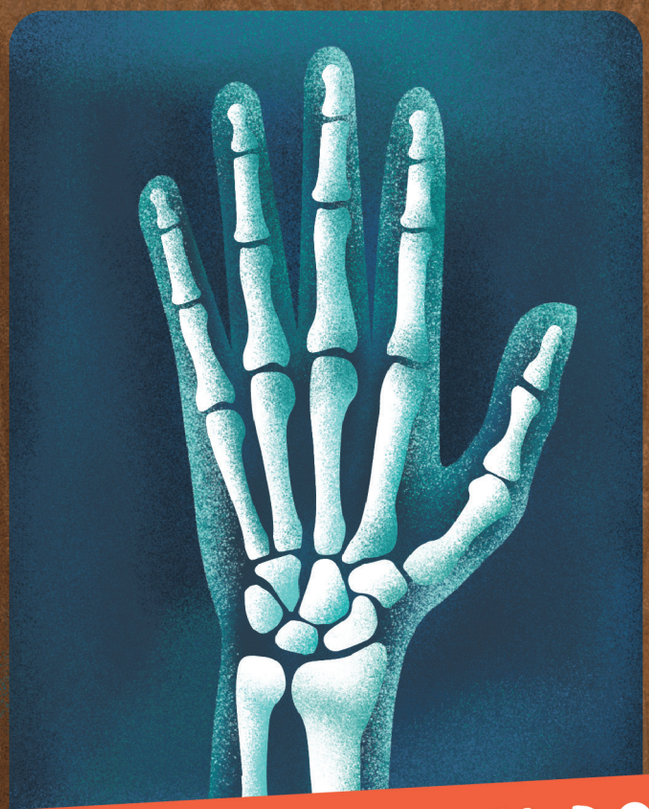
TRANSPARENCY MALDIVES
A Coalition for Integrity



WHAT CORRUPTION DOES

TO THE MALDIVIAN HEALTH SECTOR

AND WHAT WE CAN DO ABOUT IT!

Transparency Maldives, National Chapter of Transparency International (TI), is a non-partisan organization that promotes collaboration, awareness and other initiatives to improve governance and eliminate corruption from the daily lives of people. Transparency views corruption as a systematic issue and advocates for institutional change that will punish and prevent corruption.

The information presented in this publication is accurate at the time of its research period.

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ACRONYMS

ACC
Anti-Corruption Commission

ACL
Aasandha Company Ltd.

ADL
Approved Drug List

AuGO
Auditor General's Office

CMDA
Capital Markets Development Authority

CMSD
Central Medical Supplies Division

CSO
Civil Society Organization

EML
Essential Medicine List

GCB
Global Corruption Barometer

GDP
Gross Domestic Product

HA
Husnuvaa Aasandha

HIES
Household Income Expenditure Survey

HPA
Health Protection Agency

KI
Key Informant

KII
Key Informant Interview

MAHC
Maldives Allied Health Council

MFDA
Maldives Food and Drug Authority

MGFSS
Ministry of Gender, Family and Social Service

MMDC
Maldives Medical and Dental Council

MNMC
Maldives Nursing and Midwifery Council

MoED
Ministry of Economic Development

MoF
Ministry of Finance

MoH
Ministry of Health

MoU
Memorandum Of Understanding

MVR
Maldivian Rufiyaa

NDA
National Drug Agency

NSPA
National Social Protection Agency

NTB
National Tender Board

OECD
Organization for Economic Co-operation and Development

OOPs
Out Of Pocket Spending

PA
Political Appointment

PCB
Privatization and Corporatization Board

PO
President's Office

SIDS
Small Island Developing State

SOE
State-Owned Enterprise

STO
State Trading Organization plc.

USD
United States Dollar

WHO
World Health Organization

INTRODUCTION

The Maldives 2008 Constitution says that it is the state's responsibility to provide all citizens with "good standards of healthcare, both physical and mental, with special considerations for children, youth, elderly and disadvantaged populations". A major cornerstone of a healthy population is a health system that provides citizens with a full range of equitable, accessible, affordable and high-quality essential services that include health promotion, prevention, treatment, rehabilitation, and palliative care. These are also the critical components of what is called Universal Health Coverage or "UHC", which is one of the major objectives of the global Sustainable Development Goals.

Citizens rely on their health system to provide the health services that they need, when and where they need them, and without having to pay excessive amounts of their own money. Since the new Constitution of 2008, the government's investments in health have gone up. The Maldives stands out for contributing much more of the country's annual gross domestic product or "GDP" to support the health sector, spending 14.5 times more per person compared to all other South Asian countries.[1] There have also been many fundamental changes made to the structure and operations of the healthcare system. For example, in 2014 the social health insurance scheme, Husnuvaa Aasandha (HA), was introduced. This scheme is meant to ensure that all Maldivian citizens can access the public health system for a wide range of services and health products at no cost, including for treatment overseas that is not available at home.

From the outside it looks like the Maldives offers its citizens UHC, and this seems to be partly the case for some people living in the capital. But when we asked Maldivians, especially those who live in the atolls, they told a different story. One where they have had to fly abroad to get medicines that should be available in the country, or one where they had to spend three weeks in Malé waiting for their doctor's appointment.

There are many reasons why health systems don't fulfill their promises. Corruption is one of them. Like a cancer, corruption mutates and spreads throughout the system causing damage to important parts along the way. Corruption leads to under-funded or under-resourced hospitals and clinics, discontented, unqualified or absent healthcare workers, and

it destroys the public's trust in both the system and the government. But most importantly, corruption can cost people their lives.

There is a general perception among Maldivians that the health sector is corrupt, and nearly a third consider it to be "extremely corrupt".[2] The Anti-Corruption Commission (ACC), the government body responsible for preventing and prohibiting corruption in the public sector, receives more cases related to the Ministry of Health (MoH) than any other government institution.

This report is based on an in-depth study into the corruption vulnerabilities in the Maldives' health sector. It was carried out by a team of independent, international anti-corruption and health experts between August-December 2021. The study consisted of a review of publicly-available documents and interviews with 80 Maldivian key informants.

This report starts by looking at some of the overarching systemic issues and inefficiencies that increase the overall vulnerability to corruption. It then identifies ten major areas of the health sector that are particularly vulnerable to corruption and illustrates how the lives of everyday Maldivians are impacted by these problems using fictional stories based on actual events. For each vulnerable area, ways to address it and protect the Maldivian health system against corruption are recommended.

REMEMBER!

Corruption may be the reason a health system isn't performing well, but not always. Poor performance may also be due to mismanagement, bad system design or a lack of resources.

This report uses the definition of corruption established by Transparency International, "the abuse of entrusted power for private gain". It is important to remember that corruption involves intent.

(1) World Bank (2018), Current health expenditure per capita (current US$) – Maldives, South Asia. https://data.worldbank.org/indicator/SH.XPD.CHEX.PC.CD?locations=MV-8S

(2) Transparency International (2013), Global Corruption Barometer 2013 – GCB2013 Data [xls]. https://www.transparency.org/en/gcb/global/global-corruption-barometer-2013/press-and-downloads

SEEING THE FOREST THROUGH THE TREES:

The systemic challenges

GEOGRAPHY

Like many other small island states, the Maldives' geography makes it challenging to provide consistent, standardized public services. The country is made up of 26 natural atolls with 187 inhabited islands dispersed across a 871 km-long archipelago. All goods needed for the health system have to be imported and there is no reliable logistics system to get health commodities from the capital to the atolls. There are few jobs and limited opportunities, especially for the public sector and especially in the atolls. This has led to a concentration of political power, economic activity, and public spending in Malé, and has left those living in the atolls behind.

POPULATION

The saying in the Maldives goes, "everyone knows everyone". Because of the small population and historical kinship relations, there is an imbalance of political, economic and social power among the country's elites. This exclusive group is at the steering wheel of society, taking up positions in the government, state-owned enterprises (SOEs) and owning or operating private companies. The elite controls a significant proportion of the income generated through tourism, which constitutes a majority of the country's GDP. The power of the elites network makes it nearly impossible to disentangle and manage conflicts of interest, nepotism and collusion in this group. Political and policy decisions that affect the wider population are thus at a high risk of undue influence and corruption.

PUBLIC SECTOR HUMAN RESOURCES

It is difficult for the public sector generally, and health sector specifically, to attract and hold on to qualified staff. There is a high rate of vacant positions and turnover in public institutions due in part to the low wages of civil servants compared to what people can earn in the private sector.

This is a big problem in hospitals and clinics. Healthcare workers, particularly specialists, can earn a lot more in the private sector than in the public sector. This leads to healthcare professionals leaving public hospitals and clinics for private ones, or working in both public and private facilities, but prioritizing their private sector work – a situation called "moonlighting". The country generally also suffers from brain drain.

At administrative levels, frequent turnover can lead to gaps in institutional knowledge and make it hard to ensure procedures are properly applied. Young graduates might start their careers in a government ministry, but change to a SOE or private company after only a few months. Employees who switch from the public to the private sector are not required to have a break between their contracts, a so-called "cooling-off period". This means trade secrets and networks are still "hot", creating conflicts of interest and opportunities to abuse procedures to the benefit of private companies.

FREQUENT REFORMS AND POLICY CHANGES

The jobs of civil servants are not easy. The Maldives Government, the public sector generally, and the health sector specifically, are in a state of constant and rapid change. Also, there have been a number of major political disruptions in the past ten years. Since 2008, there have been so many reforms to public administration, policy and legislation that civil servants responsible for correctly implementing them are often struggling to keep up. This contributes to turnover and leads people to cut corners or find work arounds, opening up opportunities for abuse.

LACK OF TRANSPARENCY

Making matters worse, it is often not clear who is responsible for what. It is difficult to find information on the roles and responsibilities of public institutions, hospital management and governing boards, recruitment and appointment procedures, mechanisms for accountability or government policies and legislation. Even experts struggle to understand the governance structures of the health sector, how it is regulated, who is responsible for what, and what should happen when something goes wrong.

There is also very little transparency of health system data, including financial information. Annual and financial reports are not published timely, if at all. This threatens and disables any attempt at monitoring activities, including by civil society, for system performance in general, and for corruption in particular.

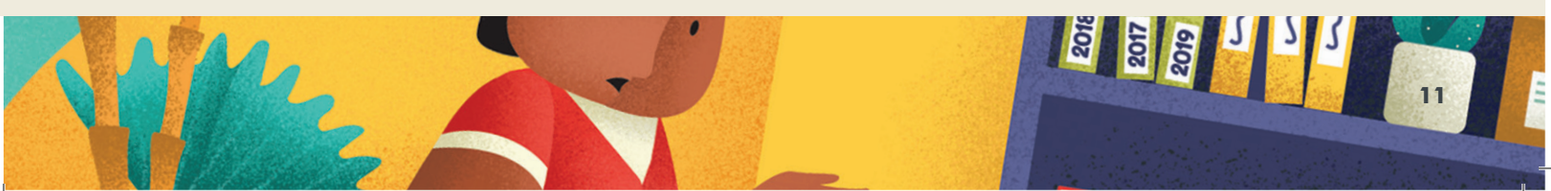
BROKEN ACCOUNTABILITY

Mechanisms to hold leaders and decision-makers accountable for their actions are weak. Institutional or "top-down" accountability and oversight is largely ineffective. For instance, the Ministry of Finance's (MoF) Privatization and Corporatization Board, which is in charge of overseeing SOEs, has no way to sanction a failure to comply with rules and regulations. Other institutions, like the Auditor General's Office (AuGO) or the ACC, grapple with overwhelming workloads, lack of public recognition, or political challenges.

As a result, misconduct or non-compliance are often not identified and even less often sanctioned. Only in 2021 was internal audit introduced to critical health sector institutions like the MoH and the Indira Gandhi Memorial Hospital (IGMH). External audits, if they are performed, are often delayed.

There isn't a strong system of "bottom up" accountability through civic engagement and investigative journalism. Civil society capacity, is limited, and the space for civil society organizations (CSOs) to carry out their activities is shrinking. The lack of transparency of government and SOEs, including their engagement with the private sector, reduces the effectiveness of accountability measures and rarely are the consequences for wrong-doing adequate if applied at all.

Weak accountability opens up opportunities for corruption and abuse, because perpetrators know they're unlikely to get caught, or if they do there will be little to no consequence.

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THE TOP 10 CORRUPTION VULNERABILITIES

1

You can't control what you can't see

Lack of government transparency

HALEEMA'S STORY

(this is a fictional story based on real events)

Haleema has just started a new job at the MoF. She is part of the team responsible for reviewing the health procurement bids submitted for things like medicines or diagnostic materials.

She's asked her colleagues if there is a procurement plan for the MoH for the year so she can see if the tenders and bids that have been submitted actually meet the sector's needs. She also wants to keep an eye on the budget to make sure that money isn't unnecessarily spent and that they get the best deals.

Haleema's colleagues tell her that the MoH is supposed to submit an annual plan for procurement as a guidance, but they never do.

Haleema isn't sure how she should do her job well without this information and make sure that the government money is properly spent.

PROBLEM

Opaque systems and procedures are difficult if not impossible to assess. It's hard to know if they are working well, what needs to be improved upon and who is responsible for what – all of which make them vulnerable to corruption.

While transparency is not a sure-fire way to prevent corruption, it is a necessary component of good governance. Never forget! A government and public service work for the people and as such they have a responsibility to act visibly, predictably and understandably by promoting participation and accountability.

In the Maldives, there is very little publicly-available official documentation that defines the mandates, roles and responsibilities, policies, procedures, reporting lines, or action plans of the major institutions of the health sector, such as the MoH and the National Social Protection Agency (NSPA), as well as the institutions relevant for the health system operations, such as the MoF, State Trading Organization (STO) or Aasandha Company Ltd. (ACL). Where there is available documentation, this is often buried and spread across the institutions' various websites. This makes it very difficult to understand what these institutions are meant to do and how they should work together. Even experts interviewed for our study struggled to describe key regulations, the roles and responsibilities of institutions, and standard procedures for basic health sector activities, like procuring medical commodities.

Similarly, there is very little proactive transparency, for example, asset declarations. While the President, Cabinet Ministers, members of the People's Majlis, and judges are all required to declare their assets. These disclosures are often incomplete, deliberately incorrect and not updated regularly. A lack of asset transparency increases the chances that conflicts of interest will arise. This is particularly problematic in the health sector, both because of the sheer number of people involved in making decisions, and the necessary dependence on SOEs and private sector companies to provide goods and services.

Without a clear understanding of and information on who is responsible, what they should be doing and how they should do it, it becomes near impossible to hold anyone accountable and apply consequences when things go wrong. There are also frequent changes to institutional mandates, regulations, and to the institutions themselves. Together, this makes corrupt behavior more attractive, especially in a situation where it is easy to get away with breaking the ever-changing rules.

RECOMMENDATIONS

ARCHIVE GOVERNANCE DOCUMENTS

While there is an online repository[3] archiving some of the legal and policy documents, this is not well maintained. Therefore, a simple action would be to ensure that this repository is updated to include all legal documents, frameworks, guidelines, mandates, regulations, roles and responsibilities of all relevant officials, policies, procedures, reports, action plans and so on. These documents should be available in both Dhivehi and English considering the Maldives reliance on international trade and migrant workers. The archive should be categorized by government institution and updated at least semi-annually.

ASSET DECLARATION[4]

The failure of key members of government to disclose or correctly disclose their assets should be urgently addressed. The requirement to disclose should be expanded to include sector-level staff, such as the MoH staff, including secretaries of state, as well as CEOs of relevant SOEs, and procurement officials. Assets decleration should be made publicly available on the respective ministry or company website in order for CSOs to monitor disclosures. Asset declarations should be updated at least semi-annually.

TIP!

Did you know about the Right to Information Act? This mechanism promotes fair, transparent and open government. It gives YOU the right to request access to government records to any person for any reason. Check out Transparency Maldives' online guide on how you can submit an RTI request.[5]

(3) The online repository can be found here: https://www.mvlaw.gov.mv/
(4) At the time of this study, an Asset Declaration Bill had been drafted by Transparency Maldives that was under consideration by the People's Majlis.
(5) The online RTI request guide can be found on the Transparency Maldives website, here: https://transparency.mv/v16/alac/rti/

2

Give it a rest!

The chaos of constant change

HASSAN'S STORY

(this is a fictional story based on real events)

Hassan works for the STO and is part of the team responsible for procuring medicines and medical supplies. He has been there for a few years and has seen a number of changes enforced on his department.

Next month, a new regulation will be put into place that STO has to procure generic products where they are available. This is meant to increase the cost-efficiency of the health system while still ensuring good quality.

Each time there are new regulations, Hassan can only shake his head. If there are standard operating procedures for medical procurement at STO he's never seen them. As far as he knows every procurement officer does things a little differently and there is no consistent or comprehensive paper trail to monitor decision making.

Hassan worries that, like for other reforms, there will be no way to know if STO is actually following the new rules for procuring generic products and that this reform will be as ineffective as all the ones that came before it.

PROBLEM

Too much change, especially when done in haste, can be as destructive as too little. Rapid and frequent changes in the system (especially when combined with a lack of transparency) create instability and confusion, and open up opportunities for negligence, abuse and corruption.

The rules and regulations in the Maldivian health sector are constantly being changed, and leadership is swapped out at a blinding speed. There have been five different health ministers in the last five years! This contributes to confusion and the added bureaucracy leads people to cut corners. Civil servants working in the health sector are just trying to keep up with the rate of change.

At the time of writing this report there were at least eight major proposed or ongoing reform processes affecting the health sector. These include an overhaul of the social health insurance scheme to a National Health Service; instituting maximum retail prices for pharmaceuticals and prioritization of generic purchasing; a further amendment to the Public Finance Regulation – the fifth one in four years; and a complete change to regional public administration from a centralized system to a decentralized one. Many of these reforms are very welcome in principle, but the rate and frequency of change makes it challenging to monitor them, determine if they are correctly implemented and if they are having the intended effect.

Here the lack of transparency is also a big concern as there is little publicly-available information about the basis for decisions around reforms. This calls into question how good they will be at addressing core problems in the health system. For example, the proposed decentralization reform is meant to empower local level institutions (councils), but the country is already struggling to manage public services centrally. Accordingly, regional hospitals should be upgraded to expand services in the atolls and hopefully patients will not have to travel to Malé so often for advanced care. Hospitals will have greater autonomy for their own operational planning, which could increase their efficiency. But in contexts with low technical and human capacity, education, and civic engagement, decentralizing decision-making power and budget can increase vulnerabilities of capture by local elites.

Most concerning is that the reforms that have been undertaken in the past have not reflected recommendations from both national institutions or international organizations, and they have done little so far to actually achieve improvements. Time after time, entities like the ACC, the People's Majlis, and the Auditor General have repeatedly made the same recommendations for health sector improvements. For example, in 2012, an audit report from the AuGO noted concerns that STO procurement is not achieving value for money[6] – this is still a problem ten years later.

Finally, the speed and frequency of reforms leads to fatigue on the side of oversight agency staff, reflected in high levels of turnover in these institutions, as well as an attitude of cutting corners. They also contribute to disinterest or complacency in the general public – government reforms become lip service and people don't expect things will change for the better.

RECOMMENDATIONS

UNDERSTAND THE CHALLENGES

With the support of civil society and the academic community, a sector-wide survey of civil servants regarding the challenges they face in doing their jobs because of rapid reforms and changing regulations should be carried out. This survey should focus on understanding what "corners are being cut" to work around challenging bureaucracy, misaligned incentive structures and sources of staff grievances. The intent would be to propose fit-for-purpose remedial measures that can be applied in a participatory way and will aid in reducing risks for systemic inefficiencies and corrupt behavior.

BE CLEAR ABOUT OBJECTIVES AND OUTCOMES

For those reforms that are applied, transparent timelines, milestones and expected results that follow the implementation of each proposed reform, as well as implementation reports should be made publicly available so that citizens, other institutions and CSOs can track and monitor progress.

(6) The full audit can be found here in Dhivehi language: https://www.audit.gov.mv/Uploads/BulkUpload/Procurement-of-Medical-Supplies-Special-Audit-Report.pdf

3 You scratch my back, I'll scratch yours

The dangers of conflicts of interest

FATHIMATH AND JAMEELA'S STORY

(THIS IS A FICTIONAL STORY BASED ON REAL EVENTS)

In response to the COVID-19 pandemic, Fathimath and her sister, Jameela, decide to start a business in Kulhudhuffushi making FFP2 masks.

They register their business, organize suppliers for the raw materials, receive successful approval for the prototypes against international standards and start production.

When the time comes to sell their masks to pharmacies and other shops, they are only able to secure a few small, independent buyers. They try to also secure open government contracts and even lower their prices to be more competitive than the current supplier, but they can't seem to get any buyers of their masks.

Jameela later finds out that the major supplier company in the Maldives is owned by the brother-in-law of a procurement official at the STO.

PROBLEM

Conflicts of interest can incentivize staff not to perform their duties in the public interest or lead them to exercise undue influence on important government processes, like procurement, recruitment and policy development. Left unaddressed, conflicts of interest can contribute to what is called state capture, where governing systems are designed in ways that allow for corruption to take place, or lead to a lack of political will by those benefiting from the status quo.

A conflict of interest is not corruption per se, but it implies a likelihood that corruption can occur.

A conflict of interest is a situation where a person or the place where they work has to choose between the duties, rules and interests of their position and their own private interests.[7]

In a country like the Maldives, managing conflicts of interest can be a serious challenge for a number of reasons, including complex kinship or political ties, limited job opportunities and economic competition, as well as the missing protective rigor in government procedures. Existing efforts to manage conflicts of interest in the Maldives are thus very limited. For civil servants, there is a Code of Conduct from the Civil Service Commission (CSC),[8] but this does not include a conflict of interest management policy. Experts interviewed couldn't give decisive information about whether or not conflicts of interest management policies exist for any government institution and there was no publicly-available documentation. In any case, declarations of conflicts of interests by civil servants, politicians and those working for SOEs are either not required, not comprehensive, not transparent or have little consequence.

Because of the small size of the Maldives' population, and the social fabric of the political elite and resulting inequality, conflicts of interest in public decision making are basically part and parcel of the Maldivian society. There are open secrets of civil servants and politicians owning or having shares in healthcare companies that receive government contracts and it is common for them to have friends or family members whose job or financial engagements are facilitated through conflicts of interest.

RECOMMENDATIONS

CONFLICTS OF INTEREST MANAGEMENT POLICIES

Addressing conflicts of interest starts by having comprehensive conflict of interest management policies based on compliance good practice and that include proportional sanctions for failure to comply in all government institutions. A mandatory and uniformly applied conflict of interest management policy should be introduced by the CSC that includes all public healthcare staff. Additionally, conflicts of interest policies should also be required of SOEs where staff are not governed by the CSC, like STO.

ESTABLISH A BENEFICIAL OWNERSHIP REGISTER

Currently, the Maldives does not have a beneficial ownership register – a transparent list of who owns or is connected to private companies. When appropriately updated and monitored, this could help prevent collusion with private companies and ensure that government contracts are going to the best bidder. As a complement to mandatory asset declarations proposed such a register should be introduced in the Maldives and political decision makers, senior management and procurement officials should be required to make transparent their private interests to prevent conflicts. As a first step in developing a beneficial ownership register for the whole of government, it could initially be implemented for those working in the area of health procurement and then expanded.

AD HOC OVERSIGHT FOR CRITICAL DECISIONS

Relevant national institutions, such as the ACC, and CSOs can fulfill a supportive oversight role by monitoring or retrospectively auditing the outcomes of public health sector decision making, such as for large procurements, infrastructure projects, key appointments or empaneling overseas hospitals, to monitor whether procedures are being correctly applied and conflicts of interest properly managed.

(7) https://www.transparency.org/en/corruptionary/conflict-of-interests
(8) https://www.csc.gov.mv/En/Regulation2014

4 A doctor's visit a day

Abusing health service provision

SANA'S STORY

(THIS IS A FICTIONAL STORY BASED ON REAL EVENTS)

Sana has been experiencing shortness of breath a lot lately and the doctor on her island, Nilandhoo, suggested she go see a lung specialist. She and her husband, Aslam, have been two weeks already in Malé waiting for an appointment.

Their insurance doesn't cover the extra costs while they wait and they are having to dip into their savings.

Each day they go to the hospital hoping that she will be seen. Patients go in and out of the specialist's office all day, but they don't seem to be very ill like Sana.

Aslam catches up to one of the patients as they are leaving and asks him how long he had waited for his appointment. He told Aslam that the doctor is a friend of his brother and he just called today to come get a quick refill of his prescriptions. It was easier than going to his local clinic.

PROBLEM

Everyone has the right to live a healthy life. This means having access to quality health services. But if healthcare workers and patients abuse and overuse the system there is less to go around, and those who really need care may be unable to receive it.

In 2014, the social health insurance scheme that would evolve into Husnuvaa Aasandha was created. This scheme is fully funded by the government and citizens have no monthly contribution requirement in order to receive healthcare. The Husnuvaa Aasandha scheme does not have a limit for services or medical commodities that patients can access. It is totally cashless and patients are not faced with additional out-of-pocket payments for services or commodities covered by the scheme.

This leads to three problematic dynamics. First, it creates perverse incentives for health facilities and hospitals to overmedicalize patients by ordering more diagnostics, prescribing more medicines, and demanding that they return for unnecessary consultations. Second, it encourages what's called "upcoding", a process where healthcare workers will record patients as having a worse condition or needing more expensive treatments than they actually get in order to increase the payment amount that the health facility or hospital receives. Third, it influences health-seeking behaviors of patients by incentivizing them to seek out health services for any and all complaints or to engage in "doctor hopping", whereby patients go to a number of different doctors for the same problem.

The health system also does not have a referral procedure, where patients must first report to a general practitioner before being directed to a specialist if needed. This means that patients can consult specialists directly without referral, leading to excessive waiting lines for patients, like Sana, that truly require a specialist.

Because neither patients nor providers are incentivized to rationalize services or commodities, or to be vigilant and report bad practices, the result is an abuse of the system and waste of limited health sector resources.

As the administrator of the social health insurance scheme, Aasandha company is the body primarily tasked to prevent or detect any abuse of the scheme. Currently there is a fraud detection department at Aasandha company that manually reviews suspicious cases, but there is no automated system that alerts red flags, so it is unlikely that Aasandha company is catching all cases of upcoding or overmedicalization. When healthcare workers are found to be upcoding they are suspended.

RECOMMENDATIONS

AUTOMATED FRAUD DETECTION FOR HUSNUVAA AASANDHA

A digital fraud detection system using algorithms that detect abuse, like upcoding, should be adopted by Aasandha company. Consideration should be made to establish proportional sanctions for repeat or serious offenders, for example by extending the duration of suspension, or issue proportional fines to be deducted from their salaries. The list of healthcare workers with repeated or serious misconduct should be made public.

Likewise, this detection system should include algorithms to detect doctor hopping by patients that is met with proportional consequences.

CAPITATION AND REFERRALS

As part of the upcoming reforms to evolve Husnuvaa Aasandha into a National Health Service a tailored capitation for the existing reimbursement system should be considered. Applying capitation means there is no limit to the health services that a patient can receive but there is a cap on the amount of reimbursement that a health facility or hospital can receive for services. So, for example, a dental clinic could only perform limited procedures procedures after which Husnuvaa Aasandha will no longer reimburse them. This would lead to facilities and healthcare workers being more mindful about making sure that only those patients that need procedures, diagnostics or treatments receive them. This should also be joined with a referral system that requires patients who make an appointment with a specialist to first have a prescription from a general practitioner or community health worker.

CIVIC INFORMATION CAMPAIGNS

CSOs can also help reduce the overuse of health services by developing campaigns directed at citizens to inform them about the problems associated with overmedicalization and their role in rationing health service use.

TIP!

Patients can also help with monitoring rational service use. Through the Aasandha mobile phone app, you can check your health records and prescriptions, and report any inconsistencies or suspicions of upcoding.

5

Procurement

The health system's honey pot

MOHAMED'S STORY

(this is a fictional story based on real events)

Mohamed is a fisherman, as was his father before him, and he has worked his whole life on the dhoni they built together.

Over the years Mohamed has developed serious back pain from the hard physical labor. Thankfully he has worked with his doctor to find a pain medicine that doesn't make him drowsy and is covered by Husnuvaa Aasandha. He's been able to continue working because of this and keep his family fed.

On his next trip to the pharmacy, the pharmacist explains that the drug that Mohamed has been using is no longer available – he doesn't know when it will be available again. Mohamed will have to take something else and he is devastated.

Worried that the new medicine will impact his ability to work, he asks an acquaintance who will be traveling to India in two weeks to buy the pain medicine for him. He has to pay for it himself and this means he will have to work more to cover the cost.

PROBLEM

Procurement is generally considered to be an area of a public sector that is inherently vulnerable to corruption. When there isn't sufficient oversight and transparency, funds can be poorly spent on overpriced or poor-quality products and contracts can be given to suppliers who have conflicts of interest with procurement officials or politicians.

The Maldives relies heavily on the imports for the public health sector to operate. Procuring medical goods is the largest part of the country's health sector spending. The costs of pharmaceuticals alone are about one third of the total public health budget.

Most procurement in the Maldives is carried out by STO. For most of the health sector, the arrangement for STO to procure health products is laid out in an agreement between STO, the MoH, and the MoF.[9] Under this agreement, the MoH informs STO what is required in intervals of three to six months. For the major tertiary hospital, IGMH, there is a separate agreement between the hospital group and STO, and procurement bypasses the MoH. In both cases, the payment for procured goods is made by the MoF.

Before anything can be procured, you have to know how much of what you need. There appear to be a number of fragmented systems for forecasting what products are needed and how much, but none of these are based on actual demand. For example, the STO uses historical purchasing data, but this data is not proactively shared with the MoH or connected to any centralized stock management system. This makes it impossible to compare what was bought with what was used or was needed but out of stock. As a result, it is hard to plan procurements, order the right amount of stock, and ensure that products are where they are needed at the right time in the right amount. Some health facilities anticipate that they won't receive the stock they order and try to compensate by requesting more than they need, hoping that they will end up with the required amount.

It takes a long time to carry out the standard procurement processes and it can also be a challenge to procure specific products, like Mohamed's pain medication. Combine this with poor forecasting and planning, procurements are often carried out at the last minute. This has led to an overreliance on single-source procurement meant for use in emergencies. In this case a supplier is appointed, rather than using a transparent, competitive procedure where tenders are advertised online, suppliers are compared and the best one with regards to quality and price is chosen. And because STO is entrusted to carry out procurement through the joint agreement with the MoH and MoF, the MoH doesn't have a record of whether the procedures used were warranted or correctly followed. MoH has to trust that STO is selecting the best and most cost-effective supplier. This severe lack of transparency makes procurement in the Maldives particularly vulnerable to corruption.

One rationale for single-source procurement is that often there is a preferred branded product already decided. Typically, branded products are more expensive than generic products although generics are just as effective. The majority of products approved for use in the Maldives, and thus procured, are branded. Even commonly used products such as paracetamol, antibiotics and vitamins. This drives up the overall costs of medical commodities and reduces the overall cost-efficiency of the health system.

As mentioned above, conflicts of interest are also a big problem in procurement. As part of the agreement between STO, the MoH and the MoF, STO procures either directly or through third-party suppliers for more than 90% of all needed products. Interviewees for our study said that some third-party suppliers and pharmacies are owned by current or former ministry staff. Healthcare companies are said to intentionally recruit ministry staff to use their insider knowledge of how the ministry procurement system works so that they can manipulate it. And suppliers can bribe doctors to request a particular pharmaceutical they have an exclusive import license for.

Also, (former) civil servants have been known to start their own companies because they know how to acquire lucrative long-term supplier contracts through an unregulated medical equipment scheme. In this case, medical equipment is donated to health facilities and hospitals. Typically, it is donations of equipment that require materials like chemical reagents in order to be used. The company supplying the equipment will then receive long-term contracts from the government to also supply the materials. There is little scrutiny carried out if quantities of materials or even the equipment themselves are needed at all.

After products have been procured and brought into the country, it is a big challenge to know whether they reach their destination. For example, MoH relies on STO to get medicines and supplies to small islands in the Atolls from Malé. When these deliveries are made, STO is meant to have a receipt signed by the responsible healthcare worker on the island as proof of delivery. This paper-based system is problematic because signatures can be forged. Without a digital stock system, it is also impossible to know if the right quantity of products actually reaches health facilities or if they get there at all.

(9) Note, the agreement or "Memorandum of Understanding" is not publicly available.

RECOMMENDATIONS

IMPROVED STOCK FORECASTING AND MANAGEMENT

A first step would be to prioritize improving stock quantification and forecasting of facility needs through improved stock management and planning at the facility level. This would help the MoH and hospitals to better plan for procurement and prevent unnecessary, single-source or overpriced purchasing. Knowing the needs can provide a benchmark against which actual procurement can be appropriately managed and monitored.

INCREASED TRANSPARENCY OF PUBLIC HEALTH PROCUREMENT

Overall, procurement processes need to be made more transparent. All procurement processes must be published online using the MoF's centralized open procurement system that already exists, and procurements over an established threshold must be subjected to competitive tenders. The use of single-source procurement should only be permitted in bona fide emergencies, its use for branded products strictly disallowed and when it is applied the process must also be made transparent. Increased transparency of procurement would better enable CSOs and journalists to exercise a monitoring role and be an additional safeguard against corruption and abuse.

Ideally, the management of tender processes should be moved from the STO into the MoH. This would allow MoH greater control over the analysis and selection of bidders. Alternatively, the STO must be obliged to use the same open procurement system mentioned above so that MoH can exercise oversight of the procurement process and ensure a transparent and accountable process.

STOP MEDICAL EQUIPMENT DONATIONS

The current donation scheme should be disallowed. The MoH should put together a review board to assess the medical equipment needs of facilities. This board should compare proposals for equipment donations against minimum needs standards before approving any donation. Facilities should only be able to receive machinery for which there is an actual need and where the equipment maintenance is included. Any contract to supply the chemical reagents should offer no more than a standard market price and contracts should be re-issued to competitive tender after a shorter duration.

TRACEABLE LOGISTICS MANAGEMENT

The STO should be responsible for the transparent and accountable management of the logistics of procured products. Regarding the final delivery of products, the receipt process should be made digital. Using scanners or smartphones and a tailored app, the entity responsible for delivering commodities can show proof of receipt through barcodes, images, and digital signatures in order to increase both the transparency and the accountability of product delivery. Such a system is commonly used in postal delivery services worldwide.


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There's no place like home

Medical travel overseas

MARIYAM'S STORY

(THIS IS A FICTIONAL STORY BASED ON REAL EVENTS)

Mariyam has recently received the devastating news from her doctors that she has cervical cancer.

At the time of the diagnosis, thankfully the cancer was not too advanced and Mariyam was advised by her medical team to undergo a minor operation to remove the cancerous cells, after that she can start on chemotherapy as a precaution.

However, there are no cervical cancer treatment centers in the Maldives so Mariyam gets placed on a waiting list to be flown abroad for the operation. After getting the approval and waiting many months, Mariyam is finally able to fly to Sri Lanka. The doctors there tell her that the cancer has grown substantially and she must now get a hysterectomy.

Mariyam and her husband Ismail's dreams for their family are dashed; they had been planning on having a second child.

PROBLEM

Although healthcare provision in the Maldives has expanded a lot in the last decade, the system is not able to provide comprehensive care for all diseases – a situation common in small island states. To compensate, services are "imported" from neighboring countries and patients are sent abroad. Providing these services, often in emergencies at facilities abroad, is challenging and there are opportunities for corruption both in the selection of patients and the dealings with foreign facilities.

The first part of this challenge concerns the selection of patients and the treatment they receive. Selection needs to be based on actual medical needs. But bribes, favors, or family connections may distort the selection and prioritization of patients for care overseas. It can lead to patients being referred for unfounded reasons in an attempt to seek overseas service coverage and, as in Mariyam's case, to undue delays of actual urgent cases.

The second part of the challenge concerns the facilities abroad. Under the Husnuvaa Aasandha scheme, patients are covered for travel and care at 41 empaneled hospitals in India and Sri Lanka. However, there is little transparency around how these facilities are selected. The distance and lack of oversight of these hospitals adds an additional hurdle to ensuring quality, timely, and adequate treatment is provided, or that billing for services is correct.

Research has shown that Husnuvaa Aasandha is paying more for services at foreign facilities than individual patients using private insurance are charged for the same services[10] – which raises suspicions that something is going very wrong in price negotiations. There is also a risk that referring physicians (e.g., foreign) in the Maldives or those involved in the process of selecting and accrediting facilities have vested interests (i.e., beneficial ownership) in empaneled facilities, meaning their decisions may not be in the interest of patients.

RECOMMENDATIONS

CONFLICT OF INTEREST MANAGEMENT

Like other areas of the health system, conflicts of interest are a core vulnerability for medical travel overseas. Decisions to send someone abroad for care should be based on medical need alone. Therefore, as proposed above, a mandatory and uniformly applied conflict of interest policy should be introduced by the CSC that includes all care providers that refer patients for overseas treatment and for Aasandha company staff, particularly those that decide who goes abroad or which facilities should be empaneled.

REVIEW SERVICE AGREEMENTS AND SERVICES PROVIDED

The reimbursement agreements for services at empaneled hospitals should be reviewed and compared with prices paid by private patients. If they are found to be higher, Aasandha company should renegotiate these agreements. Additionally, prices paid at different facilities should be benchmarked to ensure competition between them.

E-HEALTH RECORDS FOR PATIENT MONITORING OF OVERSEAS SERVICES

Additional functionality should be integrated into the Aasandha mobile phone app for patients receiving treatment abroad to check the correctness of the diagnostics, treatments and prescriptions they receive. In this way, patients can help support monitoring of upcoding or incorrect billing for services not rendered.

COMPETITIVE ACCREDITATION AND MINIMUM STANDARD

Overseas health services is good business for the empaneled hospitals receiving Maldivian patients. Aasandha company should ensure that hospitals compete for this business. Rather than waiting for hospitals to apply to be accredited, as is currently the case, it should invite a critical mass of hospitals to express interest to provide the needed services and propose service agreement conditions. To be eligible for accreditation, Aasandha company should define and exercise a minimum quality standard. This entire process and its results should be done transparently – through the Aasandha company website, for instance – to allow for CSO and public scrutiny.

(10) Suzana M, Mills A, Tangcharoensathien V, et al. (2015), The economic burden of overseas medical treatment: a cross sectional study of Maldivian medical travelers. BMC Health Serv Res 15, 418. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4583732/pdf/12913_2015_Article_1054.pdf

7

Hospital governance

Seriously, who's calling the shots?

AZRA AND FAISAL'S STORY

(this is a fictional story based on real events)

Azra and Faisal are the co-chairs of the new governing board at Addu City Regional Hospital.

The board is responsible for oversight of the hospital and its operations. Together with the other board members, they are meant to set out the governance standards for the hospital and how the board should function.

Faisal contacts a colleague who is on the board of another large hospital in Malé to see if he can be of any help, but there are no set standards that he and Azra can use as guidelines. Faisal's colleague in Malé indicates they have no mandate to properly monitor the finances or operations.

In the past three years, their board has made a number of recommendations on how to improve operations and make services more cost-effective, but the hospital management has not taken any of them up.

PROBLEM

The lack of clear definitions of leadership roles, as well as the absence of key governance functions in major hospitals, have left this critical area of healthcare provision without good governance standards making it rife with opportunities for corruption.

Governance and administration of public hospitals have been subject to a rollercoaster of reforms over the past 15 years. For example, since 2008, the ownership and governance structure of IGMH has changed three times, from public to private, then back to public, and now to a status labeled as "autonomous", which is also being applied to other large regional hospitals.

Through this last transformation, the overall hospital management was transferred from the MoH to a CEO and a board that are both appointed by and separately report to the President's Office. This new model leaves hospitals without guidance and capacity for developing good governance.

To start, there is no publicly-available information on how the hospital board is governed, or what their boundaries, spheres of responsibility or power of decision-making are. Although there are no standardized terms of reference that would clarify the board's role, it appears to be limited to an advisory capacity. Additionally, the setup with both a CEO and board that report separately to the President's Office makes one wonder how the hierarchy works and what the purpose of the board is at all.

Together with the World Health Organization (WHO), the MoH developed a quality assurance standard for health facilities, the Maldives Healthcare Quality Standard, in 2018. However, it provides very limited guidance on governance-related topics. For example, it doesn't define requirements for key governance components, such as a standard hierarchy of policies, procedures for risk management (corruption and other types of risks), internal controls, compliance, or internal audit. It even lacks basic tools and mechanisms, such as a code of conduct, policies and procedures to manage conflicts of interest, or how to establish and operate whistleblowing channels.

This situation leaves hospitals without a clear framework for appropriate governance, which impacts on facility performance. Instead, they have to come up with their own solutions, leading to each facility having a different and potentially inadequate approach. As of writing, in spite of plans to upgrade regional hospitals and institute hospital boards, the MoH has not reviewed the implementation of its standard – and it is not publicly available.

RECOMMENDATIONS

ESTABLISH A GOVERNANCE STANDARD FOR HOSPITALS

A uniform governance standard to guide operations should be developed and applied across all autonomous hospitals rather than leaving this task to each hospital individually. It should include, as a minimum, a set hierarchy of key governance policies and procedures, that define the roles and responsibilities of the CEO and hospital board, as well as for key governance functions, such as risk management, internal controls, conflict-of-interest management, and whistleblowing. Given the low capacities in these areas at the hospital level, this task should be done at the central level to ensure uniformity and to establish a quality standard across the country. The MoH-quality standard is a first step, but governance topics must be more explicit, and implementation should be carefully monitored. Once the uniform governance standard is developed, it should be made publicly available on the MoH website as well as on hospital websites.

SET UP WHISTLEBLOWING HOTLINES

Healthcare staff, patients and the general population can play an important role in good hospital governance by reporting poor performance or concerning practices when they see them. Whistleblowing channels for autonomous hospitals that are trustworthy, easily accessible and allow for anonymous reporting should be established.

TIP!

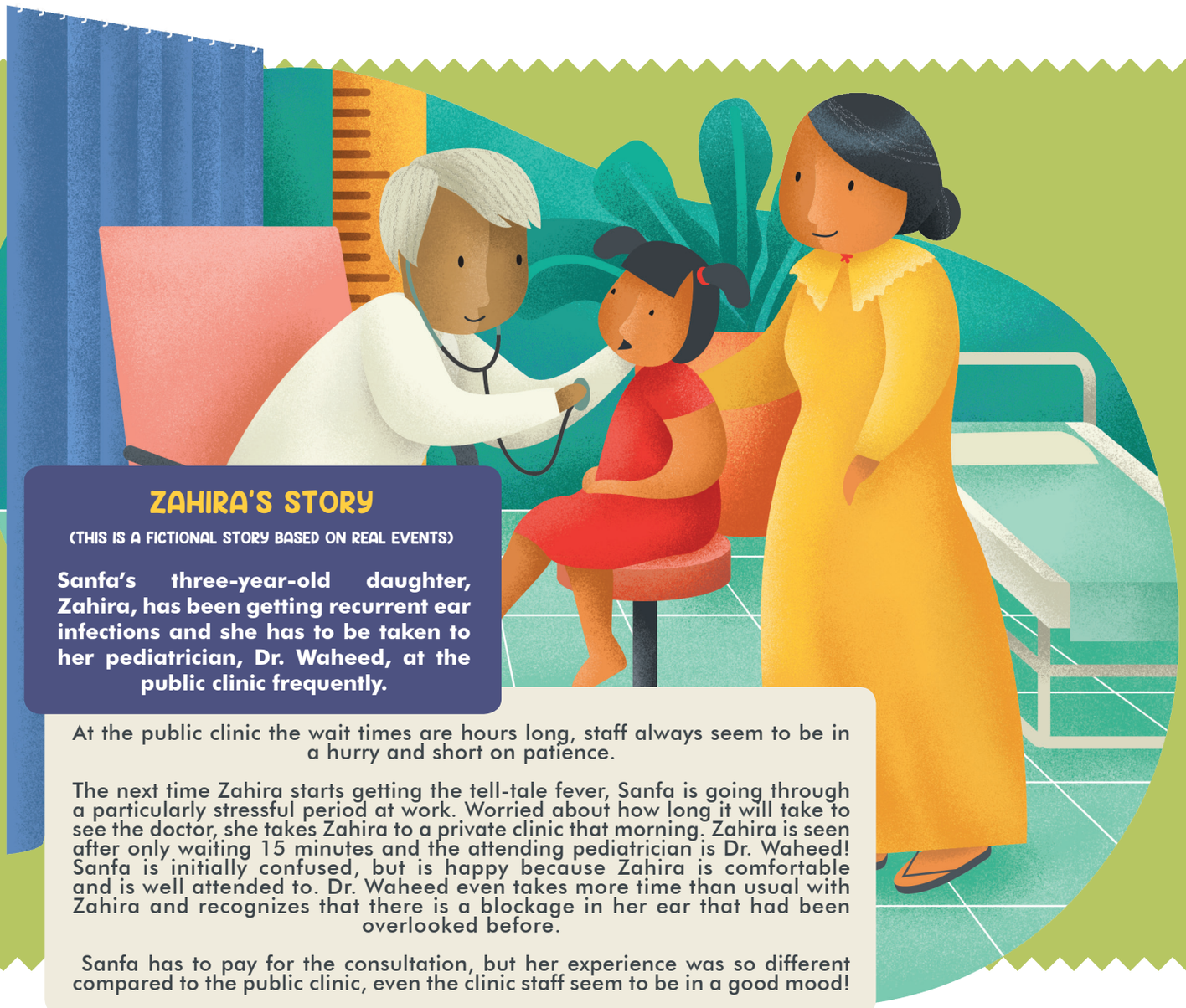
TRANSPARENCY MALDIVES
A Coalition for Integrity

Did you know that if you have witnessed corruption, you can reach out to Transparency Maldives' Advocacy and Legal Advice Centre for free and confidential advice and support on how to voice a complaint, seek redress and stand up for justice?

8

Working hard or hardly working?

Incentivizing poor performance



ZAHIRA'S STORY

(THIS IS A FICTIONAL STORY BASED ON REAL EVENTS)

Sanfa's three-year-old daughter, Zahira, has been getting recurrent ear infections and she has to be taken to her pediatrician, Dr. Waheed, at the public clinic frequently.

At the public clinic the wait times are hours long, staff always seem to be in a hurry and short on patience.

The next time Zahira starts getting the tell-tale fever, Sanfa is going through a particularly stressful period at work. Worried about how long it will take to see the doctor, she takes Zahira to a private clinic that morning. Zahira is seen after only waiting 15 minutes and the attending pediatrician is Dr. Waheed! Sanfa is initially confused, but is happy because Zahira is comfortable and is well attended to. Dr. Waheed even takes more time than usual with Zahira and recognizes that there is a blockage in her ear that had been overlooked before.

Sanfa has to pay for the consultation, but her experience was so different compared to the public clinic, even the clinic staff seem to be in a good mood!

PROBLEM

There is an inherent lack of incentives to improve public health facility operations. Inefficiency can be a driver of corruption, as it creates opportunities or necessities for cutting corners. It can also be a consequence of corruption, when people are not doing their jobs properly. Regardless, inefficient operations place a huge financial burden on the system and lead to poorer service delivery and health outcomes.

The operational structure of public health facilities in the Maldives is not organized to provide quality healthcare in a timely and cost-effective way. The interests of staff are not aligned with the public interest and incentives are not appropriately set.

Public sector staff are civil servants and work for a low, fixed salary. Medical professionals, particularly doctors, are at risk of having little motivation and interest in good performance. They are allowed to moonlight (work in private and public facilities at the same time) and may thus be absent from their public positions or simply not perform at their best when at the public facility. Data show that doctors in the Maldives attend to up to six times more patients per day when they work in private practices, where they personally benefit from increased efficiency, and patients report equal if not greater satisfaction with private services.

Foreign doctors hired to work in public facilities often try to find jobs in the private sector or will not practice long in the Maldives because of the low wages. This makes it difficult to establish a senior medical workforce with a continuously improved routine that creates a legacy of high-quality care.

Similarly, management is neither able nor incentivized to optimize operations. First, they have no way to attract and maintain quality staff, as they are bound by conditions of the civil service regulations and hiring and firing is done by the CSC. Second, in hospitals there is a separation of budgetary responsibility and management. Budget responsibility lies with the MoF, while hospital management (who are also civil servants on fixed salaries) reports to the MoH or President's Office. Neither their pay nor the facility budget is increased in response to better performance. Hospital managers claim that they do not get the budget they request nor do they have enough staff.

This situation is both cause and effect of high staff turnover in public health facilities and poor value for money at the facility level. The lack of incentives and poor performance can, among other things, lead to a shortage of services, long waiting lines, or in the worst case, inadequate care that could have dangerous consequences for patients. Poor system performance can also cause patients and the general public to distrust the public health system, which motivates unfair practices such as queue jumping or seeking preferential treatment through informal networks. Those that can afford it may go to private clinics, but those that can't are stuck with a "second class" service.

RECOMMENDATIONS

REALIGNING INCENTIVES FOR STAFF

Pay scales for healthcare professionals in the public sector should be made more competitive with the private sector, and in particular remuneration packages should be partially tied to individual, section, or facility performance or seniority, for example. Other non-monetary incentives, such as team-building or sponsored trainings should also be considered.

REALIGNING INCENTIVES FOR LEADERSHIP

Similarly, those managing facilities should be enabled to operate the facility and be held accountable for the results it produces as measured by its performance. First, the separation of responsibility over human resources, budget, and management in the case of autonomous hospitals should be considered as an area for immediate reform. Unless autonomous hospitals are able to attract, hire, maintain, promote, and fire staff to ensure a suitable and qualified workforce, efficient and effective operations are difficult if not impossible to achieve. Second, budgetary responsibility must be in the same hands as operational responsibility for the same reasons. And third, facility performance should be monitored by the MoH or the President's Office, respectively. Critical indicators, such as number of patients seen, repeat patient visits for the same condition, instances of medical malpractice, and so on, should be tracked and assessed on an ongoing basis – including benchmarking across the sector. Efficient operations should be rewarded as an incentive – or, alternatively, poor performance could be disincentivized.

MONITORING AND SHARING PERFORMANCE DATA

Both Aasandha company and hospitals have data regarding service provision. MoH, Aasandha company and autonomous facilities should actively make data, such as average waiting time, number of patients treated, or prices paid, available on their websites to enable patients and the public to help monitor and identify inconsistencies or unfair practices.

PERFORMANCE AUDITS OF MAJOR HOSPITALS

According to the database of the AuGO, only a single performance audit conducted in 2016 has been carried out for a major hospital so far. For large hospitals, external audits of performance should be carried out on a frequent basis to ensure external oversight as an additional measure.

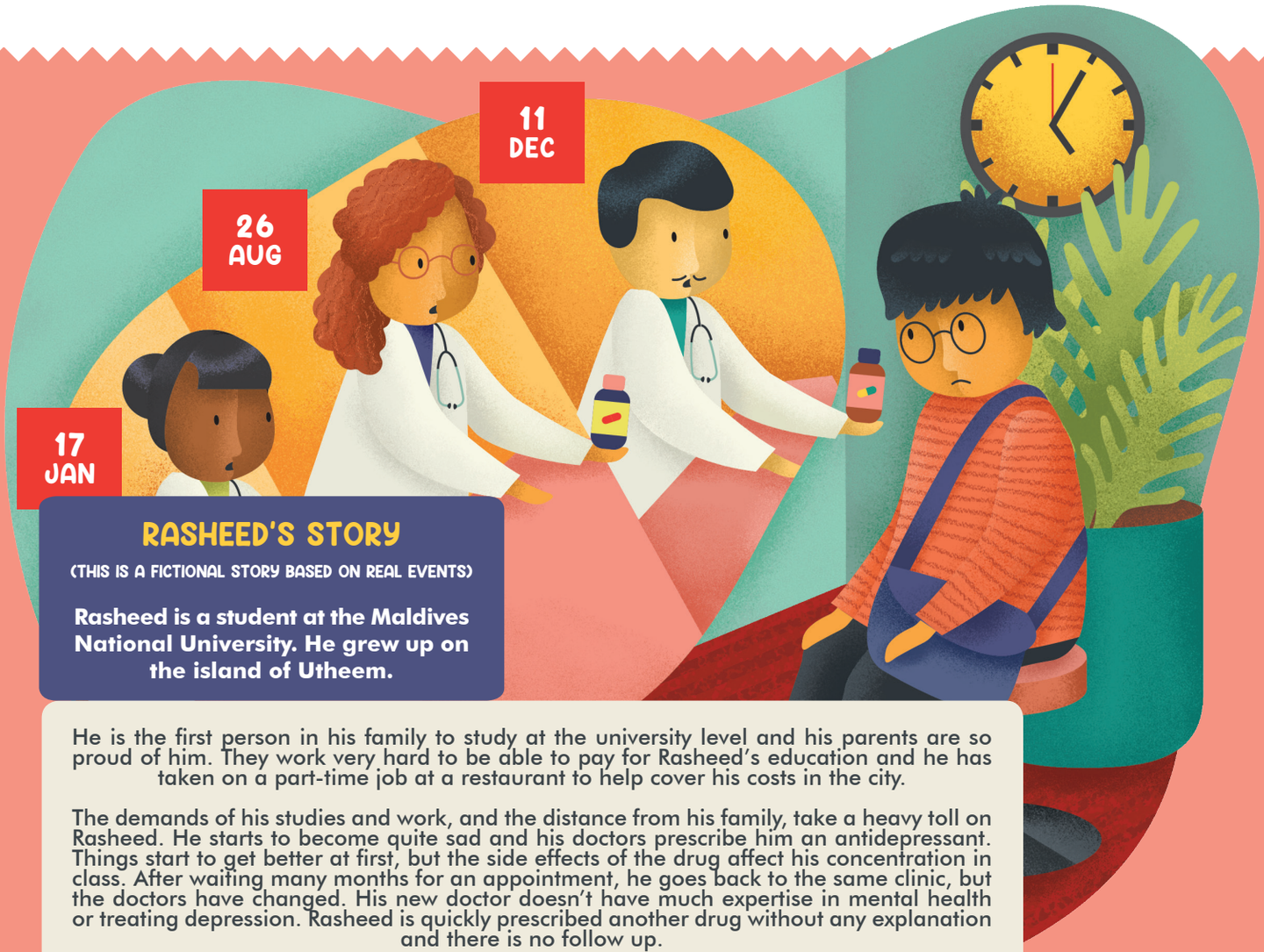
THIRD-PARTY PERFORMANCE MONITORING

Using tailored surveys and Right to Information requests, CSOs can also help monitor health sector performance, for example, to determine if policies are being correctly applied, if action plans for improvements are being carried out, compare sectoral reforms against actual performance data like wait times, number of patients treated and perceptions of patient satisfaction.

9

The house built on sand

Human resource challenges



RASHEED'S STORY

(THIS IS A FICTIONAL STORY BASED ON REAL EVENTS)

Rasheed is a student at the Maldives National University. He grew up on the island of Utheem.

He is the first person in his family to study at the university level and his parents are so proud of him. They work very hard to be able to pay for Rasheed's education and he has taken on a part-time job at a restaurant to help cover his costs in the city.

The demands of his studies and work, and the distance from his family, take a heavy toll on Rasheed. He starts to become quite sad and his doctors prescribe him an antidepressant. Things start to get better at first, but the side effects of the drug affect his concentration in class. After waiting many months for an appointment, he goes back to the same clinic, but the doctors have changed. His new doctor doesn't have much expertise in mental health or treating depression. Rasheed is quickly prescribed another drug without any explanation and there is no follow up.

Rasheed's depression doesn't improve and he becomes hopeless, his grades start to go down, he believes that he is a disappointment to his family and will never succeed in life. He keeps going back to the clinic, but the doctors are always different and no one really seems able or interested to help him.

PROBLEM

Human resources are scarce in the Maldives, including the health sector, and in particular medical specialists. Public health facilities struggle to recruit and maintain qualified doctors. This situation is exploited by recruitment companies and medical personnel recruited overseas. It results in low levels of staff, staff that lack needed qualifications, and high rates of turnover. It leads to poor quality service delivery, like in Rasheed's case.

Public hospitals struggle to recruit and maintain qualified doctors, as the competition for talent is stiff. The low public sector wages can't compete with private sector clinics and hospitals at the national level, or with remuneration packages offered in other countries, particularly the Middle East. These problems are compounded by the fact that management and responsibility over human resources, including hiring and firing of public employees, lies with the CSC. Health facilities are at the mercy of the CSC's lengthy recruitment procedures. As a result, there are many vacant positions that go unfilled, leaving facilities constantly understaffed. In the atolls, the situation is even worse. Medical staff are reluctant to work on small islands because of the lack of social network, the living and working conditions, and absence of opportunities to work in the private sector or increase their income. Additionally, professionals worry they won't be able to build up or maintain their skills because they'll see very few patients. As a result, there is high turnover of staff in public facilities and a high demand for foreign healthcare workers; currently 69% of physicians working in the Maldives are from abroad.[11]

Assessing the qualifications of foreign employees is also difficult, and there are opportunities for corruption in foreign recruitment, both in the source countries and in the Maldives. Recruiting agencies abroad may select unqualified candidates and assist them in the vetting process. These agencies can charge candidates high recruitment fees, and collude with domestic companies or office holders, or even be co-owned by them to illicitly facilitate the recruitment process by getting visa quotas for a profit. Once in the country, unqualified candidates may bribe their way through the official examination. Lastly, MoH-contracted health professionals, including foreign employees, can moonlight and work in both the public and private sectors, or abandon the public sector altogether for the more profitable private sector. Foreign health workers who do move to the private sector may unlawfully retain their MoH-sponsored visas and some of their public sector allowances, such as subsidized accommodation. The weak oversight of the health workforce by the MoH results in a lack of capacity in the public sector and a major waste of public health funds.

RECOMMENDATIONS

INCREASE RECRUITMENT TRANSPARENCY AND COMPETITIVENESS

There is little publicly-available information about the recruitment process for foreign health professionals. Relationships between applicants, recruitment companies and stakeholders in the Maldives are not well understood. Making information publicly available is recommended as a first, low-effort measure. Likewise, there is also no publicly-available information on decision making for the numbers of quotas issued, criteria for issuing a quota or procedures for visas for foreign healthcare workers. For instance, the MoH could assess the requirement for foreign specialists and publish this information on its website. Based on this need, the quotas for respective visas could be tendered to recruitment companies using a transparent and public procedure to ensure a competitive process. This activity should contain safeguards to ensure that companies don't exploit applicants or forge applicant qualifications.

CONFLICTS OF INTEREST MANAGEMENT

Here again, conflicts of interest need to be identified and managed for all stakeholders involved in the recruitment process, including the recruitment agencies at home and abroad, those responsible for acquiring and issuing quotas and those responsible for assessing applicant qualifications.

MONITOR AND CONTROL STAFF POSTINGS

More stringent controls over moonlighting and particularly ensuring that those doctors recruited from abroad stay in the posts at the facilities they have been recruited for would contribute to improved facility staffing and reduce the overconcentration of healthcare personnel in Malé. Tying visas to sponsoring institutions is common practice in other countries that rely heavily on foreign recruitment. A foreign recruit wishing to change jobs can be obliged to change their visa sponsor with immigration, private sector companies recruiting from the public sector could be obliged to pay a fee to allow the public sector to recover the recruitment costs. Options to incentivize medical staff outside CSC scales should also be considered.

QUALIFICATION AND LICENSING OF FOREIGN PROFESSIONALS

Review of qualification documents by the relevant medical councils prior to visa approval is essential. The current practice of examining doctors after arriving in the Maldives should be a rare exception, as it is contradictory to recruiting experienced professionals. Where warranted, examinations should be held by an independent entity not connected to those involved in recruitment and appointment, for example a medical university or professional accreditation board. This is a task that is common in all countries recruiting from abroad. Recruitment agencies should be held accountable in case of document scams by recruits who received a visa from their quota.

WHISTLEBLOWING CHANNELS

Competitors, successful and unsuccessful applicants, as well as patients and the general public should have effective ways and channels available to denounce malfeasance. It is recommended to have whistleblowing channels both at the institutional and central level, for example, the CSC, MoH, or ACC. That way, those wishing to come forward have options to voice their concerns. Domestic, not foreign, companies that receive quotas and provide visas should be held accountable in case of malfeasance during recruitment processes.

(11) Ministry of Health Maldives (2020), Maldives Health Statistics 2017-2019. http://health.gov.mv/Uploads/Downloads//Publications/Publication(106).pdf

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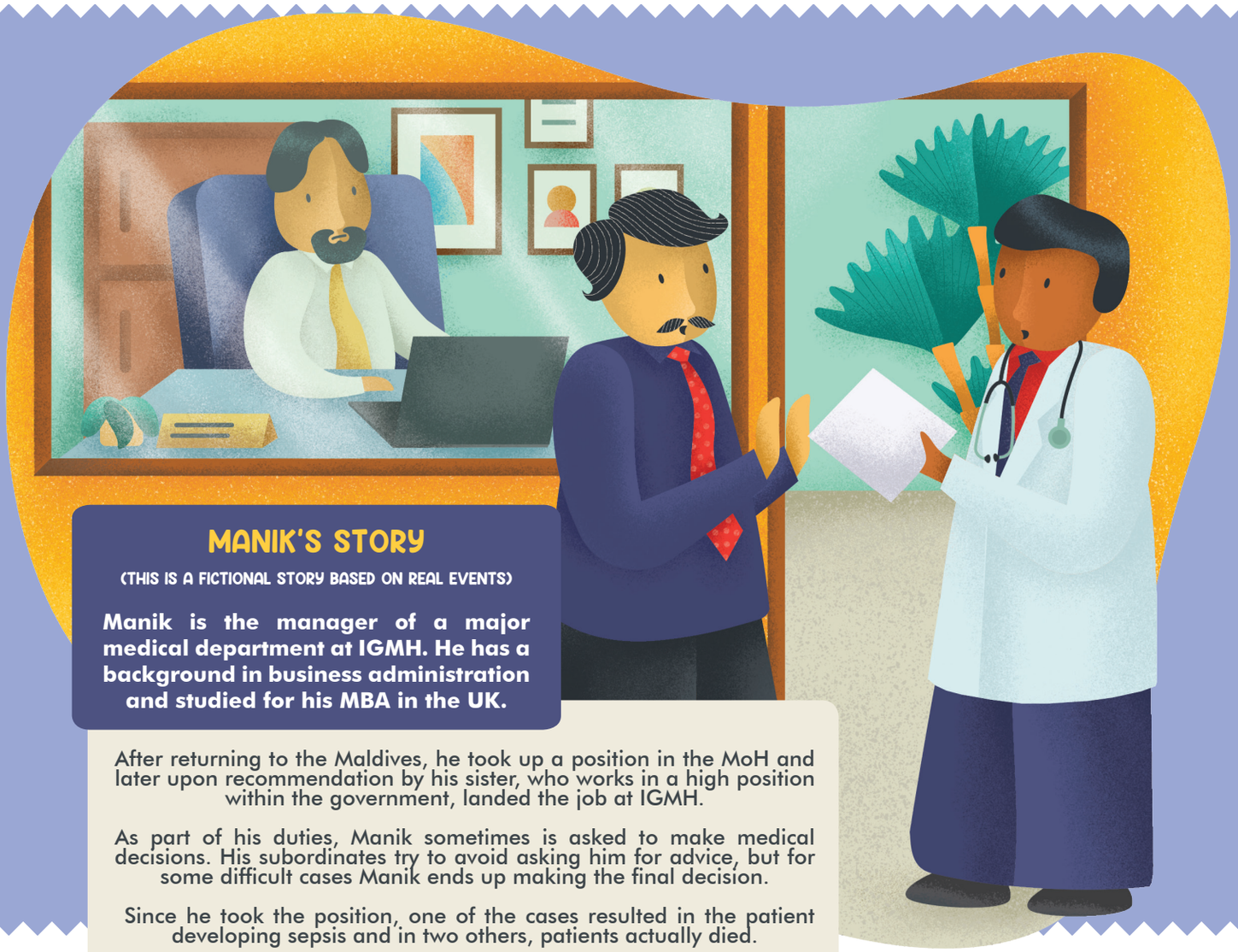
Only as strong as the weakest link

Non-merit-based management appointments



MANIK'S STORY

(THIS IS A FICTIONAL STORY BASED ON REAL EVENTS)

Manik is the manager of a major medical department at IGMH. He has a background in business administration and studied for his MBA in the UK.

After returning to the Maldives, he took up a position in the MoH and later upon recommendation by his sister, who works in a high position within the government, landed the job at IGMH.

As part of his duties, Manik sometimes is asked to make medical decisions. His subordinates try to avoid asking him for advice, but for some difficult cases Manik ends up making the final decision.

Since he took the position, one of the cases resulted in the patient developing sepsis and in two others, patients actually died.

PROBLEM

Appointments to public positions are not always based on merit. Absence of this principle opens the door to abuse on both sides – those who want a job and those with the power to award it – to give or take bribes, and to build corrupt networks to milk the system in the future.

While any change in government administration is naturally accompanied by political appointments to top offices, such as ministerial positions, the same is not true for top functions of the civil service. On the contrary, it is vital to have a qualified and consistent civil service that remains in office across changing administrations in order to define and pursue long-term goals and strategic objectives. An overabundance of reforms instead of consistent approaches is a key weakness of the Maldivian health sector. Additionally, appointed leaders without the needed qualifications may not have the trust and support of their staff.

In the Maldives, political appointments are often made to positions of importance across the public sector. There is no publicly-available information regarding how people are appointed to these positions, such as the appointment criteria, and there are no accountability mechanisms to monitor their performance. The leadership of public health institutions is replaced on a regular basis whenever there is a reshuffle of cabinet or a new administration comes into power. These changes in leadership interrupt, delay or halt needed sectoral improvements.

Corrupt practices like nepotism and clientelism – putting family members and friends into positions of power – thrive in such an environment where appointees tend to be loyal to those who appointed them and there is an expectation to return the favor in the future. There is also a risk that political appointees are being used to exercise influence and control over institutions, including financial decision making.

There are many instances where political appointees are not qualified for the job. This is especially problematic in the health sector where non-medical managers, like Manik, make medical decisions. Apart from the obvious ethical violations and health risks, such situations lead to a lack of loyalty, indifference or even feelings of contempt for new appointed leadership that doesn't have the right expertise, experience, training or skills.

RECOMMENDATIONS

LIMIT POLITICAL APPOINTMENTS THROUGH TRANSPARENT AND ADEQUATE PROCEDURES

Processes should be in place that define the limits of political appointments. Recruitment procedures should be as transparent and inclusive as possible. The job posting, job descriptions containing minimum technical requirements, and curricula vitae of the candidates under consideration should be made publicly available. Positions that are subject to political appointments should be limited to a very few leadership positions. Laws or bylaws of the respective institutions should clearly define these positions and include minimum requirements of expertise and experience. Rather than just a political decision made by the governing party or minister, other institutions should be involved in the proposal and approval of candidates. Professional councils or other bodies can play a role in such decisions.

Given the extent of this problem in the sector, all positions currently subject to political appointment should be reviewed to see if political appointments are appropriate or if the position should rather be filled by a senior civil servant. Any job that shouldn't be filled via an appointment should instead be subject to normal recruitment procedures of the CSC.

CONCLUSION & SUMMARY

Health is a human right and critical to upholding this right is access to an equitable, accessible, affordable and high-quality health system. In the Maldives, improvements to the health system have led to fantastic returns on many important health indicators, such as reducing or even eradicating some communicable diseases, reducing rates of maternal and new-born deaths and ensuring that children are fully vaccinated. The Maldives disease burden profile today now looks like what one will find in most high-income countries. For these achievements, much praise is certainly due.

But now, there are many threats to the sustainability of the health system that need to be urgently addressed. Corruption is one of them.

Through our study of the health sector, we have identified many corruption-related vulnerabilities that contribute to inefficiency, poor value for money, and negatively impact on patient care. Most of the vulnerabilities are the result of three critical dynamics, 1) the speed and frequency of sectoral reforms; 2) the lack of transparency across the board; and 3) insufficient monitoring and oversight.

With each new administration, and sometimes during the same administration, the rules of the game change. Reform after reform is proposed and rolled out in the health sector before the previous one could be properly implemented or have the intended effect. What's worse, these reforms are rarely based on the recommendations made by national or international institutions and so the real problems with the system don't get addressed.

The health sector itself is very opaque and it is hard to know what's really going on. Our study found that there is very little publicly-available documentation to help understand how the health sector works, who is responsible for what and what happens when something goes wrong. If corruption is a disease, then transparency is part of the treatment. Of course, transparency in itself won't stop corruption from happening, but it is an important element to be able to hold leaders and decision makers accountable for their actions. Without it we're in the dark.

And so it's no surprise that there is a major gap in monitoring and oversight of the health sector. Poor monitoring and oversight is in part due to the lack of transparent, publicly-available information of critical laws, frameworks, procedures, processes and decisions. Considering how much money is spent in the health sector this is an area that needs to be addressed now to increase the system's value for money and ensure that Maldivians are getting a comprehensive and quality service at an affordable price.

(12) You can contact TM's Advocacy and Legal Advice Centre here: https://transparency.mv/v16/alac/

BUT YOU CAN HELP!

There are lots of ways that citizens can contribute to safeguarding our health system starting with sharing this report. Three other ways are:

IF YOU SEE IT, SAY IT!

If you witness corruption when engaging with the health sector, you can raise your voice and lodge a complaint, either through your organization's whistleblowing hotline or our Advocacy and Legal Advice Centre.[12] We'll ensure that you remain anonymous and keep you up to date on the status of your complaint.

GET INFORMED

Interested to know more about how your health facility is functioning? Got a concern about health sector infrastructure projects? You have the right to request access to government records. Remember, they work for you!

You can follow our guide on Requests for Information to submit your own RTI request. And in case you are interested in our detailed report on corruption in the health sector, find it here.[13]

SUPPORT US

Organizations like ours encourage community participation and citizen monitoring. You can help reduce corruption through local-monitoring of health services and submit citizen reports through our Thaalhafili survey. We also regularly hold campaigns, disseminate research like this, and hold events.

Corruption and inefficiencies are standing in the way of a functioning sustainable health system. With a greater understanding of how corruption threatens our health sector and by offering ways to address the vulnerabilities in practical and tried ways, it is our hope that we can work together to build a system based on transparency and accountability that truly provides health for all.

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