' in prison is itself a challenge (Heidari et al., 2017). Geriatric syndromes—falls, dementia, incontinence and poor diminished vison—are part of the ageing process. Physiological decline, however, is often exacerbated by psychological burden of life in prison. An ageing prison population (Blundell-White et al., 2023; Brooke et al., 2020; Cipriani et al., 2017) is thus a challenge for the prison and healthcare services. The impact of prison health on public health is thus undeniable (Heidari et al., 2017) as are the social, economic and healthcare costs.

Evidence-based healthcare research has translated into clinical practice, in some jurisdictions, but still to reach into the prison sector. Gaps in access to healthcare services, though, are across and within jurisdictions for 'citizens' that affect marginalized or lower socio-economic populations (World Health Organisation, 2018). To counteract this some jurisdictions have the principle of equivalence where people in prison should have access to a standard of care at least equivalent to those outside of the prison. Yet, evidence suggests equivalence is often not achieved, compounding existing health inequities (Health and Social Care Committee, 2018). Furthermore, there is the dilemma of

'dual loyalty' (Heidari et al., 2017; Merkt et al., 2021) where prison employees are part of a 'justice system' where strict measures limit access to healthcare regardless of what care medical employees wish to offer. In some jurisdictions, though, where disadvantaged populations have no health insurance, even restricted healthcare access in prison might still be better than what was available beyond institutional walls. In this sense then the equivalent principle is only relevant depending on the population's access to healthcare beyond institutional walls.

The challenge to offer healthcare services is heightened in custodial settings, where adherence to recommended practice is compromised (Blackaby et al., 2023). This is due to a confluence of factors specific to the prison healthcare context. For instance, whilst most healthcare resources are limited, prison services and associated healthcare provisions are subject to harsh financial cuts (Ismail, 2020; Stephenson & Bell, 2019), depending on the jurisdiction e.g., England and Wales, with a lack of medical and prison employees compromising access to healthcare effectiveness (Royal College of Nursing, 2018). Even if healthcare is available medical appointments are missed due to lack of prison officers to escort prisoners to a prison hospital (Association of Members of Independent Monitoring Boards, 2018).

Whilst providing healthcare in a prison is challenging, it also offers an opportunity to address health needs that were otherwise unmet in community settings, such as providing vaccinations, and/or enrolment on a screening programme (Blackaby et al., 2023). Efforts to increase the quality of care in prison beyond health outcomes have also helped staff morale and control of healthcare issues on release. Neglecting the health needs of incarcerated people then has negative implications for the individuals concerned and the public (Leaman et al., 2016) such as communicable diseases and mental health. This, though, reflects life outside of a prison where healthcare services differ based on demographics, location, etc. As with most of the literature on crime, however, research into prison healthcare services considers the male population. Even though more men are in prison than women around the world, little research, so far, has been conducted on women's healthcare needs, in prison (Public Health England, 2018). Recent research, though, has highlighted that women suffer from long-term physical health conditions

(Wright et al., 2021) and mental health (Tyler et al., 2019). All prisoners, however, can contract blood viral infections in prison, engage in substance misuse, suffer post-traumatic stress disorder (Kinner & Young, 2018), hypertension, asthma and conditions with ageing populations, such as heart disease and dementia.

The problem here, though, might not be what healthcare services are on offer but whether prisoners access services that are available. How prisoners view medical care also influences to what extent disease is controlled in and beyond prison walls. Incarcerated individuals sometimes claim prison care is substandard care (Christopher et al., 2017). This of course can depend on a number of factors. Institutional conditions lead to a mindset of distrust and reluctance to seek care, particularly if as in some institutions healthcare correctional officers are present at medical meetings and examinations. People in a prison/correctional system then might see the quality of correctional healthcare as inferior to that available outside the prison/institution, and see treatment by correctional healthcare workers as less humane (Christopher et al., 2017).

Individuals with a record of criminal justice encounters and incarceration claim healthcare discrimination once released, too. This is not as straightforward as it seems, though. Research in the USA (Vandergrift & Christopher, 2021) highlights that age and ethnic background play a part in how healthcare in a prison is viewed. As we age chronic diseases and ill-health are part of life, and limited access to healthcare might colour the perception of some of those incarcerated. Non-Latinx White individuals (Vandergrift & Christopher, 2021) held negative views on prison healthcare whilst Non-Latinx/Non-White individuals had a far more positive view of healthcare services in prison. This could, of course, reflect structural racism regarding healthcare beyond prison walls, as Non-Latinx White individuals had access to healthcare services prior to prison whilst Latinx and Non-Latinx/Non-White individuals lacked access, and had limited insurance coverage prior to incarceration. I do not suggest here that prison is a 'health option' for some, only that such views reflect access to healthcare in the USA. As a caveat, though, some people refuse to access available healthcare services that have no involvement with a criminal justice system. Limited healthcare is thus available but butts its head on changing health behaviours (Vlaev et al., 2016),

managing chronic diseases (Mollenkamp et al., 2019) and vaccinations (Dubov & Phung, 2015) regardless of whether an individual is sentenced to prison.

Research has also highlighted the links between pre-incarceration criminal justice contacts—police stops and arrests—and health (Del Toro et al., 2019). Individuals and/or a 'specific community' that is distinct because of race and/or religion and culture, depending on encounters with criminal justice, countenance increased health risks, including mental health. Regular encounters highlight how contacts with law enforcement, in particular, can cause stress in the lives of individuals—fear and distress, the financial burden of paying fines and fees, and stigma—in ways that harm health (McFarland et al., 2018, 2019). Those that work in the criminal justice system, however, also suffer from stress and health issues.

The links between criminal justice and healthcare or more appropriate illness and/or disease, though, are contested. Involvement in crime and/or the consumption of illegal substances should not be read as evidence of a relationship between arrest, incarceration, release and health (Boen, 2020). Many factors that increase individual risks for criminal justice system involvement—such as socio-economic hardship—also impact on health. In this way, an observed relationship between criminal justice contacts and health might simply reflect the underlying differences between those reporting no contacts with the criminal justice system, and those with a history of criminal justice contact rather than reflect health effects (Porter, 2014).

Other research has reviewed the spread of infectious diseases in jail/prison/secure units and/or examined chronic disease outcomes (Boen, 2020). The problem here, as above, is pinpointing how criminal justice contacts affect pre-disease markers of health and disease. In addition research has highlighted how exposure to incarceration impacts on health beyond the duration of a sentence (Schnittker & John, 2007). Length of a prison sentence, without doubt, has an impact, but so too will the number of times an individual is detained in a jail/prison/secure unit (Porter & DeMarco, 2019). The age of the offender also shapes life outcomes for health (Del Toro et al., 2019). Age-rates on criminal justice contacts indicate that encounters with the criminal justice system

are often in the life course of an individual, suggesting that these contacts have the potential to contribute to trajectories of health inequality (Boen, 2020; Esposito et al., 2017).

Pre-incarceration health risks also show that contact with a criminal justice system leads to poor health outcomes. This, however, is only if encounters with law enforcement are regular and stressful. Dosage, or number of times a person is placed in a jail/prison, also matters for health. A caveat is needed here, though. Individuals who have been incarcerated once appear to have health risks beyond those incarcerated multiple times. After multiple sentences, *some* offenders 'adapt' and are equipped to handle the stress of incarceration (Porter & DeMarco, 2019).

Furthermore, contact with the criminal justice system is a 'criminal justice continuum' that impacts on health (Wittouck & Vander, 2019). For example, contact with law enforcement, arrests, detained or on remand, police interview techniques, plea bargaining with prosecutors (depending on jurisdiction), sentence and subsequent incarceration. Regardless of the system—prosecutorial or adversarial—involvement with a criminal justice system as an offender, victim or criminal justice employee is thus stressful.

Drawing this section to a close, it is possible to state that contact with a criminal justice system, particularly incarceration impacts on health outcomes. The physical and emotional environment of a jail/prison, which is characterized by solitude, isolation, violence and fear has the potential to lead to physiological stress (Porter, 2014). The stigma and damage of social relationships that extends beyond a sentence can also exacerbate psychophysiological outcomes. Incarceration also exposes individuals to heightened infection of risks shaping young adults' health, with the health consequences for them but also family members, local and national populations and health services.

Conclusion

In this chapter I highlighted the links between medicalization and crime, and how medical issues are constructed and shaped by human action. This is reflected in mental health institutions decline, in some jurisdictions i.e., the USA, and rise in new correctional institutions. As mental hospitals declined, the criminal justice system and prison network has expanded and absorbed those with mental health issues. The criminal justice system and carceral state has thus *criminalized* some mental illnesses. This criminalization, however, is in part down to the organization and structure of the medical profession that has had an impact on how we 'treat illness'.

The majority of offenders, though, depending on the jurisdiction, are released and have either a mental health issue prior to incarceration, one that is exacerbated by it or one that is caused by it. The impact of incarceration also extends beyond release, where ex-offenders encounter challenges with accommodation, employment and stigma (Kirk, 2018; Testa & Jackson, 2019) and the erosion of individuals' social contacts. Furthermore, in prison there is the potential for and exposure to communicable diseases and infections, which once offenders are released become a health issue beyond institutional walls.

All of these are healthcare costs; these costs, however, are unequally distributed. They of course impact on offenders and ex-offenders, the families of offenders/ex-offenders, and the victims of crime. But criminal justice systems can also affect—police, probation and prison officers—health too. The criminal justice system affects health outcomes—physical and/or mental health issues—that impact on health inequality. This inequality, however, is structural and access to healthcare services is a problem in a prison but also beyond prison walls.

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9

Uncaring Homes: The Corruption of Care and the Control and Exclusion of Residents and Patients

Introduction

This chapter highlights how those most in need are often neglected and encounter exclusion and victimization due to dependency and powerlessness. I use the term care homes here to cover all residents/patients in different types of institutions. The reason is some people have multiple issues, e.g., ageing with physical and mental health issues, and that all institutions, *should care* for those under its supervision but are sometimes subjected to neglect and abuse. These 'homes' are part of the healthcare sector but corruption of care, uncovered years after the 'event', exposes poor treatment, neglect and abuse (Botngård et al., 2021; Cooper et al., 2013; Hirt et al., 2022; Moore, 2016). This is not the case for all care homes, but all too often scandals occur (Hirt et al., 2022; Moore, 2019; Moore & Hanratty, 2013) because of poor practice, poor supervision of employees and lack of regulatory oversight.

I start this chapter with a review of how difficult it is to sometimes differentiate between neglect and abuse. The range of acts that these cover is extensive and sometimes blurs. In the next section of the chapter, I breakdown who the offenders are—serial, pathological and stressed

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employees, and also highlight why and how residents/patients are victimized. A caveat here, though, is that the boundary between victims and offenders blurs, e.g., a resident/patient is subject to abuse by a care home employee but the same resident might also abuse a fellow resident/patient. In the next section, I consider how the institutional context affects, how we behave and how it can alter behaviour and the quality of care, and types of neglect and abuse. In the final section of the chapter, I consider how difficult it is to expose poor healthcare, where active and passive neglect (Lacher et al., 2016) become systemic abuse.

Neglect and Abuse: Poor Care to the Corruption of Care

Relying on official statistics to determine levels of criminal acts in care homes is limited (Lacher et al., 2016; Moore, 2018) as it is with all criminal justice data (Huebner & Bynum, 2016; Hutt et al., 2018; Klingele, 2019; Morabito & Gaub, 2022). In addition, a dependent child and/or adult might hide neglect and abuse for fear that disclosure might lead to the offender(s) arrest and conviction. It is also difficult to establish some estimate and extent of 'non-crimes' because of varying definitions of neglect and abuse (McCarthy, 2002, Moore, 2016) and the desire for corrupt care homes to hide the neglect and abuse. Furthermore, a poor, ineffectual, incompetent regulatory body is also a potential conduit of corruption. Taking all these issues into account and the nature of clinical and social circumstances, we are vulnerable at different stages of human life, and as such a part of a population is subjected to the risk of neglect and abuse (Andela et al., 2021).

Neglect consists of a range of acts that harm the residents/patients in a care home. It can be intentional and unintentional; unintentional neglect stems from either inexperience or the inability to deliver care. Intentional neglect is where a deliberate act fails to fulfil the level of care expected, that harms the resident/patient. Neglect then is ignoring medical and physical needs, failure to deliver relevant and appropriate care, and to withhold medication, adequate nutrition and warmth. Neglect is also broken into passive and active neglect, too (Lacher et al., 2016). These

can blur, however, e.g., a care home nurse overlooks the need for water for a resident/patient or knowingly withholds water/food/medicine. The route taken is different but the outcome is the same. It is perhaps a continuum of neglect leading to abuse such as neglecting a resident/patient that has limited opportunity of personal movement without assistance to tying a victim to a chair and/or bed to prevent self-abuse for 'inappropriate' amount of time.

Abuse of residents/patients, however, is *verbal* and *physical* such as the use of abusive language, slapping and shoving a resident/patient; *psychological abuse* is verbal or nonverbal insults, humiliation, isolation, abandonment and infantilization, or threats (Andela et al., 2021); *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.

The reason(s) put forward, and risk factors that explain neglect and abuse differ, but the literature often highlights that the outcome is one of a complex situation in which a wide range of medical, psychosocial, economic and interpersonal factors are present. Some risk factors—chronic work stress, lack of supervisory support and organizational resources, poor communication between care home employees and 'management', along with tacit acceptance of neglect and abusive behaviour towards residents/patients and emotional exhaustion and depersonalization of residents/patients and employees (Stimpfel & Aiken, 2013).

Nurses and nurse's aids encounter aggressive residents/patients, particularly elderly patients with dementia who are subject to threats and violence and sometimes respond in an aggressive and inappropriate fashion that leads to neglect and/or abuse. I do not consider this an excuse for neglect and/or abuse; I simply highlight that the context in which some work is stressful and abusive. The problem, however, is that some seek out the opportunity to abuse patients—young, old and with a mental health issue—and do so under cover of providing care in an institutional environment.

To neglect people in need, for whatever reason, is perhaps moral corruption, but abuse, depending on the level and type is or leads towards criminal corruption. Abuse, though, is also committed between residents and seen as a 'normal part of nursing home life' (Myhre et al., 2020: 1); abuse in a care home from familial members, though, is often seen as a private affair.

These types of abuse are 'western' as 'institutional care' is part of a state's response to those deemed vulnerable. For the sake of some clarity, though, which can, I suggest apply to other types of institutional abuse, the WHO (2002) has defined elder abuse as a single, or repeated act, or lack of appropriate action, within a relationship where there is an expectation of trust which causes harm or distress to an older person. This definition, with some caveats, could also refer to children and those with mental health issues in a care home/hospital. Prevention of harm is a core principle in healthcare services, and in this chapter, but relevant to all chapters, the corruption of this principle leads to predatory offenders that we consider in the next section.

The Corruption of Care: Offenders and Victims

Care homes are complex social systems that consist of different participants, including nurses, nurse's aids, team leaders/supervisors, management, residents/patients and visitors in ever-changing interactions. The aetiology of abuse in care homes is complex, comprising varying personal, social and organisational relationships and factors. Residents/patients often have complex care needs, dementia or limited cognitive capacity, and display challenging behaviour and depend on assistance to complete simple tasks; all these factors have the potential to lead to a high risk of neglect and abuse (Myhre et al., 2020).

There are, however, different types of offenders and offences (Kamavarapu et al., 2017). Some acts are due to the stressful work environment, whilst others are those of pathological and serial offenders (Payne & Gainey, 2006). A note of caution is needed here, though; the distinction between pathological and serial offenders is blurred. A pathological offender(s) might have been caught once, but a serial offender

will have a track record of similar offences. Pathological offenders might be serial offenders without the official record of abuse. Both pathological and serial offenders, however, seem to have similar motivations to control and abuse (Payne & Gainey, 2006).

Structural and psychological influences explain, to some extent, *why* and *how* people commit offences in care homes (Parker, 2021). People make choices in a structured environment and under set circumstances (Felson, 1998: 119). Placing vulnerable people into a care home is to put some people in danger of victimization. This is, of course, in some care homes but institutional settings where vulnerable children, adults with physical and cognitive demands and patients with mental health issues reside, dependent on and under the control of others is to place people in potential danger.

In this context, a motivated offender(s) might seek out the opportunity to prey on a suitable victim or property of a victim in an environment where there is little supervision to deter crime(s). There are ample pressures and allures for engaging in crimes, where some institutions appear to attract those motivated that want to harm and abuse. Institutional care then, depending on the type of care and employees and supervision of them can increase the exposure of people with physical and cognitive issues to potential offenders and isolate vulnerable people in need of care from sources of internal and external protection such as adequate supervision in a care home and law enforcement and the criminal justice system (Petersilia, 2001).

What is clear, though, is the desire of care homes to keep cases of abuse out of the reach of the criminal justice system. Care homes/mental health hospitals, regardless of the type of patient(s), hide such acts. Those that engage in this silence (see Chapter 11) are offenders, but also doctors, nurses and nurse's aids that maintain institutional silence for a number of reasons. Furthermore, law enforcement has shown limited interest in dealing with such cases, in different jurisdictions (BartKowiak-Theron & Asquith, 2016; Punch & James, 2017). This, though, is down to a number of factors: attitudes towards this type of crime, and most of all victim(s), lack of resources to deal with the crime, if seen as one, inadequate knowledge and skills (Collins & Murphy, 2022) and communication between 'young' officers and 'old' patients and familial

members that block investigations into cases (Payne & Gainey, 2006). All of this, as with other cases—mental health patients—have cognitive and behavioural issues that make it difficult or nigh on impossible to secure clear evidential statements, too.

For some care home residents/patients, particularly the elderly, their lifestyle or 'routine inactivity' (Payne & Gainey, 2006: 6) makes them suitable and vulnerable to abuse and crime. Research (Payne & Gainey, 2006) has shown that those with cognitive conditions, in particular, are vulnerable to sexual abuse and victimization. Dependent on others to help with movement, consumption of food and medication and cleanliness, patients are victimized. Nurses, nurse's aids, supervisors, familial members and other visitors all 'prey' on vulnerable people. The act might be different, e.g., abuse or theft of personal possessions, but for those with a number of physical and cognitive issues to deal with, exposure to the range of offenders—pathological/serial and/or employees under stress and absence of capable individuals is, for some, the norm rather than the exception.

It is important to note, though, that vulnerability works in conjunction with other elements to increase victims' risks. Some potential victims take preventive measures to reduce risk, but those with certain conditions are unable to take measures that afford some protection. This protection, though is either a capable individual or other patients. This, level of protection, however, depends on the cognitive capacity of the other patients/residents. Residents of long-term care settings, though, have little choice, and are dependent on often limited formal measures as a source of safeguarding to prevent victimization. With an array of offenders and victims it is perhaps useful to have a broad descriptive categorization of the corruption of care in care homes. The boundary between each categorization below, though, will blur, but at least highlights the reach, level and depth of potential neglect and abuse residents/patients suffer.

1. Verbal, physical *abuse, sexual offences and theft by co-residents to other residents*, and seen, by some as commonplace, and a 'normal part of nursing home life' (Myhre et al., 2020). With a greying population in some parts of the world where there is a high prevalence of residents

with neuropsychiatric symptoms of dementia, that are aggressive and/or suffer from psychosis, resident-to-resident aggression might become a common form of abuse. For the victim, resident-to-resident aggression has both physical and psychological consequences.

2. Verbal and physical *abuse, sexual offences and theft from relatives towards those in care homes*, which is seen as a 'private affair' (Myhre et al., 2020: 1). This is difficult to discover and deal with, particularly if the resident/patient has dementia. Physical and sexual abuse from relatives towards residents/patients is the most hidden form of abuse (Myhre et al., 2020) in care homes and sometimes the type of abuse—sexual, physical and/or theft (Lloyd-Sherlock et al., 2019)—has antecedents in past family conflict, with mental health issues and/or addiction issues.
3. Verbal and physical *abuse by residents towards nurses and nurse aids'* in care homes. This can happen with aggressive residents/patients in some care homes/hospitals. Such a stressful environment has the potential to lead to combustible incidents where harm to employees and residents/patients occur.
4. Verbal and physical *abuse, sexual offences and theft by nurses, nurse's aids and supervisors on residents* (Gil & Capelas, 2022; Hirt et al., 2022) where abuse is a calculated act or one that is 'in the moment' because of stress. Physical and chemical restraint techniques are, however, used in care homes, and as with all techniques of restraint it is the type, length and duration of them that reaches into abuse and in extreme cases death. A caveat here, though, is that physical and chemical restraints are sometimes used or justified as a way to protect the resident/patient from self-harm. These techniques, though, are used as techniques of control and exclusion, depending on the offender(s). The use of chemicals to subdue and/or abuse a resident/patient is often under the control of those with the power to dispense and administer 'medication'.
5. Verbal and physical *abuse, sexual offences and theft by nurses, nurse's aids, supervisors, etc., towards fellow employees in care homes.* This is the most under-research aspect of abuse in a care home. This is understandable as we conduct research on neglected and abused residents/patients but in institutions there is always the potential for

bullying, neglect, abusive behaviour and sexual offences towards work colleagues too.

In this broad categorization above there are acts of commission, e.g., theft but also acts of omission, e.g., delaying/refusing medication to residents/patients. Abuse in all its manifestations is on a continuum of corruption (Brooks, 2016). Some of the acts are immoral and some lead to or are criminal. In such a context, care home employees might therefore engage in techniques of neutralization (Sykes & Matza, 1957) to cope with the environment and/or in time alter behaviour under the pressure of socialization, institutionalization and rationalization (Ashforth & Anand, 2003). In the absence of institutionalization and interaction, however, it is doubtful that acts of corruption become embedded in organizational structures and processes and become part of a routine of 'care' or lack of it and thus the rationalization and subsequent socialization of such acts will be absent too.

Institutionalized socialization, however, increases new employees' acceptance of organizational practices and can lead to common interpretations of 'care' and reaction/response to it, and thus less questioning of healthcare practice. Abusive acts are potentially therefore more likely to be accepted because it is packaged in a way that prevents dissent (Brooks, 2016). Socialization and rationalization thus reinforce one another and serve as an explanatory sedative and justification for acts of corruption. The social cocoon of socialization can provide a protective environment for actions that new employees might reject, unless inducted into the culture of the organization. If left unchallenged unacceptable practices have the potential to seep into the fibre of an organization and its practices through the process of institutionalization and affect the conduct and actions of individuals (Ashforth & Anand, 2003) leading to neglect and abuse in care homes.

The Corruption of Care: Institutions

The above section of this chapter highlighted the range of potential offenders and victims and situational factors such as the level of conflict with nurses and patients/residents and other employees and supervisors, and levels of stress, responses to aggressive patients/residents, numbers of nurses and nurse aids on a shift which all impact on the environment that contributes to poor care, abuse and the corruption of care.

Rules and regulations in institutions—a care home and a prison—however, have the potential to be abusive themselves, e.g., power to decide residents' or inmates' sleeping patterns and meal times, the use of restraint techniques, and control of communal spaces (Myhre et al., 2020). The difference between a care home and a prison, however, is that residents/patients have committed no crime(s) and are 'sentenced' to an institution. Both institutions, though, have similarities as highlighted above. Furthermore, some offenders, however, as mentioned above, seek out the opportunity to prey on people and commit a range of offences. Institutions are able to hide corruption and residents/patients have little or no recourse for justice. However, once the level of abuse is unearthed (and this is often years after the abuse), residents/patients encounter a second set of institutions—the criminal justice system—that because of the threshold of evidence needed in a criminal trial, and obfuscation of a care home(s), make it difficult for vulnerable victimized residents/patients to secure help and protection needed.

Regardless of the type of care home, and jurisdictions that have care homes, abuse disappointedly reoccurs (Moore, 2018, 2019). If we are unable and/or fail to learn and prevent abuse in care homes, and it appears that we do, then we should consider the role of the institutional environment beyond individual offenders and victims. So, how do institutions that are supposedly committed to an ethic of care and respect become 'corrupted' and abuse vulnerable populations?

It is important to distinguish between the kind of corruption which takes place *in pursuit of a institutional policy* and the kind of corruption which is *in place of policy*. For example, a scandal in a care home that attempted to achieve its policy objectives is unethical, whilst the use of

violence towards residents/patients is corrupt, as such actions are irrelevant to policy objectives. Therefore, as mentioned in this chapter and elsewhere in this book, corruption is part of a continuum. The essential element, however, is that corruption of care constitutes an active betrayal of the values—healthcare values—on which the organisation is supposedly based. It is much more than a passive neglect of the principles of acceptable practice. It amounts to active abuse of a position of responsibility and of a client's fundamental human rights (Wardhaugh & Wilding, 1993), where recognized.

As with corruption in law enforcement and the financial sector, the healthcare sector often claims that corruption is caused by a 'bad apple', a rogue instead of a culture of abuse. This approach, as with law enforcement and the financial sector is inadequate. Instead it is worthwhile that we examine the corruption of institutional care as part of the nature of institutions (Goffman, 1961). To do this, I draw on an old text (Kelman, 1973) that explained how the institutional conditions for violence occur and weaken a commitment to the normal canons of care in healthcare services and how a care home stumbles, falls and then adopts and accepts a decline in institutional care. People in care homes, for some, are seen as beyond the normal bounds of moral behaviour. Subject to ritualized admission to institutions that have the potential to lead to depersonalization residents/patients are subject to humiliation. Bureaucratic structures, which are needed to some extent in institutions, adjust human actions to an ideal of rationality where moral considerations are silenced (Bauman, 1990) and moral issues are matters of organisation or technique. People are reduced to subjects or objects that must follow a command. As Bauman (1990: 136) put it we become 'specimens of a category'. This might seem an extreme way to view care homes, but with recurring scandals within and across jurisdictions, there is some explanatory value here in how we treat those in need.

The corruption of care then depends on the neutralization of care for those in need. Neutralization takes place via the processes of depersonalization and dehumanization which depend on the creation of moral distance and thus lead to humiliation, dispossession and degradation of vulnerable populations unable to physically defend or secure attention in an institutional environment. Instead access to rooms, materials, etc., as

standard care are seen as 'privileges' (Wardhaugh & Wilding, 1993). Residents/patients are subject to isolation and ridicule as a means of control which degrades and depersonalizes those subjected to care home rules and regimes.

Most of those who have been victims of the corruption of care are vulnerable and powerless. Residents/patients have little power or influence, little knowledge of how the organisation works, or awareness of how to assert rights or how to call to account those whom should care for them. Those responsible for residents/patients, in some cases, have almost absolute power, e.g., control of movement and access to food and water. This, I suggest, is a potential conduit of corruption. However, if power corrupts, so too does powerlessness. Care home employees might have nearly absolute power in providing care, but employees too, are in some respects powerless; with limited recognition, no official control or consulted about institutional care, care home employees are marginalized, too.

There is no simple causal connection between abuse and employees powerlessness and the corruption of care but if employees' status is one of a lack of recognition and powerlessness, it is possible that some employees behave in an immoral fashion. The crucial issue is that some employees are both powerless and powerful and this can create a dangerous ambivalence (Wardhaugh & Wilding, 1993). Furthermore, within an institution there is a hierarchy of power and powerlessness and these conditions, depending on how pronounced, might contribute to a climate within which abuses of power occur. Inadequate supervision, lack of proper inspections and limited liability of one's actions leaves open the potential for employees to arrogate power to themselves. There is little or no deterrence here in such a context, and so some employees might engage in inappropriate care.

A note of caution is needed here, though. Often marginalized, even now, people with mental health issues, and/or ageing and mental health/cognitive disorders lack full 'human' status, and as such resources and care is limited. This, of course, can depend on the type of institution and resources available, but where resources are limited, emphasis is on completing 'tasks' (e.g., dispense medication but fail to check if the resident/patient has taken them) instead of the quality of care. In such a

context the emphasis is on control and order, on an institutional rather than individual level (Ryan & Thomas, 1987). This is both the product of the depersonalization of residents/patients which pressure causes and is a cause of depersonalization. The slide from care to control is inevitable in some situations where stress and pressure of care leads into violence towards residents/patients.

In addition, with distant and disinterested 'management' and ownership of care homes/institutions, which is a recurrent theme of abuse in care homes (Moore, 2018, 2019) an organisation without a clear framework of care, is replaced by order and control. The smooth running of the institution, rather than the individual resident/patient, becomes the key concern and some care homes/institutions are closed or semi-closed environments where access is limited and controlled. In this situation, it is possible to see how a care home slides into the corruption of care. Expected standards are published but unless adhered to much depends on the attitudes and judgements of fallible, stressed and/or predatory individuals and limited external regulation. Resistance to criticism and threats to employees (see section below) are yet another potential cause of corruption, as stressed care workers act in an inappropriate way, and predatory individuals have the scope to engage in physical and sexual abuse of residents/patients.

Whilst care home workers have direct contact with residents/patients, 'management' and particularly middle-management encounter demands, too. Stranded in the middle of an organization with pressures to maintain order valid criticisms of care are dismissed and/or downplayed. This, however, is no excuse for a failure to respond to manifest abuse, but it helps to explain the atmosphere in which abuse is discredited. In addition, and as was seen in Chapter 7 claims to clinical and professional independence, depending on the claimant, inhibit management action and are used to justify inaction.

Residents/patients lack the capacity to assert themselves in an institution, but so do family members. The enclosed nature of institutions and organisations means that there are few links to the outside world. We can all condemn poor healthcare treatment, neglect and of course abuse of residents/patients, but we, the outside link are often absent too, and

in this context it is hardly surprising that the corruption of care is often exposed only after years of abuse.

The corruption of care is down to individual offenders' predilection to abuse and/or highly stressed employees, but also institutional structures, regimentation and depersonalization of residents/patients with an array of mental and physical issues and narrow clinical models of professional independence, vigorously defended with clinical knowledge, which can contribute to the silence of moral considerations (Bauman, 1990) and neglect and abuse.

Exposing the Corruption of Care

Cases of poor treatment, neglect and abuse in care homes reappear regardless of an extensive inquiry or investigation (Daly, 2020; Goodwin, 2018; Hutchison, 2016; O'Neill et al., 2020). As seen above, the offenders are often, but not always, those that work in the healthcare sector that engage in poor treatment, neglect, abuse and theft. But often it is an individual who witnesses unethical, illegal or dangerous conduct. Institutional inertia or corruption of care is sometimes due to internal organizational rules that are more of a 'system of obfuscation' rather than an attempt to deal with an issue. Once a 'concern' has been raised, individuals are either praised, which is rare, or more often abused, demoted, labelled and stigmatized (MacDougall, 2016; Lim et al., 2021; Taylor & Goodwin, 2022). Those that expose poor treatment, neglect and especially abuse are often unwelcome as they disclose confidential information, which was obtained as a result of 'working on the inside' (Gobert & Punch, 2000: 27) as an ethical employee and/or involved in the corruption.

Institutions prioritize internal rules and function(s); as such this can block and slow down exposure. A culture that suppresses criticism, particularly if 'junior' employees, or powerless 'outsiders' such as agency employees are critical of the standards of care and treatment of residents/patients. Raising practice or moral issues (Çekiç et al., 2023) or challenging group conduct or behaviour leads to isolation at work. In the enclosed organization, norms are powerful and the costs of challenging

them are substantial. In addition, in a closed or semi-closed isolated organization, there are often few new ideas or practices and the best elements of professionalism wither and perish (Wardhaugh & Wilding, 1993). A closed/semi-closed institution thus maintains a pattern of practice which is routinized and conservative. Its aspirations are control, order and the absence of trouble. Such a pattern of 'care' is an avenue to the corruption of care. In this context residents/patients and some employees are marginalized and isolated.

Exposing corruption and the corruption of care then is problematic. However, corruption is a term that is often defined in different ways (see Chapter 1). It is suggested that exposure of corruption no matter how we define it, should contain eight elements: (1) an actor(s), i.e., a current and/or previous employee of an organization; (2) the target, i.e., the organization or employees which/who conduct unethical or immoral act(s); (3) the disclosure recipient, i.e., the person or organization that is revealed; (4) the subject, i.e., the form and nature of the unethical or immoral conduct; (5) the information, i.e., documentation that is provided as evidence of some significant kind of misconduct or immoral practice; (6) the act, i.e., the information that is released outside normal channels of internal and/or external communication; (7) the motive, i.e., the release of such information as a personal moral protest and (8) the outcome, i.e., as a result, the unethical or immoral conduct is stopped and the public interest is protected (Blenkinsopp et al., 2019; Boatright, 2000; Çekiç et al., 2023; Glazer, 2002; Jubb, 1999; Miceli et al., 2008; Pohjanoksa et al., 2019; Taylor & Goodwin, 2022).

There is significant literature on this subject attempting to highlight the variables and antecedents of those that expose corruption, i.e., male/female, age, ideal values, character individuals' dispositions, religion, tenure, education, satisfaction felt and loyalty (Barnett et al., 1996; Barton, 1995; Glazer & Glazer, 1989; Miceli et al., 2001; Sims & Keenan, 1998) towards an organization. Institutions/care homes, though, should have educational, moral, charitable and healthcare elements to it; a public, social purpose. An institution is also a broad term and can refer to abstract and concrete structures with rules and regulations but also customs and values. Exposing corruption in the

healthcare sector then is a breach of customs and values, a moral breach of professional codes beyond formal rules.

Regardless of the breach, however, human behaviour is a result of one's cultural and social background, and employees with different cultural upbringings and under different socio-economical influences have different views on what is ethical or unethical (Çekiç et al., 2023). Both contextual and individual factors are possible influences on the individual's decision to expose abuse in a care home.

However, it is suggested that we will only behave in a particular way if the resources and opportunity are available. The individual will not have an intention to expose abhorrent behaviour if unable to control the situation and the potential outcome. This 'locus of control' is one of the characteristics that affect exposure. The context is thus important. Near and Miceli (1995: 692) have claimed that people seek anonymity to avoid retribution from employers and fellow employees. But in doing so the credibility of the claim/accusation is diluted and/or lost as the individual and/or organization is unable to confront them. For Near and Miceli (1995) this makes the public exposure less effective. This, however, is doubtful. It is more to do with the type of corruption and value (Moore, 2017) we place on those victimized. People undergo a cognitive process prior to exposing unethical conduct. They—the doctors, nurses, care home assistants—might countenance a range of 'abuses' that 'push' them towards such conduct, in time.

Gundlach et al. (2003: 113) suggest that people use a cost–benefit analysis and weigh up the benefits prior to exposure (i.e., a reward, stopping malpractice or workplace and public safety) alongside the costs of silence (i.e., loss of employment, jeopardize a career and defamation of character). The costs and benefits, however, differ with the characteristics of both the individual and organization. Consequently the reaction of the organization will vary in accordance to the characteristics and position of power (e.g., management) of the person, as much as the exposure.

Internal disclosures allow an organization a chance to fix the problem(s) 'prior to public exposure' (Barnett, 1992: 950). If, however, the organization's climate is conducive to suppressing internal disclosure, poor treatment, neglect and abuse can continue unabated. Although

internal and external exposures appear to be different, they are conceptually similar. For instance, both start with an individual's observation or involvement in an act. Exposure threatens organizational norms and culture, that leads to an atmosphere of hostility and retaliation (Lim et al., 2021; Taylor & Goodwin, 2022). All of this, however, is dependent on the culture and characteristics of the organization.

The power—often the unequal distribution of it—of an organization affects the environment and tolerance, or lack of it, of exposing healthcare abuse and corruption. All organizations in the healthcare sector fear negative public exposure. After all, the health care profession is supposed to care for those most in need. The far more egregious the act, e.g., abuse of children, the individual willing to expose corruption can secure public support. The size of an organization also plays a part in the potential exposure of corruption. Large organizations such as the NHS in England and Wales are less dependent on one individual, and hierarchical, bureaucratic or authoritarian organizations prevent exposure (see Chapter 7 on the use of 'gagging orders').

Perhaps one of the most important indicators is the position of power the person holds. Power resources are material as well as immaterial. Power can accompany expertise (i.e., a doctor/physician) or management position (a CEO) or is embedded in informal structures and networks. Access and use (or abuse) of power is control over resources to influence outcomes (Çekiç et al., 2023). The person responsible for the reported misconduct, i.e., a doctor/physician or nurse in a care home can mobilize and thwart, block and/or discredit the individual that seeks to expose poor treatment, neglect or abuse. The hierarchical position of the corrupt individual, however, is therefore important in this context, and I suggest that the organizational culture in the workplace matters as much as access to power when reporting misconduct, as well as dealing with it.

Organizations operating under poor communication channels, a bureaucratic, hierarchical or centralized control system, might consider implementing alternative mechanisms within the organization to encourage internal disclosure and consider the use of an internal or in-house review board, hot-line, suggestion system, arbitration, internal organizational consultant, employee assistance program (EAPs) and a host of other avenues. But such approaches, unless delivered and

followed, are little more than a paper exercise, a website for public consumption instead of a real attempt to stamp out poor treatment, neglect, abuse and corruption in care homes.

Conclusion

This chapter highlighted how those most in need are often neglected and encounter obstacles, exclusion and victimization in care homes. Neglect and abuse can and do blur as neglect can reach into abusive acts and practice(s). There is a clear difference with some acts, i.e., sexual abuse, but neglect and abuse in a care home is sometimes a complex and difficult problem to establish.

We can, however, highlight types of offenders—serial, pathological and stressed employees and *why* some patients are victimized. To complicate matters verbal and physical neglect and abuse are committed by residents on residents, by residents towards nurses and nurse aids' in care homes, by family members on family members in care homes, by nurses, nurse's aids, supervisors on fellow employees and residents/patients in care homes. None of this helps those that are victimized, though, and such analysis is often 'after the event' where the abuse has occurred.

It appears then, that care homes suffer from similar types of crimes and corruption as other institutions, e.g., a prison. Institutional practice and a hierarchy of power and powerlessness have the potential to lead to the corruption of care and obfuscation of exposing abuse of residents/patients and also some employees. Care homes, for some, then, are *uncaring*, brutal environments, and with some scandals, uncovered years after the abuse, it is difficult to tell if those in a care home are residents, patients or inmates.

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Part IV

Reducing Healthcare Corruption

10

Rational Choice and Behavioural Economics

Introduction

This chapter will examine and assess to what extent corruption is a rational choice based on a cost–benefit calculation (Becker, 1968; Brooks, 2016; Mauro, 1995; Mehlkop & Graeff, 2010; Juraev, 2018; Redlawsk & McCann, 2005). I start by highlighting the conventional economic approach to corruption (Becker, 1968) and how this view of human behaviour resonates within and across the broad church of criminology in explaining crime and corruption (Cornish & Clarke, 1986) and the impact this has had on crime and criminal justice systems in some jurisdictions. I then assess the application and usefulness of behavioural economics to help explain and reduce corruption (Muramatsu & Bianchi, 2021). This approach analyses incentives, automatic thoughts and social preferences that combine under particular contexts that shows that corruption is not reducible to a crime of calculation alone and instead is affected by customs, conventions and emotions. Then, I consider if it is rational for individuals and institutions to remain silent once corruption is obvious. Drawing on Starystach and Holy's (2021) conceptual framework of *structure, context and legitimacy* I

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explain *how* and *why* silence occurs and manifests into a 'wall of Silence' in institutions.

An 'Rational' Economic Approach to Corruption

Explaining why people engage in corruption is complex. It is a multi-faceted phenomenon that is a combination of economic incentives, political factors, institutional signals, moral commitments or lack of them (Heywood, 2015; Rose-Ackerman & Palifka, 2016). To complicate matters, as we have seen, in Chapter 3, the definition and measurement of corruption is often criticized for its limitations. However, crime and corruption, in some cases are perhaps a rational act. The reason(s) behind these acts is sometimes clouded but the end result—a range of economic benefits—such as cash, property, etc., is apparent.

But whilst a few benefit from corruption, it thwarts economic development and impacts on other human behaviour (Spyromitros & Panagiotidis, 2022). In addition it blocks access to services, such as healthcare and threatens the rule of law (where is exists), and in its ultimate manifestation is a conduit for organized crime (Schwuchow, 2023) and terrorism. Trying to make sense of corruption we thus consider rational choice as an explanation for corruption. The reason is that whilst challenged as a limited explanation for corruption, it is a popular description in common discourse, with a dash of moral approbation and presents corruption as a crime of calculation (Muramatsu & Bianchi, 2021).

Corruption, for some, is built on the assumption that 'individuals' are 'rational' and we act in our own self-interest in a world of scarce resources (Rose-Ackerman, 1978: 5). This view of people has historical antecedents, but as a 'modern' view, attributed to Becker (1968) it is assumed criminal behaviour is based on *conscious judgements* regarding projected costs and benefits. All costs and advantages are reduced to a cost/benefit analysis. This 'equation' suggests that criminal behaviour encompasses judgements and a decision(s) under risk. Corruption might occur even with risk-averse individuals if the considered benefits outweigh the chances of apprehension and punishment.

Those that favour this view of human behaviour, and still do, study corruption at the interface of the public and private sectors (Dimant, 2013). Corruption occurs where a person(s) are offered a financial incentive or some other incentive, e.g., property, through personal or political connections (Muramatsu & Bianchi, 2021) to breach rules and/or break laws. This economic framework infers a deviation from contractual relations (an exchange relationship) between public officials and a third party (individual and/or company) that offers an incentive such as a bribe. To prevent corruption, if seen as rational, anti-corruption measures are developed with some rewards in mind, e.g., such as increased level of payment for type of work, but most of all swift, harsh punishment is promoted as a deterrence to deter those seduced by corruption. As a result, the conventional economic approach is concerned with strong controls and swift, severe punishment directed at individuals whose role(s) allow for substantial discretion in the public and sometimes private spheres (Rose-Ackerman & Palifka, 2016). Economic research claims that the potential for increased detection has an impact. But it has also been noted that there are unintended and undesirable consequences of levels of control that impact individual judgement(s) and thus motivation to adhere to rules and laws. Excessive control can thus backfire and undermine intrinsic motivation to behave in an ethical manner (Muramatsu & Bianchi, 2021), and such swift, serve punishment is, for public officials often more rhetorical than factual, in some democratic states.

Transparency and/or information disclosure is considered another standard measure to reduce corruption. However, to complicate matters, disclosure of potential conflicts of interest can be followed by unintended consequences. Disclosure of information can thus backfire (Loewenstein et al., 2011, 2012). For example, a doctor(s)/physicians might disclose some financial incentives/offers from a pharmaceutical company to patients to prescribe 'new' medication. Professionals signal to people (patients) that information disclosed reflects that conflicts are thus manageable. Referred to as strategic exaggeration, this serves to anticipate a reaction to a declaration of personal interests. There is then another approach, alone or in combination with the above called moral licence. Here, information is disclosed and available to patients and the professional (doctor/physician) rationalizes what is best for them. In addition,

there is evidence suggesting that disclosure of doctors/physicians' financial incentives to patients often leads patients to deem doctors/physicians deserve extra remuneration (Hampson, 2006).

Transparency and information disclosure are thus complex. It is not straightforward as often presented. The neoclassical economics on rational calculation underlying corruption and its transactional nature is thus unable to cope with challenges involved in understanding and preventing corruption. Research on corruption needs to examine the complex ways in which individuals make judgements beyond a model, in the real world.

Is Crime a Rational Choice?

Theoretical approaches on human behaviour have a slow and gradual development where we grapple with understanding both the theoretical approach proposed and the social and political context that considers its explanation(s) as a viable interpretation of human conduct and behaviour and the subsequent underlying causes of crime and how to prevent it.

Instead of theoretical debates on why people commit crimes (even though rational choice is a theory as to why people commit crime) it favours a pragmatic approach to crime prevention (Brooks, 2016). The notion of individual responsibility is embedded as a central tenet of this approach that is connected to a conservative view of personal responsibility, human behaviour and accountability, with the criminal law defined by the state and its composition as non-problematic. Rational choice, however, was originally used to explain street crime instead of white-collar crime, and corruption, but this has changed as rational choice unwittingly perhaps, lends itself to explaining crimes of calculation (Juraev, 2018), i.e., some acts of corruption.

The individual, apart from predisposed factors such as age, intelligence and personality learns how to behave in the social world based on what type of behaviour is rewarded and under what circumstances. This approach thus draws on psychological behaviourism and how individuals react to the environment or more pointedly *their* environment. In order

to understand the propensity to commit crime, it is important to understand the ways in which the environment might affect the individual in conjunction with the constitutional 'facts' such as age, intelligence, etc. Wilson and Herrnstein (1985) suggest that individual differences are key factors rather than the impact of the environment; a specific type of familial and social background *could* indicate the potential for crime, but this is not always the determined outcome. A conscience is viewed as a conditioned reflex; in this sense we have internalized a set of attitudes, primarily in childhood, which prevent us from the temptation to commit a crime. A conscience is thus conditioned via socialization. This view suggests that some of us might break the law depending upon the circumstances (see differential association Chapter 3) due to less effective and weak internalization of conduct, and some will commit crimes regardless of the consequences of their actions. The effectiveness of a conscience, though, will prevent and/or reduce the amount of crime dependent on the individual's constitution and reaction to the environment (Walklate, 1998).

This approach has similarities with the rational choice/action framework in economics. In this model, used for understanding social and economic behaviour, the premise is that aggregate social behaviour can be determined from the behaviour and choices of the individual. Its focus is on the causes of individual choices and assumes that we have preferences amongst those available to us and that we state, and act on, those which we prefer. We are thus assumed to be rational and to take account of the available information and the potential costs and benefits in shaping our preferences, and then to act on the self-determined 'best' choice of action.

However, with the complex interplay of factors, it is not difficult to assume that such an approach is simply saying that we are unable to reduce crime and so must accept it as an inevitable consequence of 'a way of life'. Success in preventing different types of crime and corruption can be achieved based on what we know and thus must use limited criminal justice sources accordingly. Rational choice is thus primarily about the management of crime rather than its causes (Brooks, 2019). Understanding some humans are driven to profit maximization, this theoretical approach presumes that individuals make rational choices on the basis

of a cost–benefit analysis: as Cornish and Clarke (1986: 1) make clear: 'offenders seek to benefit themselves by their criminal behaviour: … this involves making decisions and choices, however rudimentary … and that these processes exhibit a measure of rationality, albeit constrained by the limits of time and the availability of information'.

The rational choice to commit a crime based on the time and place and other available information, be it accurate or inaccurate, is made. Rational choice recognizes the limits in explaining crime but seeks to prevent it by making it as hard as possible to commit crime and punishing the offenders when convicted so as to deter others. With little interest as to the underlying causes of crime, effective prevention is concerned with situational measures that might make some small difference.

However, rational choices are limited or bounded by reality. Therefore, we emphasize the extent to which individuals and crowds of people can streamline a decision based on all the information and possible alternatives available. Bounded rationality thus circumscribes the reach of rational thought due to cognitive limitations and extreme emotional events. Sometimes this emotional arousal or event can be acute, and we are 'out of control' and rational considerations are absent. Access and opportunity perhaps explain crime more than rational choice, but this opportunity is dependent on a cost–benefit analysis, socio-economic status, risk of detection, the situational context and type of offence. Furthermore, an opportunity is dependent on the current surroundings and consequential factors. In this sense rational choice is perhaps of some use in explaining instrumental rather than expressive, violent crimes. Even though bounded and restricted by reality, rational corrupt acts are often committed, such as healthcare corruption.

The social and political conditions that render such an approach popular—depending on the offender(s)—favour deterrence and hence custodial sentences. However, it is an approach that wishes to withdraw from the economic and welfare sphere, yet the state expands its reach by regulating the private sector. It thus increases its size and reach. This is a form of net-widening (Cohen, 1985) that was/is aimed primarily at specific types of offenders and crimes such as street crimes. Rational choice in criminology then is primarily concerned with visible street

crime, and whilst it recognizes that a 'choice' to commit crime, is limited, it lacks the explanatory depth of *why, how* and *what* we can and should do to reduce corruption. Behavioural economics, though, offers some insights that I reflect on in the next section.

Explaining Actions: Behavioural Economics

Behavioural economics contributes to the debate above in financial, health and environmental economics (Zamir & Teichman, 2018; Zúñiga, 2018) and notes that conventional anti-corruption approaches have, at best, had a modest impact (Camargo, 2017). Rational choice, and cost–benefit calculation and PA model (see Chapter 3) fail to offer a comprehensive explanation of how cognitive bias and reciprocal relationships lead to systemic corruption (Muramatsu & Bianchi, 2021).

Behavioural economics is built on the notion of bounded rationality (Kahneman, 2003) where there are two modes or systems of thought and acts. (1) Refers to automatic judgements, an in-built mental shortcut (Camargo, 2017) and how a decision(s) are triggered by cues, mental shortcuts or default solutions and heuristics under context-specific situations, simplifying matters that enable individuals to react fast to cognitively arduous and stressful tasks. Then (2) refers to deliberate, controlled thought that appeals to logic and/or high order cognition to deal with solving tasks (Muramatsu & Bianchi, 2021) and social and cultural expectations of what is acceptable behaviour. One implication of the automatic system of judgement is that behaviour is sensitive to how a problem(s) and choices are viewed in a cost/benefit analysis. In addition actual behaviour is subject to intuitions, emotions and social norms that frame bounded rational individuals that are not necessarily in tune with their best available options and interests (Kahneman, 2003).

The 'standard' economic and criminology rational choice approach and its transactional nature with acts of commission and omission fail to uncover how incentives, automatic thoughts and social preferences work together, under particular contexts. Corruption is thus not reducible to a crime of calculation and/or insensitive to reciprocal acts and emotional

contexts. Kahneman (2003) highlights that human perception is imperfect and context dependent. Therefore individual choices are responsive to how options are represented rather than to the alternatives themselves. As a result, a decision depends on the perception of relative losses or profits.

Kahneman (2003) highlighted that individuals make a loss aversion decision instead of one of profit, depending on the context. Dishonest choices can occur when individuals see themselves in a loss context instead of profit (Kern & Chugh, 2009). In the above section, we are seen to act if the benefits outweigh the losses but here under the pressure of potential losses individuals react by adjusting their behaviour and ethical preferences where the perception of loss is perhaps an incentive to act instead of one of profit.

Building on this, Feldman and Halali (2019) claimed that the ambiguity underlying conflict of interest triggers automatic judgements and a decision(s) towards individuals' moral blind spots' revealing abuse of their public position to obtain personal benefits. As such ambiguity and intuition have a role in dishonest conduct even when individuals still view themselves as professionals committed to ethical values. Behavioural impacts are associated with the prevalence of mental models and narrow frames—e.g., narrow frames of reference that refer to that which is automatic and 'comes to mind' such as bias and prejudicial views (World Bank, 2014: 6). Such narrow frames can influence what is collectively viewed as expected and acceptable behaviours of citizens and professionals, often legitimising a tacit tolerance—and even acceptance—of corruption (Camargo, 2017). In some contexts then, professionals' moral preferences adjust to the context and combined with overconfidence blur how we reason and explain a situation. In a broad and descriptive sense then behavioural economics is where:

- Automatic thought(s) are those we 'think' and make judgements on *without* deliberation.
- Social thought(s) are where we recognize the way people 'think' often depends on what others around them do and 'think'
- Mental models of thought(s) is where individuals share common perspectives and ideas—such as stereotypes and prejudices—that make

sense of the world around them (Camargo, 2017: 2, Muramatsu & Bianchi, 2021: 56–62).

Furthermore, interventions to raise awareness about the incidence of corruption have limited impact in such contexts where corruption is the norm. Campaigns that highlight the levels and prevalence of different types of corruption, e.g., paying a bribe, run the risk of strengthening the notion that everyone is corrupt and thus acceptable.

The context in which automatic judgements are made then plays a role in explaining some instances of ethical misconduct and corruption. Feldman (2018) suggests that people underestimate their own ability to recognize the moral aspects of their own thought processes and choices. Individuals process information in ways that are tuned to their pre-existing views and often delude themselves to present justifications for dishonest actions (Shalvi et al., 2015). Such automatic psychological mechanisms might prevent people from recognizing their wrongful conduct (Feldman, 2017: 88) when situations allow them to view themselves as honest, decent people. To complicate matters, individuals can think that their professional competence is a necessary as well as a sufficient condition that helps avoid suboptimal judgements and/or a decision(s). For instance, doctor(s)/physician(s) with a strong commitment to patients' health and precise clinical choices might underestimate the fact that their medical prescriptions can be influenced by a pharmaceutical company that often sponsors their conferences and research team (Muramatsu & Bianchi, 2021: 11–12). This can also manifest itself in medical trials and subsequent prescriptions of medication (see Feldman et al., 2013).

Overconfidence might enable the person to overlook his or her own (and some others') moral lapses, with inflated confidence in their own integrity. What appears to happen here is that we (or some of us) invoke a reason to explain our conduct, instead of acknowledging a preference for a corrupt or dishonest option. This happens because people's judgements of appropriateness are cue-dependent; this allows us to distort a personal self-image and to justify unethical conduct. For example, individuals who have power, e.g., hospital administrators that focus on broad political or organizational objectives fail to notice that extreme confidence precludes

realization that some of their conduct is unethical and/or corrupt and harming patients.

We thus have social preferences, engage in relationships that are reciprocal and collaborative; this is also what we do when we engage in corruption. Corruption, thus continues because of its collaborative roots (Lambsdorff, 2012) and different informal social networks such as family, clan, village, friends or professional association. Such networks, however, are a double-edged sword; solidarity and reciprocity, and a sense of obligation is a cause of corruption but, depending on the context, resistant to it. This is different from abstract laws that often lack legitimacy and where informal social networks are highly valued as they represent an effective way of pooling limited resources to address local needs.

The survival of a corrupt relationship, however, depends on the enforcement of reciprocity. For example, a doctor is bribed to allow an individual access to healthcare ahead of others (paying to jump the queue). The outcomes here are that (1) a doctor(s)/physician(s) contacts the relevant body regarding the patient that has offered a bribe, to help them access healthcare and thus 'jump the queue' and is fast tracked beyond others in need of healthcare. (2) The doctor(s)/physician(s) maximizes his/her own financial position by accepting the bribe, but fails to fast-track the patient and help them 'jump the queue'. (3) The patient, is 'cheated', out of the bribe with no fast rack access to healthcare and no recourse to challenge the doctor(s)/physician(s). The lesson here is that individuals' willingness to reciprocate might pose an extra challenge in preventing corruption. Dishonest deals have collaborative roots and credible contract enforcement (Hollander-Blumoff, 2007; Muramatsu & Bianchi, 2021) mechanisms.

The prevention and reduction of corruption have thus shifted from conventional cost–benefit analysis and the PA model to a new interdisciplinary/multidisciplinary approach where behavioural factors in dishonest and corrupt practices complement traditional accounts of corruption. Many cognitive, emotional, social and cultural factors are central to corruption and how automatic and social mechanisms impact on judgements and how we make a decision(s). In addition there is evidence that 'dishonest practices' can occur where individuals see a

potential loss instead of a profit (Kern & Chugh, 2009) as a motivation to commit a corrupt act.

Furthermore, another possible source of corruption is overconfidence, where 'professionals' fail to notice the influence of self-interest in personal working practice. Conflicts of interests, intuition and ambiguity also provide fertile soil for corruption, since in many circumstances ordinary people's self-interest can conflict with professional roles (Muramatsu & Bianchi, 2021). Behavioural economics then has key elements to it. These are:

- Corruption is complex and pervasive (but not inevitable)
- Traditional/conventional economics is too narrow and limited to understand and explain corruption
- Corruption is best explained by bounded rationality
- Corruption is reciprocal (and can become systemic)
- Nudges (subtle interventions) help reduce corruption (see Sunstein, 2020 Chapter 12)

In these contexts, full disclosure of information can thus backfire, leading the individuals to rationalize and act in a self-serving way, where social controls and strict anti-corruption laws fail to deter corruption and, in some cases, might even lead to unintended and negative consequences. Instead of an emphasis on deterrence and punishment then it is perhaps useful to consider how we frame choices, e.g., what people will lose if they engage in corruption—via institutional reforms. Moral or immoral behaviour and choices that we exercise are dependent on context instead of some simple cost–benefit calculation. To complicate matters we should also consider why we remain silent when we encounter corruption too. This is addressed in the next section.

Is It Rational for Individuals and Institutions to Remain Silent?

How and *why* do people remain silent in corrupt institutions? To understand behaviour we need to consider and differentiate between individual and organizational corruption and individual and organizational silence. No organization follows its expected rules all the time, regardless of the sector. Organizations and its employees negotiate between useful illegal behaviour (Luhmann, 1964), necessary to attain organizational aims, and external societal expectations and state laws, necessary to obtain legitimacy. As a result, how we behave is to a certain extent a necessary evil in organizations (Kühl, 2020), and engage in obfuscation and concealment, and hence silence is a normal part of organizations. Organizational silence (or attempts to control it) then could be presented as 'rule-breaking is necessary to achieve even mundane organizational aims, but on the other hand, cannot be addressed or admitted openly without endangering the legitimacy of the respective organization' (Starystach & Holy, 2021: 71).

The question that arises is *why* do we remain silent, which is morally reprehensible and/ or when not even useful for the respective organization? Why do members who are not directly involved in crimes and acts of corruption in organizations shield offenders? Some of this is obvious: threats, intimidation, promises of future promotion, fear of repercussions, etc. But it is still important to understand how organizations build, expand and consolidate forms of self-regulation (Miller, 2017). Drawing on Starystach and Holy's (2021) conceptual framework of *structure, context and legitimacy* I explain how and why silence occurs (Gibson & Singh, 2003). Silence in organizations is the outcome of employee silence, i.e., the absence of voice, which can have a plethora of reasons or motives, but here, silence in organizations is understood as an organizational climate of silence, the extent of the existence or absence of 'speaking up' and exposing corruption.

Silence in organizations is regularly considered as the outcome of individual behaviour based on personality and perceptions. To explain organizational behaviour, this strain of research considers factors such as

the effectiveness of voice, forms of detachment, perceptions of powerlessness or dynamics of loyalty. In addition contextual factors explain silence in organizations, such as a climate of fear and distrust, an instrumental organizational climate, the deaf ear syndrome and spirals of silence (Blackman & Sadler-Smith, 2009; Brinsfield, 2013; Knoll & van Dick, 2013; Mannion & Huw, 2015; Whiting et al., 2012). But to understand *how a climate of silence is formed* structural effects and the formation of subcultures and informal norms in an organization need some consideration too.

The breaking and bending of rules are ubiquitous in organizations. No organization can stick to all its formal rules and at the same time fulfil what is expected of them (Kühl, 2020). This is why 'service by the book' is capable of paralyzing organizations (Starystach & Holy, 2021). Therefore, organizations are to some extent characterized by informal structures and useful illegality (Kühl, 2020; Luhmann, 1964; Pohlmann et al., 2016). There is, though, an established difference between individual behaviour that serves particular interests at the cost of the organization and organizational behaviour which serves the (shared) interest of the organization (Pinto et al., 2008; Pohlmann et al., 2016). Although there are cases which fit both, the distinction between them helps understand behaviour. In the case of individual silence, members of the organization decide on their own, or a small number of individuals are intimidated to keep silent about corruption in an organization. This, of course, is done to protect themselves from demotion, retaliation and/or unemployment. Such a focus considers personality or contextual factors that make speaking up a poor option for an individual. Not speaking up and out then is an individual rational choice within a specific context.

Examples of individual silence are workplace harassment or unwanted sexual attention from a colleague; these, though, often fulfil the desires of an individual instead of the organization. They can, of course, influence culture if pervasive in an organization but this, in most cases, depends on power structures in organizations where 'offenders' are immune from sanctions. Other individuals that witness such acts remain silent, and in

this context it is seen that individuals remain silent because of personality and context factors, such as opportunity structures and a climate of silence.

However, organizational silence focuses on cases where the actions of the employees of an organization are based on shared norms for the benefit of the organization. Depending on the size of an organization and its location some or all its employees might act in a corrupt manner for the benefit of the organization. This type of silence is often used as an example of professional walls of silence. A number of powerful individuals in a company/organization then act/behave in a way to safeguard the organization that entails at least a partly shared frame of reference (Starystach & Holy, 2021), a system of informal norms and an organizational subculture in which these norms are reproduced. These systems provide an overarching structure of meaning and enable corrupt behaviour and silence in organizations.

Here a wall of silence is simply protecting the organization, i.e., child abuse in children's homes, neglect and abuse in old people's homes, etc. (see Chapter 9 for corruption in care homes). People use their position of power to secure personal financial and/or sexual 'benefits'. The wall of silence, however, is primarily protecting the offenders to prevent the de-legitimation of the institution. In this case, the abuse is explained as a combination of personality and context factors, but the organizational silence is based on the norm of 'servitude' to the institution (Starystach & Holy, 2021), e.g., care home, church and hospital. This leads to a climate of silence, but its main purpose is to protect the organization. In other words, it is normalized and rationalized. The main outcome is that members/employees of organization keep silent but some also vigorously protect the offender(s) and help build a wall of silence to block investigation into 'corrupt' behaviours, even though they were not engaged in the corrupt act(s).

What the above examples highlight is the key to understanding the role of informal rules to explain some forms of silence in organizations and understanding the standards of justification and legitimation to obfuscate and shield acts of corruption that contribute to the justification of the offence(s). Therefore, the framework helps to understand which explanatory factors are relevant, by understanding the underlying

standards of justification. An example of this in action in healthcare is the German Transplant Scandal (Starystach & Holy, 2021) where a doctor/physician manipulated the medical data of his patients, such as blood tests and size of their carcinomas to increase his patients' prospects of organ allocation. This violated the organ allocation rules of the German Medical Association. The doctor/physician was accused of attempted homicide as his actions helped his patients 'jump the queue' and displace other patients in need of vital organ transplants. The doctor/physician, however, was acquitted, in 2015 of all accusations.

This case and subsequent investigation, however, unearthed that systematic violations were happening at other transplant centres in Germany. Unwritten norms of interpretation and action, used to justify and explain such acts, were shaped by the medical profession itself. Actions appeared shaped, in particular, by medical competition, medical professional influence, a professional ethos and the claim to autonomous problem-solving (Starystach & Holy, 2021). Some, rather than all centres, breached the rules, but the numbers of people involved in these centres leave no room to claim the acts were accidental or the acts of negligent individuals (Pohlmann et al., 2016). Instead, the rate of incidents (per centre with violations), and complexity of 'managing' the transplant lists, perhaps indicates that a number of people were part of the process in and outside of the respective centres. A system that needs coordination, administration and documentation and the involvement of multiple actors, i.e., surgeons, anaesthetists, assistant doctors/physicians and nurses that maintain contact with patients and familial members make it impossible to claim only 'corrupt' individuals were involved and that others were unaware of such actions. The reason this was possible was that hierarchical power plays a significant role here and in other contexts in the healthcare sectors. Embedded in the organizational structure of hospitals there are clear relationships of power and subordination.

Hierarchical power is established as part of the institution role allocation but also medical knowledge and expertise (Starystach & Holy, 2021). This later medical power is relevant in transplant centres where professional medical power influences the behaviour of subordinate personnel at work prior to potential prosecution and sanctions. Silence

in this context could be explained as a form of *individual silence* with the causes rooted in a climate of fear. However, medical practitioners encounter moral and ethical dilemmas; in the event of organ shortage, regardless of organ allocation, some patients will encounter death before a transplant. If rules favour patients who respond to a transplant, the serious cases have an increased risk of dying. If, on the other hand, the most serious cases have priority, the risk of dying on the waiting list increases for the 'less' seriously ill. In such a context it is conceivable that the toleration of the manipulation of waiting lists is justified by a doctor(s)/physicians for patients under '*their* care'. Therefore, elements of *organizational silence* are apparent here, too.

The *professional power* of the doctors/physicians, however sometimes exceeds officially established rules. If corruption is noticed, there is the likelihood that it results from medical considerations regarding the patient's welfare. Sovereignty in medical matters is thus ascribed exclusively to doctors/physicians. Justification that rules can/should be circumvented is marginalized and reinterpreted as medical decisions. A wall of silence is thus presented as a medical matter where expertise and knowledge hold sway. In addition, in an organizational context, where the procedure of allocation—often under time pressure—is established to cure and/or sustain life lends themselves to the deviation from rules.

The German Transplant Scandal (Starystach & Holy, 2021) highlights the interconnectedness between the type of 'corruption' and the type of silence. Informal standards of justification and legitimation underlying organizational deviance and organizational silence overlapped in this case where waiting lists were manipulated. The manipulation of the lists was not a case of individual corruption but rather organizational corruption based on medical professional standards. The reason for silence across a number of people in different roles in this case is also located within the scope of professional power and autonomy of the doctors/physicians; this suggests an interconnectedness at the cognitive level and legitimation of acts, which we need to understand as we examine and attempt to reduce acts of corruption.

Conclusion

This chapter has highlighted the impact and limitation of the conventional economic approach in explaining crime/corruption where human behaviour/acts are seen as a cost–benefit calculation. This view of human behaviour echoes in criminology literature and rational choice. This too is limited. The use and application of behavioural economics, however, reaches a level of sophistication beyond cost–benefit calculations and considers automatic thought(s)—judgements *without* deliberation—social thought(s)—recognizing the way we 'think' is dependent on what others around us *do and think* and, mental models of thought(s)—where we share common perspectives and ideas—such as stereotypes and prejudices—that make sense of our world (Camargo, 2017: 2). The latter approach appears to hold out so hope that we can tackle and reduce corruption to some extent. It sees corruption as complex and pervasive, but not inevitable, with traditional/conventional economics as too narrow and limited to understand and explain corruption, and places acts of corruption into a bounded rationality where reciprocal relationships contribute to corruption. All of the above explain why people are potentially corrupt or knowingly engage in it and explain and legitimize such acts.

The last part of the chapter, though, explained how individual and organizational culture impact on why we keep silent and protect corrupt people. The role of informal rules explains some forms of silence in organizations and combined with behavioural economics, I suggest that this is a rich avenue for us to explore the standards of justification and legitimation to obfuscate and shield acts of corruption and build a framework of reduction (instead of prevention) across a number of different sectors that engage in corruption.

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11

A Nudge in the Right Direction: Persuading People to Change

Introduction

Nudges refer to (public or private) subtle interventions that aim to suggest some courses of action to people and steer individual behaviour(s) towards an action whilst preserving personal choice. For Hansen et al. (2016) a nudge is characterized as an attempt to influence people's judgement, choice or behaviour in a predictable way, made possible because of people's cognitive limitations, prejudicial views, routines and habits in individual and social choices and rational self-declared interests. For Simkulet (2019) a nudge is to influence and alter a person's behaviour without a reduction in personal options, and Sunstein (2020: 6) claims that 'it is more precise to define a nudge as an initiative that affects people's behaviour without imposing significant material burdens or suggesting significant material benefits'.

In this chapter then I start with the theoretical foundation of nudging. Dual-process theoretical approaches are based on a popular distinction between intuitive and deliberate judgements and distinguishes two different types of cognitive processes that propose an architecture of interaction between competing intuitive and thoughtful processes. This leads on to how we can affect behaviour employing the key elements

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of a nudge to influence choices and judgements in the next section of the chapter. However, it is acknowledged in this section of the chapter that behavioural approaches are a supplement, part of the toolbox of anti-corruption approaches and not a substitute to traditional approaches (Loewenstein & Chatter, 2017). Following this, I highlight the key limitations of nudges, with particular reference to fatalism and how this limits the impact of well-crafted nudges in the healthcare sector—such as attitudes towards exercise, food consumption, managing chronic diseases (Mollenkamp et al., 2019) and flu vaccinations (Dubov & Phung, 2015) and anti-corruption campaigns with varying degrees of success.

A Theoretical Approach to Nudging: The Dual Process Model

There is, as expected, a debate on the reach and impact of nudges, but prior to understanding the key elements of *what* and *how* to nudge, is the theoretical foundation of them. The aim of a nudge is to make life changes in behaviour as effortless as possible. For example, health campaigns regarding vaccinations, with simple clear messages or public warnings regarding potential risks to health and/or a text message reminding the patient of a medical appointment. However, nudges are also sometimes referred to as a form of 'soft paternalism' (Sunstein, 2014: 2) when they attempt to steer people in a specific direction, i.e., stop smoking. But as mentioned above, nudges are designed to preserve full freedom of choice within some kind of social environment (or 'choice architecture', i.e., message on a phone for an appointment).

'Dual process' is seen as the theoretical foundation for understanding nudging health behaviours (Vlaev et al., 2016; Voultsos, 2021). Dual-process theoretical approaches are based on a popular distinction between intuitive and deliberate judgements that distinguishes two different types of cognitive processes of reasoning that are 'two minds in one brain' (Evans, 2010) and propose an architecture of interaction between competing intuitive and thoughtful processes. One is automatic, fast, effortless, heuristic and intuitive and the other is slow, sequential and deliberate (see Chapter 10 for view on two

processes and behavioural economics). The later process reflects cognitive capacity (rational thought) and enables the use of individual analytic and problem-solving skills. This theoretical approach, however, is not without criticism. Evans and Stanovich (2013) have proposed that these types of 'thoughts' are on a continuum of processing styles, instead of distinct. Regardless of the views here a note of caution is needed in that automatic and fast processing of information/data should not be dismissed as ineffective or in error and slow, sequential and deliberate thought correct. The latter type of thought can contain prejudicial and irrational views too. Research is still in progress regarding the processing of thought, but it appears that automatic processes are helpful to deal with our complex, changing environment. Furthermore, it is suggested (although not yet proven beyond doubt) that unconscious thought (intuitive approaches), might yield superior choices in dealing with complex scenarios (Voultsos, 2021).

Behavioural sciences, though, maintain that people often choose the default option in dealing with information. We have the propensity (cognitive miserliness) to default to reasoning processes of low computational expense (Hansen et al., 2016). This leads people who are confronted with novel questions to jump to intuitive conclusions that are prompted quickly, with an automatic response and with little effort. We thus draw on causal connections between events based on memory and personal contacts. These, though, could be spurious in certain types of hostile environments, and hence, lead to inappropriate conclusions and/or responses to nudges. A 'hostile environment' is one in which there are a few cues that allow an automatic response, or there are cues that mislead. Stanovich (2018) suggests that errors (suboptimal outcomes), and an incorrect response(s) is also dependent on hoarded knowledge (learned knowledge structures or 'mindware').

Furthermore, some nudges are emotional nudges. For example, emotional reinforcement is used to make healthy products more attractive. Whilst emotions are considered peripheral to thought processes, they are strongly thought (at both theoretical and empirical levels) as playing a significant role in how we make a choice/decision (Voultsos, 2021) on how to act. Emotions and cognition are thus interconnected and underpin every aspect of a thought process. However, a note of

caution is needed here in that the specific way in which emotions affect our choices remains undiscovered. A decision on one's health is always an emotional issue, and perhaps as Mazzocco et al. (2019) have suggested emotions and other factors, such as personal, knowledge, past experience and individual differences seem to influence the way that options and the encompassing information are interpreted and used. The line of distinction between cognitive and automatic ways of human reasoning thus remains blurred.

Less of a blur, however, are key elements of a nudge(s). For example, transparent, clear, open and obvious messages. The action/message in the nudge is that no pressure or compulsion or form of manipulation should occur. We should be able to review and scrutinize nudges. In addition, for all nudges, it is important to rely on evidence rather than intuitions, anecdotes or dogma. The most effective nudges reflect a realistic understanding of how people will often (not always) respond to initiatives. But, as with all promising research, some nudges fail in practice. Empirical research, including randomized trials are indispensable and such research is invaluable but care and attention with results are needed.

Key Elements of Nudging: A Range of Techniques at Our Disposal?

Effective nudges contain a number of elements. These are *default rules* (e.g., automatic enrolment in a health programme). Automatic enrolment in healthcare plans, or in others to prevent healthcare issues can have significant effects. A note of caution is needed here, though; unless *choosing* (also a nudge) to be involved, some kind of default rule is inevitable (Sunstein, 2014) to achieve a healthcare outcome. It makes sense to allow/request that people make an active choice, rather than relying on a default, but in some contexts, such defaults are indispensable, because it is too burdensome to allow people to choose. To secure public participation a simple message is useful. A complex message causes confusion, and depending on the subject, (e.g., taxation (John & Blume, 2018), leads to potential violations of the law), and in part because

it deters participation. A public and/or private programme *should* be navigable to increase participation.

The use of *social norms* is one of the most effective nudges to inform people that others are engaged in a certain behaviour, e.g., highlight the number of people that have cancer scans as a precaution. Such information is often powerful when it is local and specific as possible such as a local campaign in a surgery that nudges patients to scan/test for a specific health issue. The use of social norms can reduce behaviour that is harmful such as smoking, but the problem here is that sometimes people engaging in 'undesirable' behaviour dismiss and reject the nudge.

Nudges can also *increase ease and convenience* (e.g., low-cost food options or healthy foods placed in a visible position in a supermarket). We often make or take the most convenient choice or automatic one, but nudges can encourage certain behaviour, and reduce barriers—real or based on perception (Chew et al., 2023; Shaffer, 2017). Resistance to change is often a product not of discord or of cynicism but of the perception of how difficult or ambiguous a change in behaviour is viewed. In addition *disclosure* is highly effective, at least if the information is both comprehensible and accessible. Simplicity is thus important. In some settings, disclosure is a check on private or public inattention, negligence, incompetence and corruption.

It is also possible to also *use graphic warnings* (i.e., for cigarettes). One virtue of warnings is that they can counteract natural human behaviour towards unrealistic optimism and at the same time increase the likelihood that people will pay attention to a health issue in the long term. There is a risk, however, that people will respond to warnings by disregarding them as irrelevant or scaremongering. Therefore, positive messages that 'offer' some kind of reward for preferred behaviour has the potential to make an impact. Research has shown (Sunstein, 2014) that we consider change if there is also a description of the positive steps we can take to reduce the relevant risk(s).

Precommitment strategies, i.e., we commit to a course of action such as a stop smoking programme also tend to act in accordance with our own aim(s). *Reminders,* e.g., doctors' appointments via text messages can have a significant impact, too. However, the time the reminder is sent is important here. *Eliciting implementation intentions* has also shown that

vaccination rates increase if we nudge the public to consider vaccination (Lorini et al., 2020). Finally, organizations can *inform us of the nature and consequences of past choices*. Private and public institutions have data and can contact us and highlight expenditures on health or ill health in the hope of a nudge that we alter behaviour (Ubel and Rosenthal, 2019).

Nudges can thus have an impact. Government institutions have the data and can reach a mass audience and *can* and *do* use campaigns to alter behaviour, i.e., stop smoking, infectious diseases, vaccinations, etc., but can also use nudges to highlight private and public corruption (see NHS in England and Wales campaigns and promotion of successes in punishing corruption). Focusing on a particular problem instead of abstract theoretical thoughts then has the potential to lead to a significant impact. However, sometimes numerous nudges are needed as the political and social climate for 'change' is unsuitable. The problem, though, is that nudges alone have a limited impact and are best used alongside another programme.

Nudging: Part of the Toolbox of Anti-corruption Initiatives

It is accepted that traditional anti-corruption approaches impact on corruption is limited at best and that it has underestimated the social embeddedness of systemic corruption (Rothstein, 2011). In addition it has often neglected the behavioural features of corruption on the individual level (Heywood, 2018). It is here, perhaps, that nudges can play a part in reducing corruption, though. Placed into a social norm(s) framework, nudges that work draw on the injunctive and descriptive elements of social norms to help change people's expectations and behaviour (Köbis et al., 2022). The injunctive element of a social norm refers to what is regarded or believed as (un)acceptable. The descriptive item of a social norm imparts information of what is common or recurrent. Some research (see Marquette & Peiffer, 2015, 2017) suggests that the descriptive element of social norms is a helpful predictor of corruption, whilst others (Bicchieri & Dimant, 2019) stress the need to consider the injunctive as well as the descriptive character of social norms to understand why

individuals might disapprove of corruption and at the same time embark on corrupt deals.

People engage in petty forms of corruption based on the perception (and sometimes fact) that others around them do so too, even though people might consider it unacceptable (Rothstein, 2000). However, in-the-field evidence is still limited (Köbis et al., 2022). Furthermore, corruption is theorized as a social trap; once corruption has become systemic, it tends to reinforce itself (Stephenson, 2020) and thus nudges will have a limited impact. One major reason for this is that in some jurisdictions—but all are affected to some extent—is that some institutions that fall under the broad umbrella of law enforcement sometimes engage in corruption (Persson et al., 2012). In the absence of reliable punishment, corruption is thus a collective action problem (Rothstein, 2000).

A social norm(s) framework can capture the social dilemmas between personal self-interest such as reaping benefits of corruption and long-term collective interests that is a reduction in corruption. Employing social norms as an analytical tool allows us to examine the occurrence of a particular corrupt practice and social and individual factors (Bicchieri, 2016; Cislaghi & Heise, 2018). This approach offers the chance to distinguish between injunctive (what is acceptable) and descriptive (the rate/incidence of corruption) of the collective action problem of corruption (Abbink et al., 2018; Schram et al., 2019).

The perceptions of social norms are, however, subject to distortion. People often overestimate actual levels of corruption, in part because of its secretive nature, which often inhibits the actual observation of corrupt practices. Narratives of corruption, particularly a 'everybody does it', narrative can exaggerate the level of corruption (descriptive norms) and thus sustain the social trap of corruption. Since traditional anti-corruption approaches have mostly failed to escape this trap (Mungiu-Pippidi, 2017), new hope has been placed in behavioural approaches in reducing corruption, most importantly social nudging.

Yet enduring behavioural change needs much more than social nudging. Other elements—the role of civil, voluntary collective actions and shared interests and information campaigns—promoting private and public awareness are important, too. Each has a part to play in

the reduction of corruption. However, since social norm nudges supply information with the aim of changing social expectations and thus individual behaviour, such nudges need careful consideration (Bicchieri & Dimant, 2019). For Bicchieri and Dimant (2019), the effectiveness of social nudging depends on the clarity of the intervention and one that builds on reliable sources of information and emphasizes positive behaviours that endorse public and private integrity.

Köbis et al. (2022) recognize that no single monolithic corruption norm exists within and across jurisdictions and cultures. As such anti-corruption efforts need to be tailored to the social normative pressures of a particular corrupt practice such as whether public officials accept bribes also depends on the normative pressures at work, via peers and superiors (Jackson & Köbis, 2018). Social norms thus emphasize the importance of identifying the relevant reference network (i.e., the people whom we care for and/or respect in a work and home environment) (Bicchieri, 2016).

However, relying on norm nudges to reduce deeply rooted corruption is limited. Nudges alone are unable to solve the problem of corruption. Behavioural approaches are a supplement, not a substitute to traditional anti-corruption approaches (Loewenstein & Chatter, 2017). Recognizing the importance of social norms in explaining corrupt practices is essential as the example of the ineffectiveness of public salary increases to reduce corruption in selected fields of research (see the systematic literature review in Soraperra et al., 2019) has indicated.

Based on contemporary research social norms consist of (1) community involvement; (2) information campaigns via other media channels and (3) social network analysis. First, community (depending on how this is defined and if it is one of inclusion or exclusion) can contribute to potential change. Second, social media reaches wide audiences and, depending on the message and medium—radio, television and posters, etc.—could complement an anti-corruption campaign (Starke et al., 2016). Third, to unleash the full potential of localized campaigns, such efforts could be combined with social network approaches (Tankard & Paluck, 2016).

In addition nudging is about more than the message. The messenger(s) of the social information can influence, or ruin, the effectiveness

of the intervention. Government campaigns, and depending on the messenger(s), might lack credibility and thus legitimacy with some members of the public. The campaign message is seen as 'acceptable' but the medium and/or the messengers blunt the message and campaign (Arad & Rubinstein, 2015).

Therefore, nudges are no panacea. As Köbis et al. (2022) highlight, some nudges are useful and necessary to broaden the toolbox of anti-corruption measures. We need to accept, as with all matters regarding corruption, that no one-size-fits-all anti-corruption approaches and, that unless careful nudges can backfire and ruin political and economic structural reforms to tackle corruption.

Limitations of Nudging in Reducing Corruption

Nudge theory presumes that intuitive biases are influenced by our environment. Based on the presumption that we make a decision(s) that are 'intuitive and automatic' (Thaler & Sunstein, 2008: 6) with small changes in the 'choice architecture' (i.e., the environment) nudges can prompt us (some of us) to make a decision(s) that is beneficial to us and also the healthcare sector.

However, passive resistance, from some, occurs and we resist nudges intended to prompt more 'enlightened' behaviour. Then there is excessive suggestibility, where nudges manoeuvre people into a position they would not rationally adopt (Entwistle, 2021). Finally, in certain circumstances, there is a reactance, e.g., people act in an opposite way to the intended nudge.

John and Stoker (2019: 214) therefore called for a re-examination of these 'cognitive foundations'. In place of the low level psychological responses nudges can prompt high level thought processes on adherence to norms; reflection, and developing aspirations, and work in a similar way to traditional interventions in appealing to low and high level thought processes (Lin et al., 2017).

In healthcare in particular there is, with some patients, a sense of fatalism, and nudges, no matter how simple and effective fail to nudge a

change in behaviour. There are types of fatalism of which three are relevant to healthcare nudges. (1) *Passive* where we see the world beyond our control, and as such fail to act in a rational and/or social self-interest. (2) *Protective* resistance is where we have a personal bespoke understanding of the threats and measures that we can practically adopt. (3) *Pathological* is where we react to the imposition of what we see as limitations and subvert the system and in extreme cases commit acts of self-destructive rebellion.

Alone or in some kind of combination all of these have profound implications for healthcare nudges and anti-corruption. Differences in 'worldviews, ideologies and values' could lead to marked differences in how we respond to a nudge (Brown, 2012: 308). There is the notion of utility; this is where we change behaviour once we have to pay for a service that was once free. Although it is difficult to isolate the economic effect of the nudge from the normative reminder, research has shown how we change behaviour when we remove or add charges in some contexts. Here, the economic incentive plays a significant part in the explanation of behaviour change (Jakovcevic et al., 2014). Then there are nudges that contain a threat, e.g., prosecution for non-compliance/payment of a breach of a rule/law. This, however, is not seen as a nudge. Here, however, it is contested if a threat is a nudge and subsequent compliance to conform is a nudge. Finally, we contribute to public engagement without the inducement of material incentives (Entwistle, 2021). Social influence is useful here where a nudge might help increase recycling, but whilst these established accounts of motivation help us understand some behaviours in reference to a 'nudge' these still lack the potential to address public passivity, suggestibility and reactance.

Why, then, do the public often fail to respond to a healthcare nudge and fail to follow a doctor's/physician's advice, prescriptions for a healthy lifestyle, screening for disease or indeed treatment itself? Fatalism, particularly for health (and corruption) is a concern as some accept that life is predetermined or simply beyond their control. Fatalists exhibit a high external locus of control and see choices/decision(s) as 'the result of luck, chance, fate, or under the control of powerful others, or as unpredictable' because of the complexity of other forces (Rotter, 1966: 1). Fatalism is relevant in explaining that some people discount authoritative advice

on health issues and either engage in corruption and/or accept it as inevitable. Insights drawn from a critical review of the fatalism literature explain that nudges sometimes fail (Entwistle, 2021) and prompt people to react to a nudge in surprising and dysfunctional ways which has implications for anti-corruption campaigns.

Fatalism and the Persistence of Corruption

Fatalistic 'views' are problematic for healthcare and anti-corruption healthcare campaigns. Conventional wisdom suggests that non-compliance with healthcare stems from a perception of the causes of health (or illness) as lying 'outside the control of the individual' (Davison et al. in Entwistle, 2021: 8). This passive fatalism is often associated with irrational fears or misconceive threats in the environment. The effectiveness of nudges intended to prompt rational changes of behaviour encounters a passivity that undermines information type nudges impact. However, as Sunstein (2017) explains, it takes some agency to reject a default nudge (i.e., put on a list unless prepared to delete personal details), since it is questionable if passive people will exercise that agency, and as such default nudges might prove effective in behaviour change.

However, fatalism reflects a highly rational adaptation of the circumstances of life. For some, part of life is beyond their own control. Recognising 'the objective lack of control' over some aspects of life suggests that fatalism is a pragmatic acknowledgement of limited power (Keeley et al., 2009: 745) and can act as a way to reduce stress and deal with life. Cancer fatalism is functional for some patients, to the extent that it is an accurate reflection of the threat of the disease, and prepares people for the failure and/or treatment or managing a way of living with the condition (Entwistle, 2021). By accepting some aspects of life are beyond our control, protective fatalism thus helps people deal with, or attempt to deal with, some painful, demanding, aspect of life. Protective measures to deal with life then, are informed. A lay understanding of the causes and likelihoods of events can have an accurate appraisal of real life even if views on the aetiology of disease are unreliable. Research

suggests protective fatalists will respond in a positive fashion to information if seen as relevant to *their* individual circumstances, but edicts for a healthy lifestyle, or default nudges might be questioned and/or rejected by those that have developed a situated account of *their* risks and take measures that make sense for them (Entwistle, 2021).

Fatalism, however, is not always protective. For example, youth delinquency, in part, is linked to violence, victimization and unsafe sex (Haynie et al., 2014). Adolescents who view the future as unpredictable might engage in the 'here and now' with attitudes towards risky behaviour, with symbolic assertion (self-sabotage) of a 'freedom' realised as the price of self-harm. Such situational 'attitudes',are relevant to engaging and/or preventing corruption. Mars (1982) described how employees in high status professions break rules based on a personal view of worth and importance; Hood (2000) highlighted how public sector managers, in some circumstances defend personal interests and accept bribes; whilst Akbar and Vujic (2014: 208) claim that fatalism causes and/or leads to systemic corruption. If a 'system' is corrupt some people accept corruption as a way of life and thus wilfully flout nudges which are seen as manipulative, and in some cases, act, on purpose, in the opposite way to the intended nudge.

There are three distinct explanations of fatalism that are apparent in the literature, then. Value explanations point to attitudes or cultures, structural explanations refer to socio-economic factors—age, education, etc.—which are associated with life experiences, and institutional explanations subject individuals to limited and/or complex circumstances (Entwistle, 2021).

These 'explanations' are considered in turn. Value explanations suggest that some hold a fatalist worldview. These views are within the individual or culture of a community. This is contested, particularly laying the locus of fatalism on the individual (Ugwu et al., 2015). Some research (Entwistle, 2021) has located fatalism in the culture of location, ethnic background, a religious community (Franklin et al., 2007) and/or personal experience. Fatalist sentiment is cultivated at a group or community level via tacit or personal knowledge. As such interactions with others 'has a strong positive effect' (Haynie et al., 2014: 189) on behaviour and individual judgements rooted in actual experience that

reinforces views through interaction with others with the same or similar views. In the case of those resistant to, and/or changes to a healthy lifestyle individuals point to 'ancestors' (Balshem, 1991: 162) that lived 'into a healthy old age, despite…heavy smoking and drinking' in contrast to 'some…joggers' who 'fall down dead' (Davison et al., 1992: 682–683).

The role that personality might play in fatalism, then, is contested, but structural factors that contribute to 'inequalities of "power, wealth, privilege and health" (Perfetti, 2018: 61) are visible i.e., location, type of work, income that leads individuals to think that life chances are limited and that powerful "corrupt" others and unseen influences control their lives. This is fatalism born of powerlessness' through which the effects of hardship are reflected, i.e., cancer fatalism with the elderly, and those with low levels of education 'accept' cancer is beyond their control. Whilst the control of cancer is beyond *all* of us to some extent, it is the fatalism that marks a difference between 'groupings' of people.

In addition to individual or community values and structural issues there is meso-level institutional context to consider. It is perhaps obvious that in 'authoritarian political systems' fatalism is hardly surprising. As Corcoran et al. (2011: 580) predict in places where power is 'concentrated in the hands of the few', individuals will be inclined to levels of fatalism and accept and/or engage in corruption. However, whilst not as extreme, institutions in democratic nations also have the power to foster fatalism, e.g., navigating a complex system of welfare payments to deter claims and access to legal benefits.

Fatalism is also seen in public sector employees; Matheson (2018: 652) discovered that 'apathy, cynicism, and hopelessness' is apparent in some of those in junior posts where promotion is limited which can lead to a demotivated workforce and, for some, a sense of powerlessness. In addition, in some sectors, e.g., law enforcement, welfare and healthcare might lead employees to view their work as 'pointless' and impossible and are overwhelmed with issues beyond their control. Decades ago Lipsky (1980: 82) described front-line public service—teachers, social workers, police officers—as inhabiting 'a corrupted world of service' wrought by a clash of impossible demands and finite resources. In the healthcare sector such views, pre- and post-pandemic now seem prophetic in a number of jurisdictions around the world.

Furthermore, nudges raise some ethical issues. For example, should doctors/physicians nudge to undermine a patient's choice. It is clear from the literature above that this is not seen as a nudge. Nudges are not seen as problematic if there is a benefit that reflects the patient's choice. If, however, nudges circumvent a patient's choice and reduce personal agency is this problematic regarding health outcomes? Is this, though, a matter of degrees? For example, the agency of a patient is diminished (not completely eradicated) due to a disease. It's possible someone else makes the 'choice' for the patient but such thought processes (see above) between two people, are different.

In this section of the chapter, individuals, groupings of people and/or community resistance to nudges have highlighted that passivity, suggestibility and reactance need consideration, particularly if a nudge is to have an impact. It appears then, to reach some audiences bespoke interventions are useful. Nudges that prompt a 'rational choice', i.e., that is one that will increase personal health is lost on those that see *their* world beyond their control and so corruption flourishes.

However, instead of attempting to design bespoke nudges, an alternative approach is to seek to combat the causes of fatalism itself. The problem here is that there are a range of suggestions on how to tackle this issue, reasoning and questioning to prevent the adoption of a strand of fatalism; counselling and 'appropriate' role models and coping skills, and cognitive behavioural therapy. The more interventions we engage in, however, and push and/or attempt to coax, and induce a change in behaviour, the less we can claim the intervention is a nudge. Finally, rather than see fatalism as a problem, fatalism rooted in an appraisal of limited circumstances is perhaps rational. Depending on structural and life chances, a nudge is seen or dismissed as irrelevant. Nudges, no matter how sophisticated are therefore limited.

Conclusion

This chapter has highlighted how nudges can have an impact on our behaviour. The approaches here also highlighted the progress made regarding our thought processes but also the limits of current knowledge. These approaches are a useful platform on which to build nudges that make an impact in the healthcare sector and reduce acts of corruption, but as noted in this chapter nudges need to work in concert with other approaches for maximum impact.

Our thoughts, though, recognizing the way we 'think' is dependent on what others around us *do and think* and, mental models of thought(s)—where we share common perspectives and ideas—such as stereotypes and prejudices—that make sense of our world (Camargo, 2017: 2). Furthermore, our 'sense of our world' and fatalism slow down, block and reject some healthcare nudges. Fatalism, in all its forms, is a problem that dilutes the impact of nudges. Fatalism, though makes sense to some, particularly if we take the structural position into account where 'inequalities of power, wealth, privilege and health' (Perfetti, 2018: 61) are visible, i.e., location, type of work, income lead individuals to think that life chances are limited and that powerful others and unseen influences control their lives. To some, then, fatalism is a rational appraisal of the position and circumstances of life. There is much research to conduct on all the issues in this chapter and I suggest that this is a rich avenue for us to explore, particularly in criminology, where nudges offer some potential avenues of success in dealing with the intractable problem of crime and corruption.

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12

Conclusion

Final Reflections

In the introduction to this book it was made clear that I was concerned with corruption in the healthcare sector. I have highlighted what, I think, we should consider as part of the healthcare sector. I excluded the pharmaceutical sector, as there are a number of dedicated texts on this (Baldi & Vannoni, 2017; Gagnon, 2022; Lexchin et al., 2018; Martinez et al., 2017; Peltier-Rivest, 2017; Rodwin, 2013; Shapovalov & Veits, 2022) elsewhere, and explained in the opening chapter, I sought to 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.

Each chapter considered a specific type of healthcare corruption and where possible I made connections to other chapters. As such, it is hoped that the issues, debates and examples I refer to here increase the interest, analysis and criticism of the range, depth and types of healthcare corruption. A special plea was raised that we—in criminology,—need to consider research on healthcare corruption beyond the current interest.

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However, whilst those in the healthcare sector commit acts of corruption, it is also a victim of corruption. It is a victim of corruption as those on the 'inside', e.g., doctors/physicians commit acts of corruption but is also vulnerable from those on the 'outside' individual patients and/or organized crime. Undermined from within and subject to manipulation and corruption elsewhere funds are diverted meant for healthcare; the healthcare sector is thus both offender and victim.

This is the heart of the matter; if the healthcare sector, particularly in democratic states is seen as corrupt its legitimacy is diminished (Bottoms & Tankebe, 2012). This to some extent has happened in some parts of the world and distrust in the healthcare sector is a problem that 'pushes' people into the black market of healthcare, where those in need of medication and/or surgery are preyed upon. In this sense, some people in the world are victimized twice; access to healthcare is legitimately blocked for a variety of different reasons, and then people are subject to manipulation and victimization out of desperation in a healthcare black market.

Personal, prejudicial views of what is acceptable practice in the healthcare sector will manifest into corrupt behaviour. Supported by a culture that socializes and rationalizes behaviour such corruption, if allowed to flourish, as it has in some states, is a systemic problem. If the level of corruption in democratic states is allowed to flourish beyond the level it has reached, we could reach a tipping point where the majority of a population, in some states, sees the healthcare sector as biased and/or incompetent and corrupt and thus ineffectual in preventing disease.

I have some sympathy here for those that work in the healthcare sector, as public expectation(s) of what individual members in the healthcare profession and/or institutions can do is limited. Many individuals—doctors/nurses—are often having to address public expectations in a hostile public environment and subject to racism, and verbal and physical abuse from patients they are trying to help. Such behaviour is, as far as I am concerned unacceptable and often criminal.

Preventing Corruption in the Healthcare Sector

I highlighted that defensive practice is a form of professional 'collusion' in the public and private sectors and thus prevents investigation into poor practice, negligence and corruption alone or in concert with one another. As a victim of healthcare corruption, as with all corruption, we are sometimes unaware that we are a victim. As victims of healthcare corruption, though, we are subject to an individual act or multiple acts of corruption. For example, denied access to a healthcare service we are entitled to unless 'extra payment' is made; denied access to emergency healthcare, e.g., aid because of individual, organizational and state corruption or a victim of invasive unwanted surgery. The latter example, though, is, far more than corruption. It is abuse of power and physical abuse; it could be considered tantamount to rape, as whilst patient consent for an operation was obtained, it might have been secured via deception.

To advance any anti-corruption strategy and in this case, analysis of avenues of potential corruption, some understanding of the size of the problem is needed. As illustrated it is difficult to define, measure and therefore assess the extent of corruption in the healthcare sector. The issues raised here are ongoing; they are, however, in need of systematic analysis if we are to prevent corruption to some extent. There are numerous books and articles explaining and highlighting the key elements of an anti-corruption strategy and the need to prevent and reduce corruption, and these where useful were referred to in this book. The strategic list of key elements in this literature is not exhaustive. It is, however, underpinned by a growing body of work. The problem, however, is that anti-corruption strategies have so far been unsuccessful (Brooks, 2016; Heywood, 2015; Hough, 2015) and are at best patchy and sporadic, depending on the political will of an incumbent administration and organization, and whether it is expedient to endorse or block and obfuscate a change in working practice in parts of the healthcare sector.

The healthcare sector is, at times, and in different sectors and in different jurisdictions criminogenic, where organizational culture can enable 'workplace crime and corruption'. Corruption is enabled unless

we send clear messages about what is acceptable and unacceptable conduct and depends on factors such as the attitudes of colleagues and internal practices, but also the limited sanctions for acts of corruption.

Furthermore, it is questionable, though, if the healthcare sector is able to fulfil the objectives it is expected to achieve, particularly around the world, but also in those jurisdictions with an ageing population. Many of the acts of corruption mentioned in this book have a structural problem; that is they are part of a worldwide problem and system that contributes to corruption. It is these structural issues rather than condemnation of a few individuals and wayward organizations that need attention.

This, though, is difficult to achieve. Preventing corruption is the responsibility of all; the anti-corruption units of some healthcare bodies make an admirable attempt at preventing corruption, but as with the public and private sectors it is often key individuals, in a suitable political climate, which effect change. This is not an indictment of anti-corruption/integrity units but an understanding of the limits of how they can influence practice, as vested powerful interests will oppose change that might encroach on their power and status. All organizations, which attempt to prevent corruption, or are in the process of developing a strategy, are to be commended. The development of an anti-corruption unit and ethics committee is of limited value, however, if employees have no clear direction as to what corruption is, or new avenues of corruption we might encounter. Guidelines regarding risks, ethical behaviour, codes of conduct, response plan(s) and an anti-corruption strategy alone are insufficient. If they fail to educate and hold those to account who break or circumvent codes of conduct little in this sector will change. A strategy needs direction, leadership and codes of conduct, which need to be enforced if it has any chance of success, and organizations and political and legal representatives need to be held to account if we are to achieve universal health.

The healthcare sector is more a business with its product than of 'care'. The measure of its success is often how it deals with the prevention and cure of illness. Due to the need and importance of health in life, I suggest, it is naive to think that corruption *in* and *of* the healthcare sector is a blot on the landscape; it is, in some states systemic corruption. Corruption is a flexible beast and attempts to prevent and/or reduce it

must also be the same. This is not to dismiss what we have attempted so far, but to reflect on what is of use and how it can be combined with successful anti-corruption approaches. All approaches—practical and theoretical—must be realistic in that change in practice and/or use of sanction(s) have some impact *in* and *on* preventing the corruption of healthcare now and in the future. Finally, as illustrated in this book, unless sanctions have some power to deter, the current approach to corrupt individuals, units and organizations, will simply reassure them that the consequences for such acts are often, but not always, minimal, with regulatory bodies and sanctions often ineffective. Further research needs to be conducted on sanctions and deterrence in cases of corruption on those that work in the healthcare sector, and seek to understand what can prevent such egregious corruption.

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