

**CORRUPTION VULNERABILITIES  
IN THE MALDIVIAN  
HEALTH SECTOR**

OCTOBER 2022

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# FOREWORD

**Asiath Rilweena,  
Transparency Maldives Executive Director**

## Ensuring a health system that serves the Maldivian people

I am pleased to present this report which is, to our knowledge, the first to examine the unique corruption vulnerabilities within the Maldivian health sector.

No one could contest that there have been many great achievements in the Maldives over the last 50 years. As a country we have seen exceptional gains in human and economic development, reflected in better living conditions and improved health outcomes of our citizens. This growth is something that we can all be proud of. Within such a short period of time, we have progressed to upper-middle income status, and we are a respected and engaged member of the international community.

However, our collective national progress is under threat due to the COVID-19 pandemic. Our primary industry, tourism, has experienced exceptional shocks, which has implications for the resourcing of our public service. Other areas of the economy have also been negatively impacted. Even regarding health outcomes, there have been recorded regressions in the number of children vaccinated. And there have been a number of major corruption scandals and considerable political turmoil at the highest levels of elected government.

Access to health care is a human right and it is a constitutional obligation of the Maldives Government. A healthy population, supported and served by an efficient, responsive and well-resourced health system, is the backbone of a society. However, there are perceptions and sentiments from the general public that the Maldives health sector is suffering under systemic corruption. Patients have unequal access to

health products and services, wait times for consultations are excessive, and the health workforce is in constant flux due to brain drain. In addition, there is poor oversight and accountability of the system's performance. In response, we here at Transparency Maldives (TM) have undertaken a comprehensive study of the health sector through the lens of corruption. We aimed to bring clarity to the opaque and understand the areas of the health system that are vulnerable to corruption.

This report details the results of that study. Our independent, expert team of anti-corruption and health specialists have diligently considered the publicly-available information, legislative and policy documents and their de facto implementation, and spent countless hours interviewing local experts across the health sector, and related ministries and institutions. Their research has found 35 vulnerabilities across the health system that are detailed in this report. They are damaging to the system but certainly not insurmountable. Some demand larger structural reform whereas others are comparably easier to remedy. Concrete, remedial measures proposed based off the results of this study are included in a sister-publication aimed at the general population.

It is our hope that the learnings from this study will serve as a basis to drive important corrective action that will safeguard and improve our health system, and we look to our national and development partners to join us in support of our future efforts to ensure health for all Maldivians as set out in the UN Sustainable Development Goals.

**Asiath Rilweena  
Executive Director  
Transparency Maldives  
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## **Acknowledgements**

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# EXECUTIVE SUMMARY

Over the past 20 years, the Republic of Maldives has consistently prioritized its health sector through increased financial investments and efforts to achieve universal health coverage leading to marked improvements to the health outcomes of Maldivians. Compared to all other South Asian countries, the Maldives contributes the highest proportion of GDP for health expenditure and offers citizens fully subsidized, national public health insurance coverage. However, in spite of these admirable gains, the Maldivian health sector is perceived to be corrupt by both citizens and those working within it. Corruption not only causes severe financial waste, it jeopardizes the trust that underpins affordable, effective, equitable, and responsive healthcare.

This report maps out the governance infrastructure of the Maldives health sector and examines it to identify corruption vulnerabilities across health system functions. It consolidates the findings of a comprehensive review of the literature, including legal and regulatory documents, as well as the responses from interviews with 80 key informants.

Identifying and analyzing corruption vulnerabilities in Maldives requires an understanding of the overarching socio-political, economic, cultural and even geographical characteristics of the Maldives that influence corruption vulnerabilities in the health sector.

There are striking imbalances of political, economic and social activity and power. In the Maldives informal networks and kinship relationships unofficially govern society and political life. This contributes to social, political and economic divides between the capital, Malé, and the atolls. It also creates a fertile ground for conflicts of interest, nepotism and other corruption vulnerabilities in all facets of social and political life. The divides are reflected in differences of living standards between the capital and the atolls, heavy migration to Malé, high cost of living, lack of space, and disproportionate job opportunities. There is very little manufacturing capacity in the country and thus there is an overwhelming reliance on importing goods of all sorts, such as food and medical commodities. This contributes to considerable brain drain and a chronic lack of qualified personnel needed in all sectors. Many students seek their education and pursue their careers outside of the Maldives where there are greater opportunities. As a result, there is huge demand for migrant workers; estimates suggest that there are currently over 230,000 migrant workers in the Maldives, or a third of the total population, many of which

are residing illegally. The wages for those who do work in the Maldives are famously low, especially in the public sector which do not keep step with the private sector. This leads to a lot of moonlighting of public staff, unfilled positions, and prevents the establishment of sophisticated and practiced public administration and governance.

The government system and public services have experienced considerable discontinuous change and instability over the last two decades through repeated reforms. This rapid change makes it difficult to correctly apply legislation or governance policies, even where there is the political will to do so. There is also very little transparency across the whole of government, state-owned enterprises and public health facilities. This makes it difficult to understand how public services are regulated and delivered, who is responsible and therefore accountable, and what consequences exist to sanction any non-compliance. The lack of effective accountability undermines anti-corruption efforts and in turn incentivizes corruption. Although a few effective governance and anti-corruption entities exist, there is generally weak civic participation in the Maldives, and thus little civic accountability for government failures. This is made even more challenging due to the poor situation of press freedom in the country.

Taking into consideration these characteristics and by mapping the systems of stewardship, governance and regulation, financing, oversight and service delivery, both broadly and for the health sector specifically, 35 corruption vulnerabilities were identified across six functional areas of the health sector. Key vulnerabilities are described below.

## 1. Health Sector Governance and Regulation

Corruption vulnerabilities related to health sector governance and regulation regard the way the system is structured, and the roles and responsibilities of the relevant institutions. There is a lack of transparency and accountability across all institutions, as well as a failure to implement recommendations for systemic improvements from anti-corruption oversight bodies. Particularly the lack of a conflicts-of-interest management regime and the non-meritocratic process for appointing high level decision makers are of concern.

## 2. Service Delivery

Data sources show a high level of public perception of corruption in the health sector. However, actual experiences of corruption, like bribery, when accessing services are reported

to be rare. Still there are vulnerabilities to corruption and abuse when accessing services, such as patients using their personal connections to jump waiting lines. Medical travel overseas to India and Sri Lanka for procedures unavailable in the country is also vulnerable to corruption, particularly due to the lack of transparency and difficulty exercising oversight of patient referrals, as well as the accreditation process of and service agreements with the empaneled facilities abroad.

### **3. Hospital Governance and Administration**

As there is no established primary healthcare referral system, hospitals are patients' first port of call for health services and so they play an important role in national healthcare service provision. Tertiary hospitals and some regional hospitals have been in a state of constant administrative and managerial change for over a decade and there is a lack of systematic and robust approaches for governance which opens up opportunities for corruption. This is further compounded by the lack of incentives to improve facility performance – both financial and operational. There is a considerable risk that the current model for administration and management is contributing to poor value for money and low or at least inconsistent service quality.

### **4. Health Workforce**

As mentioned above, the country suffers from brain drain and poor public sector wages. This also impacts on the health workforce; there are many vacant positions and a huge reliance on foreign doctors. There is also considerable moonlighting – working in both the public and private sector simultaneously – which can lead to absenteeism. The recruitment procedures for healthcare professionals are very complex and opaque creating corruption vulnerabilities such as conflicts of interest, or bribery by recruiting agencies. Once foreign workers are in the country, oversight is also a challenge and many are said to switch to work for the private sector but keep their publicly subsidized visas and accommodations.

### **5. Health Financing**

Those institutions responsible for health service financing are inherently vulnerable to corruption. This is especially true in Maldives as there is no robust, automated system to prevent, detect, or sanction abuses. There are many who can benefit from this poor oversight, such as health facilities who engage in upcoding on claims or professionals overmedicalizing their

patients. Also, because of the non-contributory nature of the national health insurance scheme, beneficiaries have no incentive to support cost-effectiveness service use leading to irrational use.

### **6. Health Procurement and Supply Chain**

Like health financing, procurement is another area that is inherently vulnerable to corruption. Pharmaceuticals alone constitute a third of all government health spending. In Maldives, the vast majority of procurement of medical commodities is outsourced to the State Trading Organization. This arrangement itself, as well as the regulations and policies to govern procurement, are very opaque and allow much room to circumvent accountability. The process to determine procurement needs is fragmented and the procurement process itself lacks sufficient transparency. Of particular concern are the vulnerabilities for conflicts of interest or collusion in procurement tenders, contracts and awards, as there is no robust management regime, as well as the revolving door of public sector employees switching to the State Trading Organization or to private supplier companies without a cooling off period.

This report finds that despite the improvements that have been made to public health service provision and measurable improvements to health outcomes, there are significant corruption vulnerabilities that are undermining consistent and equal access to quality health services across the Maldives. The results suggest that poor governance and corruption within the health sector are both drivers and consequences of systemic inefficiencies.

It is critical that further research into these vulnerabilities is carried out, particularly to better understand the impact that COVID-19 pandemic has had, and for corrective action to be undertaken. In a sister publication to this report, recommendations for the top vulnerabilities are proposed.

# 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

# I INTRODUCTION

The Republic of Maldives is an archipelago located in the Indian Ocean. It consists of a chain of 26 coral reefs, or atolls, that run along a north-south submarine mountain range. The archipelago is made up of a total of 1,192 islands of which 187 are inhabited and a further 164 islands have been developed exclusively for tourism.<sup>1</sup> The Maldives has a population of 540,542, including non-Maldivian migrant populations.<sup>2</sup> Over one third of the population lives in the capital city, Malé, the other two thirds are dispersed across the inhabited islands of the atolls.

The Maldives has been a presidential republic since 1968, prior to which it was a constitutional monarchy. The most recent constitution was ratified in 2008<sup>3</sup> and brought with it a number of promising democratic reforms, including separation of executive, legislative and judicial powers; establishment of a multi-party system; and democratic elections. The country's official language is Dhivehi. English and Arabic are commonly used in formal and religious education, respectively. Islam is the official religion of the country and is a constitutional prerequisite for citizenship.

According to the OECD,<sup>4</sup> the Maldives is an upper-middle income country with a gross domestic product (GDP) in 2020 of USD \$4.03 billion.<sup>5</sup> Only 50 years ago, the Maldives was among the poorest countries in the world and relied predominantly on natural resource industries. However, the economic perspective of the country dramatically shifted with the introduction of tourism, which now constitutes 25% of the country's GDP directly,<sup>6</sup> and 90% of the overall government tax revenue.<sup>7</sup> The current GDP per capita is USD \$6,924.<sup>8</sup> According to 2016 data, 8.2% of the population lives

below the national poverty line.<sup>9</sup> In spite of the country's economic upturn, there is stark income inequality; 49% of the country's wealthiest households live in Malé.<sup>10</sup> Nevertheless, the Maldives has made impressive advancements across human development indicators reflected in the country's Human Development Index score which increased by 33.3% between 1995-2019. Today, the Maldives is considered to have achieved a high level of human development.<sup>11</sup>

Behind these admirable gains are high levels of perceived corruption by the Maldivian public, particularly in the health sector. This report documents a study of corruption in the health sector examining the national public health system in order to map the various system components and to identify corruption vulnerabilities. It is based on a comprehensive review of publicly available information, as well as Key Informant Interviews (KIIs) conducted with a total of 80 key informants in 41 interview sessions. KIIs included diverse expert stakeholders with local knowledge and extensive relevant experience within health or other government institutions (see Annex IV for the research methodology).

The report first introduces the overarching geographical, social and political challenges in the Maldives that contribute to or influence corruption vulnerabilities generally, as well as in the health sector specifically. Second, the perceptions and experiences of the Maldives' population with corruption in the health sector are highlighted. Third, key stakeholders for the health sector and how they function are mapped out and described. Then, fourth, corruption vulnerabilities within these key areas are laid out. Finally, conclusions are drawn.

1 Maldives Bureau of Statistics (2021), *Maldives in Figures - June 2021*.

2 World Bank (2020), *Population total - Maldives*.

3 Republic of Maldives (2018), *Functional Translation of the Constitution of the Republic of Maldives 2008*.

4 OECD (2021), *DAC List of ODA Recipients Effective for reporting on 2021 flows*.

5 World Bank (2020), *GDP Current (US\$) - Maldives*.

6 Maldives Bureau of Statistics (2020), *World Tourism Day 2020 - Tourism and Rural Development Factsheet*.

7 Scheyvens R (2011), *The challenge of sustainable tourism development in the Maldives: Understanding the social and political dimensions of sustainability*. Asia Pacific Viewpoint, 52(2), 148-164.

8 World Bank (2020), *GDP per capita (current US\$)*.

9 World Bank (2018), *Maldives: Poverty and Inequality in the Maldives*.

10 Ministry of Health Maldives (2018), *Maldives Demographic and Health Survey 2016-17*.

11 UNDP (2020), *Human Development Report 2020 The Next Frontier: Human Development and the Anthropocene Briefing note for countries on the 2020 Human Development Report Maldives*.



# 2 SECTOR NON-SPECIFIC CHALLENGES

**The Maldives has several important characteristics that are not unique to the health sector, but significantly influence its effectiveness and vulnerability to corruption.**

## 2.1 Small Island Developing State Context

As a Small Island Developing State (SIDS), the Maldives faces similar challenges as other countries in this category.<sup>12</sup> The Maldives is one of the most geographically dispersed countries in the world with the population spread across 187 inhabited islands that stretch over a large geographic area. There is an overconcentration of political, economic and social power in the capital city reflected in differences of living standards between the center and periphery; heavy migration to the capital; high cost of living; lack of space; and disproportionate job opportunities in Malé. Furthermore, like many SIDS, the Maldives must import virtually all goods, including food and medical products due to the absence of domestic production.

## 2.2 Availability of Human Resources

The opportunities for high-quality tertiary education are very limited in the Maldives, and many young talented students strive to pursue their university studies abroad, often with support through scholarships. After studies, many seek employment outside of Maldives due to limited employment opportunities. The resulting brain drain significantly exacerbates the inherent lack of qualified personnel needed in all sectors. To compensate, the country relies heavily on migrant workers. Currently, 145,000 to over 230,000 migrant workers are estimated to be present in the country, many of which are residing in Maldives illegally. They constitute around a third of the total population and place a considerable burden on the public system, including the health sector.<sup>13</sup>

## 2.3 Public Sector Wages and Turnover Rates

The wages of civil servants are not in step with those offered by the private sector. This contributes to many public employees, particularly higher skilled staff simultaneously working in the private sector during public sector job hours or choosing to leave public institutions after a short time of employment. It also results in many public posts remaining vacant because of the unattractive wages. Responses from key informants (KIs) indicate that the resulting high turnover and low staff levels prevent the establishment of sophisticated and practiced administrative and governance procedures, and building a quality workforce. Government is aware of this reality and has made accommodations in the public sector working hours to enable staff to take up employment in the private sector.<sup>14</sup>

A remedial mechanism in the form of additional pay through a Special Duty Allowance has been introduced in some, but not all, ministries and government entities as a disincentive to

constitute around a third of the total population and place a considerable burden on the public system, including the health sector.<sup>13</sup> working a second post in the private sector.<sup>15</sup> However, those receiving Special Duty Allowance are not strictly prohibited from taking on private sector employment.<sup>16</sup>

## 2.4 Frequency of Governmental Reforms

The current constitution and parliamentary system were introduced in 2008. Since then, there have been four governments. The country has experienced considerable and rapid changes to government administration, policy and legislation, and public service provision in this time. Each change in government is accompanied by fundamental modifications to institutional and regulatory frameworks of the public sector, as well as a comprehensive change of personnel at all levels. The typical election cycle is five years, so the country grapples with a complete shift in direction and procedure when there is a change in government. KIs indicate that the speed of change has made it difficult to correctly apply legislation, even where there is political will to do so.

## 2.5 Government Transparency

There is considerable opacity across government, including in governance institutions, state-owned enterprises (SOEs) and health facilities. Additionally, there is a dearth of documents available on critical aspects of public sector governance, such as the definition of mandates of public institutions, hospital management and administration, recruitment and appointments, accountability mechanisms, and policies and legislation among others. This makes it difficult even for experts to truly understand how aspects of the health sector are regulated; who is responsible and therefore accountable for what aspects of, or decision making within, the health sector; and what consequences exist to sanction failure to comply.

## 2.6 Accountability for Misconduct and Non-Compliance

Since 2018, the Whistleblower Protection Act<sup>17</sup> has been in force and in 2020 a Whistleblower Protection Unit was stationed within the Human Rights Commission of the Maldives. Additionally, an anonymous, online corruption reporting mechanism was launched in 2020<sup>18</sup> to encourage anonymous reporting. There are also national watchdog organizations, especially the Auditor General's Office (AuGO), the Anti-Corruption Commission (ACC) and to some extent the media have brought to light numerous instances of misconduct and corruption. However, KIs and documents studied reveal a general practice of very limited, if any, application of sanctions. Additionally, recommendations for system improvements are typically not implemented and there is no follow up on them. The following examples illustrative this problem:

First, asset declaration is a constitutional requirement for a number of public office bearers.<sup>19,20,21</sup> Since 2019, this is being implemented at the level of the President's Office (PO), is applied to a wide range of office holders and published on the Parliament's website.<sup>22</sup> However, it lacks key components, such as review of correctness and sanctioning of incorrect declarations. Even cursory review reveals blatantly false statements. In a small society like the Maldives, the rich families are well known; some of their members have declared that they have virtually no assets. This is a vivid example of how increasing transparency without effective accountability is futile.

Second, watchdog agencies are reported to be underfunded and understaffed, suffering from the high staff turnover and not adequately fulfilling their mandate. For instance, all three ACC commissioners resigned in December 2021 following a no-confidence vote against the ACC based on a performance audit uncovering over 16,000 pending cases.<sup>23</sup> The Public Accounts Committee of the People's Majlis reports it is as many as 800 reports behind in its task of reviewing and actioning upon the Auditor General's reports. To close this gap, the committee has now decided to focus on current reports and issues rather than catching up with the past.

Third, there is a high number of financial crime and corruption cases reported in the media regarding the tourist sector (sale, leasing, construction of islands and luxury resorts) and drug-related investigations with court cases failing to lead to convictions. This indicates a weak framework of investigations and sanctions. KIs report that the independence of the judiciary, which was only first enshrined in the 2008 Constitution, is seriously compromised with judges themselves engaging in bribery.

In sum, a lack of effective accountability discourages the general public and anti-corruption practitioners while on the other hand it encourages corruption perpetrators to continue or expand their activities.

## 2.7 Civic Participation and the Media

Section 32 of the Constitution of the Maldives states that "Everyone has the right to freedom of peaceful assembly without prior permission of the State"<sup>24</sup>; The Freedom of Peaceful Assembly Act was ratified in 2013.<sup>25</sup> In 2016, an amendment to the Act required written permission for protests, marches, parades and other such gatherings from the police or Ministry of Home Affairs, and restricts where these gatherings can occur.<sup>26</sup> In the run up to the 2018 federal election and since then, respect for freedom of assembly has said to have improved. However, in 2021 there were accounts of police using excessive force at demonstrations and a crackdown on protests under the guise of curbing COVID-19 infection spread.<sup>27</sup>

Despite these challenges, there are currently 164 approved civil society organizations (CSOs). According to Freedom House, CSOs in the Maldives operate under considerable restrictions.<sup>28</sup> As per the 2003 Associations Act,<sup>29</sup> approval from the Ministry of Home Affairs is necessary for CSOs to access domestic or overseas funding; the ministry also has discretion to both investigate and dissolve CSOs. In recent years, CSOs, their premises and their staff have been the targets of vandalism and violent acts, particularly by nonstate actors such as organized crime and religious extremists.<sup>30</sup>

Transparency Maldives is the primary entity advocating against corruption in the country. There are also allied organizations including the Maldivian Democracy Network, Women & Democracy, and the Public Interest Law Centre, among others, as well as several health-related CSOs active in the country. Nevertheless, according to KIs, the capacity of both CSOs and investigative journalism are low in the Maldives.

A critical challenge for anti-corruption efforts identified in KIs is weak engagement and interest from the general public to demand for increased transparency and accountability. It is unclear whether this is due to perceived low chances of success for inducing change and holding perpetrators accountable, a genuine low interest in the topic based on other priorities, or different reasons.

There is a general lack of proactive transparency and an unavailability of data, for example for public procurement, making it difficult for CSOs and investigative journalists to engage in monitoring of procurement and document cases of corruption. A Right to Information Act that was ratified in 2014<sup>31</sup> and provides CSOs and citizens with power to seek information and documentation from the state with regards to decision making and operations. The Information Commissioner's Office was established to uphold the Act. It stipulates that a request for information submitted to the government must be processed within 21 days. A redress procedure can be exercised if a response is unsatisfactory.<sup>32</sup> Under this Act, whistleblowers who make public information on corrupt or illegal activities are protected.<sup>33</sup>

Regarding the media, freedom of the press remains a contentious issue in the Maldives. In 2016, under the previous political administration, the Anti-Defamation and Freedom of Expression Act was ratified. This Act criminalized defamatory speech, remarks, writing and actions. It gave the state the power to shut down media outlets found to be creating and distributing defamatory content, as well as issue fines or jail sentences up to six months. It also required journalists accused of defamation to reveal their sources.<sup>34</sup> This Act has since been repealed by the current administration, but according

to Reporters without Borders, police still use physical force against journalists at protests and demonstrations. The Maldives currently ranks 72 out of 180 countries assessed on the World Press Freedom Index.<sup>35</sup>

## 2.8 Informal Networks and Kinship Relations

As is the case in many SIDS and other countries with small populations, there are strong informal networks and kinship relationships that unofficially govern Maldivian society and political life. Ethnographic work indicates that there is a historical socio-political elite that established the social hierarchy during the time of the monarchy and still persists today.<sup>36</sup> This elite, to a large extent, occupies the upper echelons of political parties, SOEs and private companies thereby influencing and controlling both politics and the economy. KIs stated that around 20 families based in Malé belong to this elite group. The concentration of socioeconomic power contributes to the Malé – atolls divide in the country and is reflected in the disproportionate distribution of services, opportunities and wealth in the capital.

Politics are above kinship with regards to how this elite group is organized. However, kinship and friendship still do play an important role. Particularly siblings and siblings-in-law can offer social and political leverage and it is not uncommon for politically driven members of the elite to enter into politically-strategic marital alliances.<sup>37</sup> KIs indicate that such relationships are commonplace throughout society.

Even beyond the elite group, the saying in the Maldives goes “everyone knows everyone” with strong expectations of reciprocity. This creates a fertile ground for conflicts of interest, nepotism and other corruption vulnerabilities in all facets of social and political life.

12 See UN Office of the High Representative for the Least Developed Countries, Landlocked Developing Countries and Small Island Developing States and UNOPS for an overview.

13 Global Detention Project (2020), [Maldives Immigration Detention Data Profile](#).

14 The President's Office, Republic of Maldives (2015), [President decides to change official Government working hours from 8 am to 2 pm](#). Press Release.

15 Note that within the Ministry of Health, Special Duty Allowance is generally not provided, except to those working in the Quality Assurance Division.

16 KIs related that there is a significant degree of opacity in public sector allowances. A recent review of the system has shown that there are 54 different types of allowances that are being paid, three of them are for clothing, including a “Sock and Tie” allowance. Some types of allowances are received by only a few people, one of them is only received by one person.

17 International Labour Organization (2018), [Bill of Protection of Whistleblowers](#).

18 Republic of Maldives (2020), [Corruption Reporting Mechanism](#).

19 Transparency Maldives (2014), [Failure to disclose assets: A pathway to corruption](#). Position Paper.

20 See a [short list on the Auditor General's Office website](#).

21 The [Prevention of Money Laundering and Financing of Terrorism Act \(10/2014\)](#) includes provisions regarding the investigation and reporting of beneficial ownership by so-called “reporting entities”.

22 Maldives Independent (2019), [Overdue asset disclosure within a week, president's office assures](#). Politics.

23 Sun Media Group (2021), [Embattled ACC members resign](#). 27 December 2021.

24 Republic of Maldives (2018), [Functional Translation of the Constitution of the Republic of Maldives 2008](#).

25 International Labour Organization (2013), [Maldives Freedom of Peaceful Assembly Act \(Act No. 1/2013\)](#), ILO Database of national labour, social security and related human rights legislation.

26 US Library of Congress (2016), [Maldives: President Ratifies First Amendment of Freedom of Peaceful Assembly Act](#).

27 CIVICUS (2021), [Despite UN Review, Maldives Authorities Crack Down on Protests and Target the Media](#).

28 Freedom House (2022), [Freedom in the World 2021: Maldives](#).

29 International Labour Organization (2003), [Associations Act \(1/2003\)](#).

30 Freedom House (2022), [Freedom in the World 2021: Maldives](#).

31 Maldives Media Council (2014), [Functional Translation of the Right to Information Act \(01/2014\)](#).

32 Transparency Maldives [provides step-by-step guidance on how to submit a request and the stages of redress](#).

33 Freedominfo.org (2014), [Maldives President Signs RTI Bill into Law; 99th in World](#).

34 International Federation of Journalists (2016), [Maldives approves defamation law curtailing press freedom](#).

35 Reporters without Borders (2021), [2021 World Press Freedom Index - Maldives](#).

36 Overton Colton E (1995), [The elite of the Maldives: sociopolitical organisation and change](#), London School of Economics and Political Science.

37 *ibid.*

## 3 Health Sector Corruption Perceptions and Experiences

There is a general perception among the Maldivian population that the health sector is corrupt. This is congruent with overall high perceptions that the wider government is involved in corruption, particularly members of government and parliament, judges and magistrates. Ninety per cent of all respondents of the 2020 Global Corruption Barometer (GCB) from Transparency International said that corruption in the government was a “big problem”. Freedom House’s latest assessment also concluded that corruption is endemic at all levels of the Maldivian government.<sup>38</sup>

According to the 2013 GCB,<sup>39</sup> the health sector is the public service that the largest proportion of respondents interacted with in the past 12 months. Thirty-two per cent of respondents indicated that the health system was extremely corrupt. However, only 2% of respondents reported paying a bribe for services; 69% of respondents who paid a bribe for any public service indicated that the reason was to speed up service provision. Looking to the 2020 GCB,<sup>40</sup> rates of reported bribery were again very low, with only 1% of respondents indicating that they had paid a bribe when accessing health services. Separately, the GCB inquired as to whether respondents used personal connections to access health services, and 10% indicated that they had done so. The main reasons included to receive a better service (43%) or to ensure that the service was received at all (35%). These results were supported by informal interviews with health

service users, who had never paid or been requested to pay bribes to access services, but who did regularly call upon informal networks and contacts within the health sector to access services faster. KIs considered the GCB reported rate of personal connections to access health services to be too low and indicate that high levels of public perception of corruption do coincide with higher rates of actual experienced petty corruption than is reported. This suggests that other forces are contributing to the high perception.

According to Transparency Maldives, their Advocacy and Legal Advice Center, a unit to which regular citizens can report their lived experiences of corruption, has not received any allegations of health sector-related corruption to-date. This could mean that patients are simply unaware of reporting and redress mechanisms when faced with health sector corruption, that petty corruption involving financial or in-kind exchange is not commonly occurring at the service delivery level or these exchanges are not considered by citizens as a form of corruption as suggested by consistently low levels of reported bribery.

Finally, in a 2021 report from the Maldives Anti-Corruption Commission (ACC) on the number of cases submitted to them in 2020, 69 cases were registered from the Ministry of Health (MoH), the highest number for any government ministry.<sup>41</sup>

38 Freedom House (2022), *Freedom in the World 2021: Maldives*.

39 Transparency International (2013), *Global Corruption Barometer 2013 – GCB2013 Data* [xls].

40 Transparency International (2020), *Global Corruption Barometer 2020 – Maldives*.

41 Maldives Anti-Corruption Commission (2021), *Statistics Book 2020*.

# 4 Mapping of the Maldivian Health Sector

The health sector of the Maldives is predominantly public, with support from private and non-profit healthcare providers. Clause 23 Section C of the Constitution of the Maldives outlines that good standards of healthcare are the right of every citizen and the State will undertake to “achieve the progressive realisation of these rights by reasonable measures within its ability and resources”. The state’s obligations to provide these good standards of healthcare with special considerations for children, youth, elderly and disadvantaged populations, is laid out in the 2008 Constitution.

There are many entities within the Maldivian health system that are either directly or indirectly responsible for realizing this constitutional right of citizens. The following figure depicts the results of a mapping exercise to identify

all relevant entities involved in the governance of the health sector organized into the following categories of responsibilities,

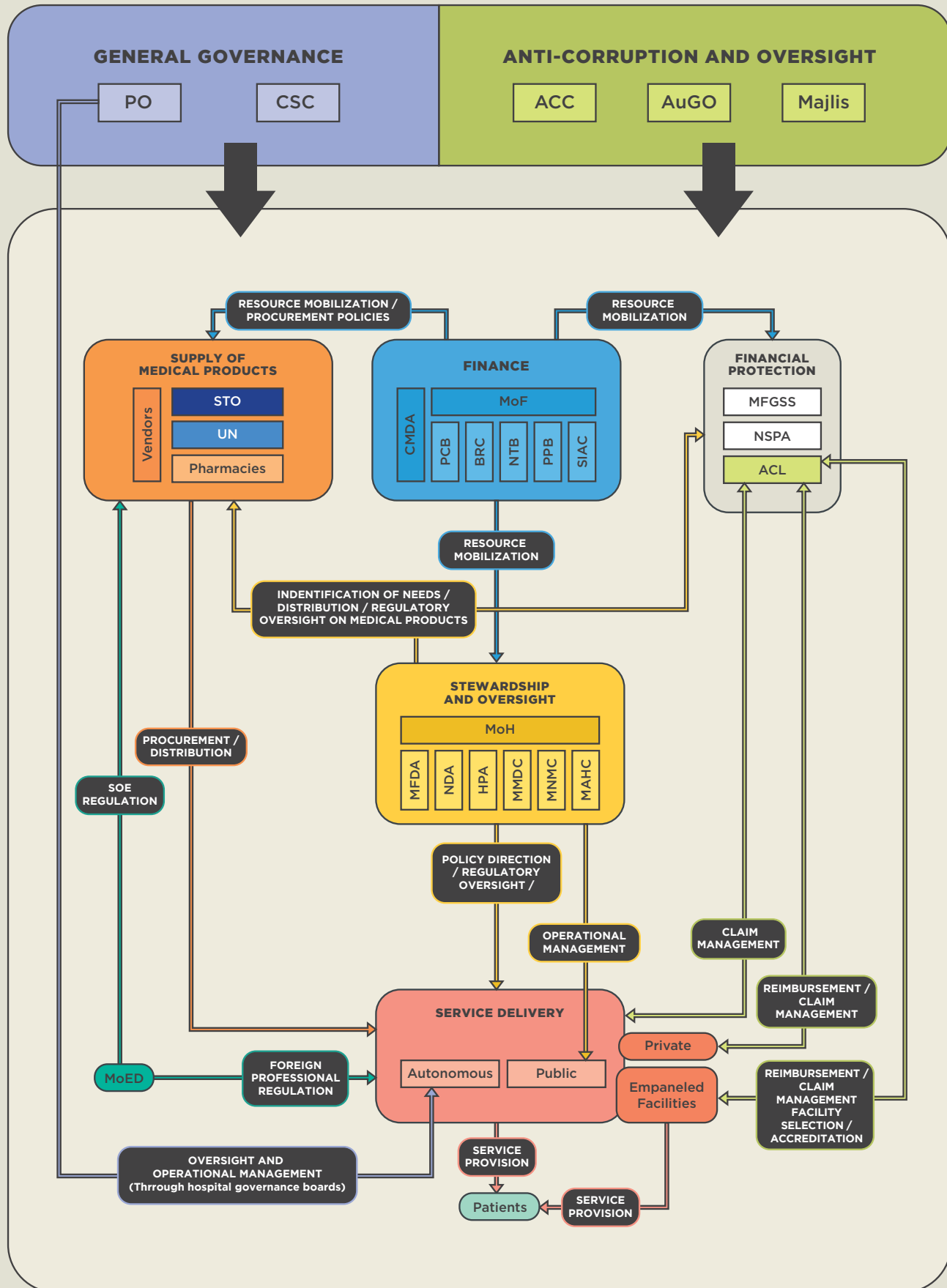
- 1) Stewardship and Oversight
- 2) Finance
- 3) Financial Protection
- 4) Supply of Medical Products
- 5) Service Delivery
- 6) General Governance
- 7) Anti-corruption and Oversight

All relevant entities and their functions are described briefly below. Further details of the major institutions are provided in Annex II.





# Figure I: Mapping of the Maldivian Health Sector



#### 4.1 Stewardship and Oversight

The primary institution responsible for the overall stewardship, implementation, regulation and oversight of the public health sector is the MoH. Under the current Health Services Act (29/2015), the MoH is the national authority for health policy, regulation, public health facility management and operations, as well as quality assurance. It is also responsible for determining sectoral procurement needs and initiating public procurement tenders; the Central Medical Supplies Division (CMSD) within the MoH is responsible for the administration of procurement for public health facilities.

The MoH is the regulatory body for medical education and sets professional standards in the country. It houses the secretariats for the following professional councils, the Maldives Medical and Dental Council (MMDC), Maldives Nursing and Midwifery Council (MNMC) and the Maldives Allied Health Council (MAHC). These councils are responsible for the accreditation and licensing of the local and foreign healthcare workforce.

The Maldives Food and Drug Authority (MFDA) is an affiliate agency of the MoH. It is responsible for the regulation of medicines and therapeutic goods imported, distributed and sold in the Maldives. This includes product registration and approval (overseen by the National Pharmaceutical Board; NPB), composition of the Essential Medicines List (EML)<sup>42</sup> and the Approved Drug List (ADL),<sup>43</sup> as well as registration and licensing of pharmacies and medical storage facilities. MFDA is also responsible for enforcement of quality, efficacy and safety standards, including inspection of pharmacies and medical storage facilities, medicines import and port control in Malé.

Two other relevant agencies under the auspice of the MoH are, 1) the Health Protection Agency (HPA) responsible for health promotion and disease prevention, such as regular vaccination, and major communicable diseases such as tuberculosis and HIV; and 2) the National Drug Agency (NDA) responsible for prevention and support service for harmful and narcotic drug use.

#### 4.2 Finance

There are a number of entities involved in the mobilization of finances for the health sector. The Ministry of Finance (MoF) holds primary responsibility for the administration of the country's macroeconomic framework. It is the steward of national procurement policy and guidelines through the Procurement Policy Board (PPB) and the National Tender Board (NTB). The NTB is responsible for the review of procurement tenders above a set threshold of MVR 5 million. The MoF also houses a number of boards and committees relevant from a governance perspective. The Bid Review Committee (BRC) is responsible for investigating procurement bid complaints, as well as suspension-related cases. The State Internal Audit Committee (SIAC) is also under the auspice of the MoF and carries out audits. The Privatization and Corporatization Board (PCB) is responsible for the oversight

of SOEs. It is an autonomous body apart from the MoF. SOEs that are in part publicly owned are overseen by the Capital Markets Development Authority (CMDA), and independent government institution which has a separate governance code.<sup>44</sup>

#### 4.3 Financial Protection

The National Social Protection Agency (NSPA) oversees the national social health insurance scheme, Husnuvaa Aasandha (HA), that provides universal health coverage to all Maldivian citizens. The NSPA sits under the Ministry for Family, Gender and Social Services (MFGSS). The HA is administered by the SOE, Aasandha Company Limited (ACL), in the Maldives and at empaneled facilities abroad that offer health services not available in the country.

There are also private insurance companies that offer health service coverage, however, the proportion of the Maldivian population using private health insurance is very low and was not included as part of this investigation.

#### 4.4 Supply of Medical Products

The supply of medical products is carried out by a mixture of SOEs, private companies and UN agencies. The vast majority of medical products used in Maldives are imported from vendors.

The State Trading Organization (STO), is a publicly-listed, majority SOE (81.63% state owned, 18.37% publicly owned),<sup>45</sup> specialized in the importation, wholesale and retail of diverse goods. It is under the oversight of the CMDA. STO is the largest importer of goods to the country and is the primary partner for the procurement of health commodities. STO maintains a tripartite memorandum of understanding (MoU) with the MoH and MoF to carry out health sector procurement.

Various UN agencies carry out their own procurement and distribution of commodities for vertical disease programming, such as those in support of the HPA, for example, UNICEF for vaccines and the WHO for tuberculosis and HIV medications.

Pharmacies that are owned by STO or private companies are spread throughout the country. The national distribution of publicly procured products is arranged and carried out by STO.

#### 4.5 Service Delivery

The delivery of public health services is provided by a network of 186 health facilities that are overwhelmingly under the auspice of the MoH. The major hospitals, such as the tertiary and specialist hospitals in Malé, are autonomous and are overseen by the PO.<sup>46</sup> For health services not available in the country, service agreements have been created with empaneled hospitals in India and Sri Lanka.

There is also a network of private facilities both in the capital and across the atolls, including private clinics on tourist islands. Private facilities were not included as part of this investigation. The Ministry of Economic Development (MoED) is responsible for the regulatory environment of business operations within the country.<sup>47</sup> Within the health sector, the MoED oversees the regulation of SOEs, and is also

responsible for aspects of employment and human resource regulation, for example the issuance of visas for foreign recruited healthcare professionals.

#### 4.6 General Governance

Two key entities responsible for general public sector governance include the PO and the Civil Service Commission (CSC). The PO is responsible for executive national governance in accordance with the Constitution, and specifically for the health sector, the appointment of hospital Boards and CEOs of relevant SOEs. The CSC is an independent body responsible for the regulation and implementation of the Maldivian civil services in accordance with the Civil Service Act.<sup>48</sup> In the health sector, the CSC oversees recruitment and dismissal of professional public staff and upholds the civil servant's Code of Conduct.

#### 4.7 Anti-corruption and Oversight

There are three primary entities responsible for anti-corruption and oversight for public services generally, and the health sector specifically.

First, the Anti-corruption Commission (ACC) which was established in 2008 as an independent statutory institution. The ACC is responsible for preventing corruption within the public sector of the Maldives.

Second, the Auditor General's Office (AuGO), which is responsible for carrying out audits of all government institutions, accounts and government trading bodies to ensure public accountability, good governance and sound financial management of public resources. The AuGO is also responsible for the regulatory oversight of the audit process. Third, the Public Accounts Committee of the People's Majlis (Parliament), which is the ultimate oversight body for public spending.

42 Maldives Food and Drug Authority (2018), *Essential Medicines List - 2018*.

43 Maldives Food and Drug Authority (2021), *Approved Drug List - Number: MTG/RE-AL/Li 0009/2021-0009*.

44 Capital Market Development Authority Maldives (2014), *Corporate Governance Code*.

45 State Trading Organization (2021), *4th Quarter Report 2020*.

46 Ministry of Health Maldives (2019), *Health Facility Registry (Updated as of 23.06.2019)*.

47 Ministry of Economic Development Maldives (2021), *Vision, Mission, Mandate*.

48 Maldives Civil Service Commission (2007), *The Maldivian Civil Service Act*.

# 5

## CORRUPTION VULNERABILITIES IN THE HEALTH SECTOR

This section of the report takes a critical look at the *de jure* functions and responsibilities of the institutions relevant for health sector governance as highlighted in the mapping, considers any gaps in existing legislative, regulatory and policy frameworks, and compares this to the *de facto* execution of institutional functions and responsibilities to identify vulnerabilities for corruption. It considers six relevant components of the health sector,

- 1) Health Governance and Regulation
- 2) Service Delivery
- 3) Hospital Governance and Administration
- 4) Health Workforce
- 5) Health Financing
- 6) Health Procurement and the Medical Supply Chain.

A condensed overview of all vulnerabilities is provided in Annex I.

### 5.1 Health Sector Governance and Regulation

As illustrated in Section 4, there are many stakeholders involved in the governance of the public health sector. Arriving at a basic understanding of these different stakeholders, their responsibilities and how they interoperate was a considerable challenge. During KIIs, there were frequently instances where senior public servants and sectoral experts were uncertain of the different roles, mandates, responsibilities of certain institutions or processes. For example, respondents struggled during interviews with the exact identification of current institutions, regulations and practices for tendering medical consumables versus tendering medical equipment.

Generally, there is a dearth of publicly available information regarding the institutions themselves, their functions, areas of responsibility, policies, procedures, reports, action plans. Where information is available it is often not easy to access, dated and/or provided in Dhivehi only.

This opacity has led to concerns about whether intra- and inter-institutional structures and their mandates are fit-for-purpose or if there is sufficient institutional independence. For example, there is general concern from health experts in the Maldives that the MoH functions as both the provider and the regulator of service provision – roles that should preferably be separate. There is also no clear separation between the MoH and regulatory bodies like the MFDA, or the MoH and professional councils, which should be independent, but are housed within the same building. Within the MoF, there is a similar trend. There are several governance and oversight boards relevant for procurement that require autonomy and independence such as the NTB, the BRC, and the PCB. However, these boards are closely linked to the MoF with their secretariats located in the MoF and the permanent secretaries are

MoF staff members. Undue influence on these entities may prevent them from appropriately discharging their mandate, as has been noted in KIIs.

Lack of clarity regarding institutional independence and the failure to disclose relevant documentation can also create opportunities for conflicts of interest that lead to opportunistic behavior and influence decision making. KIIs indicate that there are staff within the MoH who work in private companies and there are open secrets of civil servants and politicians owning or having shares in healthcare companies or private health facilities.

Proactive disclosure of these activities through declarations of conflicts of interests and assets by public servants, politicians and those working for SOEs are either not required, not comprehensive, not transparent or have little consequence. According to KIIs, there are policies that outline conflict of interest management and whistleblowing, including within the MoH, though no documentation outlining such policies is publicly available. Within the CSC's Code of Conduct for those working in the public health sector there are no conflict-of-interest rules or regimes included (see section on Health Workforce). The conflicts of interest policy for MoH staff only considers conflicts related to kinship ties and does not include any interests related to private sector activities, such as working for or owning a private company.

A further concern is the trend of political appointments from the PO for high profile and important executive positions within line ministries and their affiliate agencies. All health-related governance bodies are led by political appointees (PAs). According to KIIs, this is a new feature introduced by the current government and is identified as an important problem. For example, a number of State Ministers are also the heads of specialized agencies, such as the MFDA and the HPA. There is no publicly available information regarding the appointment procedure, criteria or accountability structures for PAs. Appointees may not possess the necessary qualifications for the assigned post. Therefore, they often come to the helm of these institutions from the outside without experience or a career in the field. Civil servants working under PAs are obliged to follow their directives, which may be ill-informed. It is also possible that key positions are being used to exercise influence for example through nepotism or clientelism and control over political and financial decision making in the health sector. Finally, the high turnover of PAs prevents strong and continuous institutional capacity and leadership development. Over the past five years, the average time in office of the Health Minister was around one year. The importance of continuous leadership and long-term sectoral/institutional strategies cannot be overemphasized, as they appear an insurmountable challenge for any country. The boards and chairpersons of major hospitals, such as

Addu Equatorial Hospital Governing Board,<sup>49</sup> Kulhudhuffushi Regional Hospital Governing Board,<sup>50</sup> the Malé Hospitals Board of Trustees for Indira Gandhi Memorial Hospital (IGMH), are also all appointed by the President.<sup>51</sup> There is no publicly available information detailing the terms of reference for these boards. Such appointments bring with them inherent conflicts of interest. Consequently, there have been accusations of nepotism within the current government, with many high-level positions, including beyond the health sector, filled with relatives and friends of the leading and coalition parties.<sup>52</sup>

A further challenge to health sector governance is that misconduct or non-compliance are frequently not identified or sanctioned. According to KIs, within the MoH there is a grievance mechanism for staff to lodge a complaint, as well as a recently established Internal Auditor and Chief Accounts Executive who are responsible for carrying out internal controls and facilitating the AuGO's annual audit. However, again, there is no publicly available information to support this. Effective and timely oversight may be limited by the lack of internal audit functions in key institutions. Both the MoH and IGMH have only recently established this function. Additionally, external audits are often delayed. Furthermore, sometimes laws, rules and regulations are not followed, yet there are no mechanisms for sanctioning. For instance, the PCB in charge of overseeing SOEs has no means to sanction them. This body was set up in 2013, but its members were first officially appointed in 2019, meaning that it was functioning for six years without official implementation.

Where oversight is carried out, this does not lead to corrective action or improvements in the health system to address inefficiencies or corruption vulnerabilities. Apart from sanctioning perpetrators, the main objective of oversight is for it to lead to improvements of the system. Findings and cases from audits and investigations should inform changes to internal controls, compliance organizations, and governance mechanisms to create a more robust system that will prevent similar issues from happening again. KIs have identified this as a major weakness in the Maldives in general, and in the health sector in particular. This is made even more problematic by the rapid rate of government and health sector reforms, which often do not take into account investigation findings and consequent recommendations. At present, there are at least eight recent, ongoing or pending reforms in the health sector, many of which do not respond to actual sectoral improvement needs. An example is the proposal to decentralize the entire system thereby adding an additional level of administration. See Annex III for details.

## **CORRUPTION VULNERABILITIES: HEALTH GOVERNANCE AND REGULATION**

**There are a number of vulnerabilities inherent in the way the public health sector is structured and how its institutions discharge their duties. In particular, the apparent lack of accountability and failure to implement recommendations perpetuate systematic weaknesses that persist through frequent reform efforts that have been conducted or are ongoing.**

**The following vulnerabilities for corruption have been identified:**

### **1. Institutional structure**

The lack of separation between institutions whose roles and responsibilities require independence may lead to undue influence on these institutions that prevents them from appropriately discharging their mandate.

### **2. Transparency: publicly available information**

The lack of transparent information regarding institutional mandates, roles and responsibilities, policies, procedures, reports, and action plans prevents effective monitoring of and accountability for corrupt practices, which can develop into a culture of impunity.

### **3. Conflicts of interest**

Conflicts of interest may lead to regulatory or state capture whereby the health system becomes designed in such a way that it allows abuse. Alternatively, it creates or compounds a lack of political will to change system failures for those benefiting from the status quo. It may further incentivize staff not to perform duties in the best interest of the people or even exert undue influence on processes (procurement, delivery of services, recruitment, oversight).

### **4. Appointment procedures**

Those in decision-making positions are not appointed through fair, transparent, merit-based processes. The absence of such procedures may lead to the selection of unqualified candidates, lack of loyalty by subordinates, or the expectation that whilst in office they will operate in the best interest of those who appointed them.

### **5. Accountability: identifying and sanctioning misconduct**

Accountability mechanisms are either not in place or not effectively applied. Like a lack of transparency, the failure of holding perpetrators responsible can contribute to a culture of impunity and incentivize continued or future misconduct, including corruption.

### **6. Improvement: findings and recommendations**

Corruption vulnerabilities identified through audits and investigations are not addressed through corrective action or improvements in the system thus allowing for systemic inefficiencies and corruption schemes to persist. The failure of findings to induce change and recommendations not being followed up by improvements render the oversight process pointless. This leads to fatigue on the side of watchdog agency staff and disinterest in the general public to carry out monitoring and demand accountability – both of which critically harm the effectiveness of the fight against corruption.

49 The President's Office, the Republic of Maldives (2021), [President constitutes Governing Board of Addu Equatorial Hospital](#), Press Release.

50 The President's Office, the Republic of Maldives (2021), [President constitutes Kulhudhuffushi Regional Hospital Governing Board](#), Press Release.

51 The President's Office, the Republic of Maldives (2020), [President reconstitutes and renames Malé Hospitals Governing Board as Malé Hospitals Board of Trustees](#), Press Release.

52 Maldives Independent (2019), [Jobs for activists raises questions over political appointments](#), 27 March 2019.

## 5.2 Service Delivery

### 5.2.1 Domestic Health Services

Over the past 50 years, the Maldives has made significant progress in improving the health outcomes. Between 1970 and 2019, the average life expectancy increased from 44 years to 78 years (81 years for women, 77.5 years for men).<sup>53</sup> The maternal mortality ratio decreased from 119 to 27 deaths for 100,000 live births between 2002 and 2015.<sup>54</sup> Today, nearly all births (95%) are delivered in a health facility and all facility births are attended by a skilled health provider.<sup>55</sup> Between 1980 and 2019, infant mortality decreased from 103 to 6.5 deaths<sup>56</sup> and under-5 child mortality from 150 to 7.6 deaths for every 1,000 live births respectively.<sup>57</sup> Child immunization rates have historically been consistently high, although results from the latest Demographic and Health Survey suggest that rates of vaccination have been declining from 93% of all children under two years in 2009 to 77% in 2016.<sup>58</sup> The country has a disease burden profile that resembles that of high-income countries with non-communicable diseases, like cardiovascular diseases, diabetes and chronic obstructive pulmonary disease, responsible for over 85% of all premature deaths.<sup>59</sup>

These positive advances can be attributed in part to the expansion of healthcare service provision across the country. Public health services for citizens are funded through the national health insurance scheme, HA, administered by ACL. HA is explained in more detail below. Although through this scheme citizens are provided universal health coverage, accessing health services practically can be a challenge due to the limited number of professionals, particularly specialists, working in the public sector or inefficient allocation of quality health professionals across the country. This is reflected in the results from the GCB and KI responses that patients use their personal relationships to jump queues or access services faster. There currently is no standard system for referral, for example, from a general practitioner for more specialist care and patients seek care even for minor ailments from specialists directly. Additionally, there has historically been no transparent waiting lists, strict triage or referral protocols.<sup>60</sup>

There are many tertiary services, as well as prescription medicines, that are not available in the country and for which patients must travel abroad or go without. This creates a problem for both continuity of care in the country and has led to dissatisfaction with service provision within the population. Specialists and tertiary hospitals located in the Maldives often have very long waiting lists and systems for triage are overridden by patients using their personal relations and contacts to access services faster. There is dissatisfaction among the population that more comprehensive service provision is not available in the country.<sup>61</sup> It is possible that in lieu of petty corruption at the point of service delivery, high levels of perceived corruption result from difficulty in accessing services, which is at least in part caused by people using their personal connections, or certain services being entirely unavailable in the country.

KIs indicate that such challenges to service provision are in part a result of the dispersed nature of the country's geography and population that makes it difficult to maintain qualified healthcare professionals in rural posts. Although there each island has a health facility, it may not be able to deliver a wide range of services. A lack of human resources also impacts the consistent implementation of regulations, as well as monitoring efforts and managing health service delivery, including medical product stock management, for example.

### **CORRUPTION VULNERABILITIES: DOMESTIC SERVICE DELIVERY**

**There is an incongruity between levels of public perception of corruption in the health sector and actual experiences of corruption when accessing services. This suggests that petty corruption is not contributing to public perception of corruption, which is unusual, as countries with low levels of petty corruption tend to score well on perceptions-based indicators.**

#### **The following vulnerability for corruption has been identified:**

##### **1. Access to services**

Patients use their personal relationships to avoid waiting lines, jump the queue and access services quicker. This results in inequal access and may contribute meaningfully to the high public perception of corruption in the health sector.

### 5.2.2 Medical Travel Overseas

Although healthcare provision in the Maldives has expanded rapidly, the system is not able to provide comprehensive care for all forms of disease. Consequently, ACL imports services from neighboring countries. Under the HA scheme, patients are covered for travel and care expenses at 41 empaneled providers in India and Sri Lanka that have signed memoranda of understanding. The administrator of the scheme, ACL does not seek out or approach health facilities abroad to become an empaneled facility. Instead, facilities approach ACL or NSPA for consideration. ACL has offices located in both countries and sometimes does site inspections of prospective facilities, but there is no standard accreditation process.

For non-emergency procedures at overseas facilities, coverage from HA is provided up to four times per year; the travel costs for someone to accompany the patient are covered for at least one journey up to four journeys depending on the circumstance. The decision to send someone abroad for non-emergency medical care under HA is determined by a specialist referral recommendation that is reviewed by ACL's Medical Authorization Team, which consists of skilled nurses and two consultant physicians. Care provided through imported health services under HA is sought predominantly for accident or injury, cancer treatment, circulatory diseases, and complex health status diagnostics and care (e.g., drug resistance, genetic anomalies, etc.) not available in the Maldives.<sup>62</sup> Based on the assessment of referral, ACL will select

a number of hospitals to provide the prescribed procedure from which the patient can choose. Patients who select to attend overseas hospitals that are higher end must contribute a co-payment for the value above and beyond the cost of the facilities suggested by ACL. Services provided at hospitals overseas must be pre-authorized. For example, a patient must first acquire the needed diagnosis and submit the results for any follow-on procedures, operations, or prescriptions to be covered under HA.

Data from the period of 2007-2017 indicated a total average annual spend of MVR 1 billion (USD \$65 million) for overseas medical care.<sup>63</sup> According to the MoH National Health Accounts 2015-2017,<sup>64</sup> the proportion of health expenditure for overseas medical services declined in both proportional and nominal terms dropping from 24.5% (MVR 656 million; USD \$42.5 million) in 2011 to 2.5% (MVR 175 million; USD \$11.3 million) in 2017. While this may suggest that the domestic capacities of the Maldivian healthcare system are expanding and fewer patients must seek care overseas, it could not be confirmed.

There is a general lack of transparency with regards to medical travel overseas including how referrals are made and how medical travel is approved, how empaneled facilities are selected, as well as negotiations for treatment services and their subsequent cost. Research by Suzana et al. indicate that of those hospitals more commonly attended by Maldivian patients, none were accredited by the Joint Commission International and only three of the empaneled hospitals in India had been accredited by the Indian National Accreditation Board for Hospitals.<sup>65</sup> Other research on costs incurred by privately funded patients that sought medical treatment overseas indicated that their medical costs were markedly lower than those receiving care through HA.<sup>66</sup> One would expect that reduced prices can be negotiated based on an expected number of patients per year. According to KIs, controls and checks are being implemented, however,

there is no publicly-available information regarding the extent of services provided and billed by overseas facilities.

## **CORRUPTION VULNERABILITIES: MEDICAL TRAVEL OVERSEAS**

**As the Maldivian health system is not capable of providing all services domestically, some patients receive treatment in selected health hospitals overseas. Organization (selection of patients and facilities), monitoring of quality, as well as adequacy of treatment in foreign facilities are a significant challenge with inherent structural weaknesses that could lead to abuse.**

**The following vulnerabilities for corruption have been identified:**

### **1. Referral for medical travel overseas**

Referrals may be provided for unfounded reasons in an attempt to seek overseas service coverage. If referring physicians (e.g., foreign) have beneficial ownership in empaneled facilities, they may be acting out of personal interest rather than a patient's best interest. If selection is not made based on medical needs, there is the possibility of inequitable access and negative effect on health outcomes if the "wrong" patients whose treatment is less urgent or who have lower chances of successful treatment.

### **2. Overseas health facility selection and accreditation**

It is not possible to rule out conflicts of interest or collusion between empaneled facilities abroad and actors in the Maldives. There is insufficient information to fully understand how and with what criteria overseas health facilities are selected and accredited.

### **3. Pricing and reimbursement for services provided by empaneled health facilities**

There is the potential for collusion between empaneled facilities and actors in the Maldives (e.g., ACL, MoH, etc.) to acquire service agreements, rig reimbursement prices for overseas medical service provision or have patients unnecessarily treated overseas.

53 World Bank (2019), *Life expectancy at birth, total (years) - Maldives*.

54 World Bank (2015), *Maternal mortality ratio (national estimate, per 100,000 live births) - Maldives*.

55 Ministry of Health Maldives (2018), *Maldives Demographic and Health Survey 2016-17*.

56 World Bank (2019), *Mortality rate, infant (per 1,000 live births) - Maldives*.

57 World Bank (2019), *Mortality rate, under-5 (per 1,000 live births) - Maldives*.

58 Ministry of Health Maldives (2018), *Maldives Demographic and Health Survey 2016-17*.

59 World Bank (2019), *Cause of death, by non-communicable diseases (% of total) - Maldives*.

60 Transparent waiting lists have recently been implemented at the IGMH in December 2021. It remains unclear if this system will address issues related to accessing services, including queue jumping. See report [here](#).

61 Suzana M, Walls H, Smith R et al. (2018), *Understanding medical travel from a source country perspective: a cross sectional study of the experiences of medical travelers from the Maldives*. *Global Health* 14, 58.

62 *ibid*.

63 *ibid*.

64 Ministry of Health Maldives (2019), *Maldives National Health Accounts 2015-2017*.

65 Suzana M, Walls H, Smith R et al. (2018), *Understanding medical travel from a source country perspective: a cross sectional study of the experiences of medical travelers from the Maldives*. *Global Health* 14, 58.

66 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.

### 5.3 Hospital Governance and Administration

As of 2019, there were 396 health facilities across the country, of which 186 are public. There are three tertiary and two specialist hospitals belonging to the IGMH Group in Malé, one urban hospital in Addu City, five regional hospitals, 13 atoll hospitals and one military hospital.<sup>67</sup> Each inhabited island has some form of basic health facility regardless of population size with the regional or atoll hospitals intended to be strategically placed to offer higher-level specialty care. Each health facility must be staffed with a minimum of five employees, one doctor or medical officer, three nurses and one administrator. On an island with only 100 inhabitants, the facility may be visited by very few if any patients per day, yet it needs to have equipment and consumables to deliver services as required. This results in a high financial and administrative burden on the health system – and it is very difficult to get qualified staff to work in these facilities on a long-term basis (see section on Health Workforce). Pharmacies are positioned throughout the country. STO alone has a countrywide network of 189 pharmacies.

There is no established primary healthcare referral system and as a result hospitals and specialist physicians are often the first port of call for patients seeking health services, even for minor ailments. There are three kinds of hospitals: private, public and autonomous. The primary tertiary hospital, IGMH, is located Malé. It has approximately 300 beds and operates 21 specialist departments.<sup>68</sup> There is an overwhelming demand for services provided by IGMH and its affiliated facilities on Hulhumalé and Villingili (together referred to as IGMH Group of hospitals). For example, at the time of writing, the waiting list for laboratory services was over 6,000 patients long. Further expansion of IGMH was announced in 2016 with the development of a new, 25-story Dharumavantha Hospital. KIs reported that while Dharumavantha Hospital is now operational, the facility is not fully utilized. In 2019, the government made announcements to upgrade five regional hospitals to tertiary level.<sup>69</sup> As of December 2021, these upgrades are still ongoing.

Regarding service quality, the MoH manages the public hospitals and provides a governance standard for all three types of facilities through the Maldives Healthcare Quality Standards that was developed with support from the World Health Organization (WHO).<sup>70</sup> It contains three quality themes – Structure, Process, and Outcome – defined through 25 Criteria each consisting of five Quality Standards. The criterion governance is limited in scope and at the time of research, MoH has not yet conducted any reviews of implementation in facilities. IGMH is currently in the process of pursuing accreditation according to Indian hospital standards.<sup>71</sup>

There has been a remarkable series of changes to the ownership of public hospitals in the recent past. Prior to 2008, all hospitals were public. Between 2008 and 2011 they were corporatized – even though according to KIs, the small catchment area is an insurmountable challenge to run them profitably. In 2012, all hospitals were returned under the MoH

and made public. In 2014/15, the public hospitals in Malé were again removed from the MoH's remit with IGMH and Villimalé becoming independent or “autonomous”<sup>72</sup> and Hulhumalé put under HA. In 2018, Hulhumalé hospital was merged into Male Group of Hospitals together with IGMH and Villimalé. In 2020, previously public Addu City Hospital became autonomous.<sup>73</sup> Neither publicly available documents nor KIs could identify a stringent approach or rationale for the transformation from public to autonomous hospitals. KIs and review of available documentation indicate that there are significant weaknesses, leaving institutions with poor or no capacity to prevent, investigate or sanction corruption, for example, in procurement or service delivery. Regardless of public or autonomous status, there is a separation of budgetary responsibility and management. Budget responsibility lies with the MoF while managers as civil servants are on a fixed salary.

From a management perspective, autonomous hospitals are outside the mandate of the MoH but are accountable to the PO. Within the PO there is a minister responsible for the oversight of the major public hospitals who appoints both CEO to manage hospital operations and a governing board to oversee operations. According to KIs, hospital boards are responsible for evaluating and resolving issues that are brought to it by the hospital management (e.g., the hospital CEO or the Management Committee) and are remunerated for their efforts. While these boards do not have any executive responsibility, they can provide advice on decisions.

There are currently three boards at the major hospitals mentioned above and efforts are ongoing to upgrade regional hospitals to tertiary level. It is expected that governing boards will also be established for these hospitals. There is no publicly available information detailing the terms of reference of hospital boards, however, the role of the boards is said to be limited to an advisory capacity. According to KIs, the IGMH Group board has developed guiding principles including a code of conduct, but there is no formalized coordination between the IGMH board and other hospital boards to establish a set of standardized governance principles. Included in the IGMH board principles are procedures for conflicts of interest management. It details management of both financial and familial interests. It also disallows hospital board member to also be employed at the hospital at which they serve. However, there is no obligation for board members to fully declare all interests as a general requirement, and conflicts of interest are not recorded or reported. Instead, the IGMH board operates on an honor system whereby members are to be aware of their interests and act in good faith when handling issues presented to the board, for example, by declaring any conflicts of interest based on board meeting agenda items and excusing themselves from those items.

KIs confirmed that issues regarding political appointments as mentioned above (see Health Governance and Regulation) are relevant at the hospital level as well. Hospital managers as well as board members are appointed by the PO. No information is publicly available on what basis these appointments are



made and what criteria for such appointments are. As a result, these positions are often populated with PAs who may not possess the necessary competencies, like a background in medicine, healthcare management or finance. Civil servants working under PAs are obliged to follow their directives, which may be ill-informed. For example, interviewees indicate that cases of medical negligence can be traced back to PAs without a medical background making medical decisions. The established hierarchy is not fit-for-purpose and even potentially dangerous to patient care.

Staff at public and autonomous hospitals are civil servants regulated by and accountable under the Civil Service Act – except for Hulhumalé. Hiring and firing is therefore done by the CSC and salaries are bound to the civil servant pay scale (see section Health Workforce). As civil servants, hospital staff are on fixed salaries that are considered low and are not adjusted based on good performance. The CSC appoints a permanent secretary in the MoH (as in other ministries) who is responsible for all public hospitals and health facilities. It further appoints a Head of Civil Service, in each autonomous hospital. These are staff given additional responsibilities, such as hiring and firing of civil servants in their respective facilities.

## **CORRUPTION VULNERABILITIES: HOSPITAL GOVERNANCE AND ADMINISTRATION**

**The ongoing transformation from public to autonomous hospitals lacks a systematic and robust approach for governance, and the model of administration and management of these facilities may lead to inefficiency and low service quality.**

**The following vulnerabilities for corruption have been identified:**

### **1. System reforms**

The continuous, un-strategic changes to hospital administration create a permanently unstable situation, critically exacerbated by the high turnover of staff and leadership (see section Health Workforce).

The rate and extent of changes themselves represent opportunities to directly exploit the activities of transformation (e.g., additional procurement of equipment, construction, etc.) or for those in power to shape a system, processes, or key position in a way that provides them with opportunities of future corruption. They also hinder attributing accountability. Discovering a violation of an outdated policy raises much less interest than getting caught “red-handed” when the rule is still in place.

### **2. Governance standard and quality assurance**

There is insufficient oversight, monitoring and accountability of public and autonomous hospitals which opens up opportunities for corrupt behavior. The standard set forth by the MoH lacks core governance functions, such as standard hierarchy of policies and procedures, risk management, internal controls, compliance (conflicts of interest management, whistleblower protection, etc.), and internal audit.

### **3. Management and control**

The lack of meritocratic principles in appointments can be caused by and also fuel nepotism or clientelism and contribute to mismanagement by unqualified managers.

The lack of clear roles, responsibilities and reporting lines lead to poor control and potentially undue influence or abuse of hospital operations.

### **4. Transparency**

As with general health sector governance, the lack of transparent information regarding operational mandates, roles and responsibilities, policies, procedures, reports, and action plans for hospitals prevents effective monitoring of and accountability for corrupt practices, which can develop into a culture of impunity. It can also contribute to public perception of high levels of corruption

### **5. Operational efficiency**

Public and autonomous hospital managers, boards and staff have no incentives to ensure high-quality of services and cost-efficiency. This enables poor performance and creates incentives for abuse and corruption.

67 Ministry of Health Maldives (2019), [Health Facility Registry \(Updated as of 23.06.2019\)](#).

68 IGMH (2021), [About Us](#), Website.

69 Malsa M (2019), [Govt to further develop five regional hospitals](#), The Edition, 17 June 2019.

70 Note: this document has not been made publicly available.

71 [National Accreditation Board for Hospitals & Healthcare Providers Website](#).

72 Note that Kils had reservations to the term “autonomous” and instead recommend the term “semi-autonomous”, as hospitals are not autonomous with regards to several key functions, such as budget, human resources, and procurement.

73 Osmanagic A (2020), [AEH and Addu Health Centers to be separated from Health Ministry](#), The Times of Addu, 15 October 2020.

#### 5.4 Health Workforce

The Maldives has a low physician per population ratio of 1.7:1,000,<sup>74</sup> and contends with a chronic shortage of quality health personnel in the public sector. This is most acutely experienced in the atolls due to poor allocation of qualified health professionals on smaller islands, and is also common in urban areas although to a lesser extent, as many quality professionals choose to work in the private sector. Forty-three per cent of all medical personnel are concentrated in Malé with the remaining 57% of health professionals serving the remaining two-thirds of the widely distributed population living in the atolls.<sup>75</sup> Most private clinics and specialist facilities are based in Malé and it is not uncommon for public providers to also moonlight in private facilities where they attend to many more patients than in public practice whilst achieving the same or greater patient satisfaction.

The disproportion of health workers in Malé compared to the atolls is due to a preference for a more urban lifestyle, and opportunities for career progression and higher wages. The public sector cannot offer wages that are competitive with the private sector, thereby contributing to high rates of turnover. According to KIs this prevents continuity and building a legacy of quality care. There are no existing mechanisms to place healthcare workers to assigned locations. Most of the less-skilled community health workers that remain in the atolls choose to do so to stay close to family. KIs relate that in some cases job advertisement processes are limited and suitable candidates living in Malé may be unaware of opportunities on islands. Also, recruitment procedures can be complex and time consuming, thereby reducing the public sector's agility.

Seventy-two per cent of all healthcare professionals, including community health workers, are local, and 28% foreign. However, 69% of all physicians (medical doctors and specialists) are foreign. According to interviews, foreign health professionals typically do not remain in the country for very long, generally leaving after a few years. This contributes to high staff turnover and makes it difficult to ensure a quality health workforce.<sup>76</sup> There are very few general practitioners, which has prevented the introduction of a domestic referral system. There is only one medical school for the training of physicians in the country that was established in 2019 at the Maldivian National University.<sup>77</sup>

As mentioned above, health professionals in the public system are civil servants and are therefore under the Civil Service Act and associated regulations. While this arrangement can offer employees job security, results from interviews indicate that it limits the amount of remuneration that can be offered to health professionals. The Civil Service Regulation mandates the CSC to formulate a Code of Conduct, and there is a CSC complaint mechanism.<sup>78</sup> There is neither a conflict-

of-interest law nor a regime for civil servants other than CSC employees. Conditions for appointment are laid out in the Civil Service Act and the Civil Service Regulation. However, identification of (potential) conflicts of interest is not an explicit part of the recruitment process. Failure to systematically deal with these issues constitutes a significant weakness, especially considering the small country context and the role that kinship and informal networks play.

Following the de-corporatization of the major hospitals to autonomous status, staff were once again relegated under the Civil Service Act. Only staff at Hulhumalé hospital remain outside of the Civil Service Act and can be offered higher wages. As part of the transformation to autonomous status, IGMH aims to have health professionals at the other hospital branches removed from under the Act as a special circumstance to increase competitive recruitment.

The employment of foreign health professionals is regulated and approved by the MoED's Foreign Employment Services under the Employment Act (2/2008). The recruitment of health professionals for the public sector is carried out in accordance with the Civil Service Act and associated regulations. Hospitals and other health facilities looking to hire foreign employees must obtain a quota which sets out criteria for different types of work. There is no information available regarding decision making for the numbers of quotas issued, criteria for issuing them or procedures for visas of foreign healthcare workers. KIs reported problems of undue influence and bribery in the processes related to issuing of quotas for recruitment, as well as irregularities in the process related to ensuring proper qualification of foreign medical staff, such as the job interviews and qualification exams. For those hired to work in the public sector, the MoH covers visa, flight and accommodation expenses. Recruitment is facilitated through recruiting companies located in sourcing countries and in the Maldives. Relationships between recruitment companies and stakeholders in the Maldives are not well understood. KIs indicate that these recruitment companies act as brokers for foreign applicants, in some cases even interviewing on behalf of the applicant. They are said to exploit applicants by unduly demanding high application and recruitment fees. The true extent of these schemes, however, is not captured; there is only testimony available from those who have been unsuccessful in securing a position. The weaknesses in foreign recruitment have long been identified by the ACC. It noted that there was no policy or written procedure for recruitment, no effective screening procedures for healthcare professionals, and no process to regulate or monitor the recruitment agencies for overseas healthcare professionals. According to KIs, these vulnerabilities have not been eliminated, even though it appears that in 2020 or 2021 new hiring procedures were introduced. The

MoF has recently ordered an audit of the department responsible within the MoH for foreign recruitment.

Many foreign health workers hired for employment in the public system will switch to the more profitable private facilities once in the country. In such cases they no longer receive the public wage, but may continue to have their visa sponsored and accommodations subsidized.

Accreditation and licensing of both local and foreign professional qualifications is managed by the three respective medical professional councils, as set out in the Health Care Professionals Act (13/2015).<sup>79</sup>

## **CORRUPTION VULNERABILITIES: HEALTH WORKFORCE**

**Low public sector wages, lack of qualified staff, reliance on foreign workers and high turnover rates are key challenges in the Maldives.**

**The following vulnerabilities for corruption have been identified:**

### **1. Low public sector wages and staff retention**

Low wages may lead to unmotivated employees that rationalize corrupt behavior, including moonlighting. It can also negatively impact on quality of services provided and overall system efficiency.

High rates of staff turnover prevent the establishment of good governance procedures, preventing effective oversight, monitoring and accountability, thereby increasing opportunities for corruption and abuse.

### **2. Appointment procedures**

Lack of transparent procedures for appointing staff or managing conflicts of interest may enable nepotism or other forms of corruption, including bribery, especially by foreign applicants and recruitment agencies.

Complicated and lengthy appointment procedures increase both the urgency for staff, which can exacerbate recruitment-related corruption, as well as understaffing at health facilities, which can have further effects on staff motivation and performance.

### **3. Regulation of foreign health professional recruitment**

Poor regulation and lack of transparency of foreign professional recruitment may lead to bribery or collusion from applicants and recruitment agencies (incl. for issuing of quotas for entry visas), waste of health sector resources spent on recruitment, and contribute to poor system performance through recruits without proper qualification.

### **4. Management and monitoring of foreign health professionals**

Foreign health professionals may abuse the public position that they were hired for by moving to private practice whilst retaining their government subsidized public sector allowances.

74 World Bank (2018), *Physicians (per 1,000 people) - Maldives*.

75 Ministry of Health Maldives (2020), *Maldives Health Statistics 2017-2019*.

76 *ibid*.

77 Shaahunaz F (2019), *MBBS studies to shift to new Medical School in April*, The Edition, 24 February 2019.

78 *Civil Service Act*, sub-section 18f.

79 Republic of Maldives (2015), *Health Care Professionals Act (Law no. 13/2015)*, Gazette: 13 May 2015 (24 Rajab 1436h).

## 5.5 Health Financing

According to the World Bank, the Maldives has the highest health expenditure as a per cent of GDP (9.4%) of all South Asian countries.<sup>80</sup> In nominal terms, the Maldives annually spends 14.5 times more on health per capita (MVR 15,194; USD \$973) than its South Asian neighbors.<sup>81</sup> The government has consistently increased financial commitments to public health. From 2000 to 2016, government spend as a proportion of total health expenditure rose from 34% to 74%.<sup>82</sup> This has contributed to reductions in health-related out of pocket spending (OOPs) for citizens both in proportional and nominal terms. In 2008, OOPs for health stood at MVR 3,900 (USD \$250) per capita and 33.1% of overall expenditure. By 2018, patients were paying on average MVR 3,123 (USD \$200) per capita and 20.6% of overall health expenditure.

In accordance with the National Social Health Insurance Act ratified in 2011,<sup>83</sup> the Maldives provides citizens with universal health coverage. The NSPA oversees the implementation of the scheme. The current social health insurance scheme, HA, was established in 2014 to offer affordable and accessible healthcare without a financial ceiling limit on per capita provisions. HA's predecessor "Aasandha" set an annual per capita ceiling at MVR 100,000 (USD \$6,480) that was removed in 2014.

HA is a non-contributory, single-payer scheme fully financed through the national budget and operates on a set fee-for-service basis. The government budget for health is reliant on economic performance; no contributions are made by the population. The consequences of this design were experienced acutely during the COVID-19 pandemic, which caused a sharp decrease in tourism due to travel restrictions and lockdowns. KIs indicate that a large portion of the annual budget is used to pay for bills of the previous year. This has been reported for both the national budget and for autonomous health facilities. The SOE, ACL, is responsible for the administration of HA. Budgetary allocations for HA are jointly determined by ACL, MoF, NSPA, and PO.

HA is a cashless system. The funds for the HA scheme are allocated through the MoF to public health facilities and hospitals in annual lump sums. Should finances for HA service coverage be insufficient, additional budget is requested by facilities. Maldivian citizens are automatically registered to HA through their national identification cards<sup>84</sup> linked to a centralized system called Vinavi, through which health services are recorded by provider. Under HA, patients are covered for both inpatient and outpatient care and can attend any public or private institution.<sup>85</sup> All services provided in public facilities are fully covered by the HA scheme; services provided in private facilities are also covered up to a set price in the public system, and patients or voluntary private health insurance must cover a co-payment to settle the difference. This can be up to 35-40% of the total service cost. According to interviews, there is a non-publicized list of all services covered under HA and their corresponding prices; prices are revised regularly.

Excessive use of public health services by patients is incentivized by the cashless HA system. Without a referral system, patients can consult specialists directly and the practice of seeking advice for the same problem from different physicians ("doctor hopping") has been reported in KIs as significant financial burden on the system.

The MoH national accounts from 2015-2017 state that outpatient care (including diagnostics and medical commodities) constitutes the largest area of public healthcare expenditure at 59% in 2017. The second largest area of expenditure is inpatient care at 18.1% followed by medical goods not used in out- or inpatient care at 10.4%.<sup>86</sup> KIs indicate that market referencing prices are not used and the mark-ups on medical products are high.

In absolute terms, pharmaceuticals constitute around one-third of all health expenditure (32% in 2017).<sup>87</sup> Data from the WHO indicate that on average patients received three prescriptions per consultation, mostly for more expensive branded medicines. Sixty-one per cent of medical commodity expenditure is covered by the MoH or HA scheme, and the reimbursement of prescription medicines through HA constitutes 40-60% of the total scheme's budget. The remaining 39% of medical commodity expenditure is paid out of pocket by patients and their families.<sup>88</sup> Within five years of the introduction of HA, spending for medical supplies has increased drastically from MVR 300 million to 800 million per month.<sup>89</sup>

Prescription medicines are collected by patients from pharmacies and billed directly through the HA scheme for reimbursement. According to KIs, pharmacy fraud is common. They report that vendors have doctors on their payroll prescribing branded pharmaceuticals for which they have an exclusive right to import. In an alternative scheme, pharmacies will sell generic products but invoice for a branded product that is much more expensive. For some medicines, there is a single importer, and ACL is aware of the amount of the medication in the country. Their data show that as much as ten times the imported quantity is invoiced by pharmacies.

Findings from the 2019 Household Income Expenditure Survey (HIES)<sup>90</sup> indicate that on average citizens spend 3% of their income on health-related costs (3% Malé, 4% atolls). However, these figures do not include any non-emergency transportation to reach secondary, tertiary or specialized care at regional hospitals. Total transportation expenditure amounts to 12% in the atolls and to 8% in Malé.<sup>91</sup> Research by Ministry of Tourism in 2016, however, indicates that domestic medical transportation, both government-subsidized and out-of-pocket, constitutes two-thirds of all travel in the country.<sup>92</sup> Typically, medical transportation costs are not covered under the HA scheme and are instead borne by patients and their families. Similarly, when patients travel to Malé or regional hospitals to receive more advanced diagnostics and care, costs for accommodation, food, and the opportunity costs

of missed work are not covered by HA. These realities make it difficult to decipher total health-related expenditure from the existing data. KIs suggest that these auxiliary health expenditures are a contributing factor for patients to use their personal relationships to jump queues to receive services faster.

The HA scheme is fee-for-service and records of services rendered are reviewed by the claims department of ACL using an SAP claims management software connected to Vinavi. This system was first established in 2017. KIs report that 85% of all HA reimbursements are for services rendered at IGMH; the hospital was only integrated into Vinavi in April 2021. There is no publicly- available information on how prices for HA services are determined or how billing for services not rendered is managed. Although claims and reimbursement fraud has been identified as a considerable problem in the HA system, there has yet to be any alert algorithms installed to identify red flags for upcoding, repeat claims, or other fraudulent irregularities. ACL operates a fraud and investigations unit that does checks claims manually. There have been instances of fraud identified, such as upcoding. One example provided by KIs was that of dentists upcoding for root canals when patients receive a standard prophylactic dental cleaning. In such a case, ACL has the authority to report and clinics and practitioners in question can be fined or suspended. In 2020, a patient-facing application for digital health records was introduced by ACL to increase patient oversight and control of their medical history, prescriptions and services. KIs suggest that this application has been useful in correcting instances of upcoding or overprescribing, acting as a tool for civic monitoring.

Beyond HA, there are private, voluntary health insurance schemes, most often provided through employers. The proportion of the population that subscribes to a private health insurance provider is negligible compared to the public system (max. 2%).<sup>93</sup> According to the MoH, top government officials receive private health insurance through their state employment and premiums are paid for by the government.<sup>94</sup>

## **CORRUPTION VULNERABILITIES: HEALTH FINANCING**

**Institutions responsible for the financing of health services are fundamentally vulnerable to abuse and corruption. Health facilities, care professionals, pharmacies and vendors benefit from poor oversight and wasteful practices while beneficiaries have no incentive to contribute to cost-effectiveness. This leaves the responsibility of preventing and detecting abuse with the financing institutions and watchdog agencies.**

**The following vulnerabilities for corruption have been identified:**

### **1. Rational service use**

The cashless, non-contributory, unlimited nature of the HA scheme incentivizes excessive use and abuse of the public health system. Vendors and users are not incentivized to scrutinize services or provision of consumables or report wasteful practices.

### **2. Reimbursement of services**

Poor oversight of HA's fee-for-service system incentivizes upcoding, over medicalization and repeat consultation due to a lack of comprehensive, efficient prevention, detection and sanctioning.

### **3. Financing of medical consumables**

Similarly, the HA reimbursement system incentivizes abuse and fraud by pharmacies, such as provision of overpriced consumables due to a lack of comprehensive, efficient prevention, detection and sanctioning.

80 World Bank (2018), *Current health expenditure (% of GDP) - Maldives*.

81 World Bank (2018), *Current health expenditure per capita (current US\$) - Maldives, South Asia*.

82 Ministry of Health Maldives (2019), *Maldives National Health Accounts 2015-2017*.

83 Republic of Maldives (2011), *National Health Insurance Act (15/2011)*.

84 Note, only Maldivian nationals are entitled to HA; non-nationals are reliant on private health insurance. KIs report that many illegal residents still receive treatment, putting an additional burden on the public system.

85 Ministry of Health Maldives (2019), *Maldives National Health Accounts 2015-2017*.

86 *ibid*.

87 *ibid*.

88 World Health Organization (2014), *Medicines in Health Care Delivery Maldives Situational Analysis: 26 May - 5 June 2014*.

89 Public Accounts Committee of the People's Majlis, protocol of the session of 22 November 2021.

90 Maldives Bureau of Statistics (2021), *Household Expenditure Household Income and Expenditure Survey 2019*.

91 The HIES does not disaggregate health-related transportation from total transportation costs.

92 Ministry of Tourism (2016), *Study on Domestic Tourism in the Maldives 2016*.

93 Ministry of Health Maldives (2019), *Maldives National Health Accounts 2015-2017*.

94 *ibid*.

## 5.6 Health Procurement and the Medical Supply Chain

The Maldives is heavily reliant on the procurement and import of goods for the health sector, including pharmaceuticals and medical devices. This consumes a large proportion of total health budget. As mentioned above, the costs for pharmaceuticals constitute 32% of total health expenditure, 61% of which is covered by the MoH or HA scheme. The value of medicinal and pharmaceutical products imported to the Maldives has considerably increased over the past decade jumping from USD \$858,849 in 2010 to USD \$3m in 2020.<sup>95</sup> With the exception of goods for HPA, the procurement of all medical consumables is outsourced to the STO via a tripartite non-public MoU between STO, MoH, and MoF.

There are several observable procurement and medical supply chain inefficiencies in product forecasting and quantification, selection, procurement, pricing, and distribution.

### 5.6.1 Forecasting and Quantification

Major procurements for the public health system are carried out at the central level on an annual basis. There are several systems used for product forecasting and quantification, none of which are based on actual demand. There are a number of problems with acquiring sufficient stock and ensuring that products are where they are needed at the right time in the right quantity. As a result, existing consumption data does not reflect actual need.

According to a situational analysis from the WHO<sup>96</sup> and confirmed by KIIs, there is no standard system for quantifying health facility needs, product ordering or managing stocks. It is therefore not possible to determine consumption, appropriately forecast future stock requirements and necessary procurement quantity. Medicines are ordered when they are out of stock or about to be out of stock – and even when ordered timely, there are delays in the supply from STO. Reports indicate that health facilities neither use inventory sheets to track incoming and outgoing products nor keep a record of the product balance. In most facilities the inventory sheets only record the minimum number of units of a product that should be available and occasionally these numbers do not match what was actually present. This suggests that health facilities, MoH and STO do not know the available or needed stock. Such a situation leads to poor service provision, wastage and makes placing bulk procurement orders – that could bring about greater value for money – difficult if not impossible.

For medical consumables, the STO and MoH have no data on consumption. Hence, the MoH sets budgets based on past purchase orders and the STO quantifies them based on historical purchase data collected through its own electronic management information system. Purchase data is not proactively shared with the MoH or connected to any centralized stock management system.

According to KIIs, the MoH reviews the annual requests for consumables made by health facilities and reduces their request as it sees fit. Health facilities anticipate order cutbacks

and so knowingly request more products than they actually need, hoping that after reductions by the MoH they will end up with the required amount.

In sum, the lack of consumption data based on standard and interconnected quantification and stock management systems leads to frequent over- or undersupply of medical products, and consequently to stock outs or spoilage due to product expiration. For example, in 2013, medical consumables totaling MVR 6 million (USD \$389,000) expired.<sup>97</sup>

### 5.6.2 Product Selection

The MFDA coordinates the Essential Medicines List (EML) which includes 440 items.<sup>98</sup> There is also an Approved Drug List (ADL) used for items covered under the HA scheme that includes over 3,200 eligible items.<sup>99</sup> Data from the WHO<sup>100</sup> indicate that upwards of 30% of medicines in the public sector and 40% of medicines in the private sector are not on the EML. There are also significant price differences for similar brands and molecules covered under HA. Most commodities in circulation in the Maldives are branded rather than more cost-effective generic products, even when therapeutic equivalents are available. According to the MoH,<sup>101</sup> most products on the ADL are branded. The WHO<sup>102</sup> also found that almost all prescriptions were branded products. The same WHO report also states that even some of the most commonly used products with generic alternatives, such as paracetamol, antibiotics and vitamin solutions, were all listed under branded names on the ADL. With regards to why this is the case, it was indicated that the MoH does not want to “compromise on quality”. Included in the MoH's 2016-2025 Health Master Plan,<sup>103</sup> and the government's 2019-2023 Strategic Action Plan are objectives to create a mechanism to increase the use of generic products and address high medical commodity expenditure.<sup>104</sup> The MFDA was appointed to take the lead for this work and a few reforms have recently been or are about to be implemented (see Annex III).

### 5.6.3 Product Procurement and Import

The MoF is the government agency responsible for oversight and monitoring of procurement by government institutions in accordance with the Public Finance Act (3/2006) and Regulation (2017), specifically Chapter 10. Annual procurement plans should be submitted to MoF as per the Public Finance Regulation and a circular issued by MoF. However, according to KIIs, there are no penalties for non-submission; even though MoH has consistently not submitted an annual plan, it can still conduct its procurement. Without a procurement plan, there is no mechanism in place for the MoF to effectively monitor procurement against need. KIIs identified that the time it takes to carry out procurement using existing procedures is very long. It can also be a challenge to procure specific products and thus difficult to provide the right products of the right quality at the right time. Procurements are often carried out in haste, and this can lead to an overreliance on, or abuse of, single-source procurement and emergency procedures. According to KIIs, tenders are frequently carried out using single stage bidding processes.

The division responsible for health sector procurement

within the MoH is the Central Medical Supplies Division (CMSD). At the time of this review, there was no publicly available information about the CMSD. In May 2021, the MoH decentralized procurement, empowering regional health facilities to conduct their own procurement. Health facilities can now procure up to a value of MVR 35,000 through their respective bid committee. Regional hospitals can procure up to MVR 5 million and above MVR 5 million through MoH or the NTB, respectively.

STO procures between 90-99% of all medical products that enter the country. The MoU establishes a single-source procurement agreement with STO outsourcing the responsibility for procurement to the SOE. However, it does not include stipulations as to how STO is to carry out procurement and there is no way for MoH to reliably check. According to KIs, the MoH prefers this arrangement because it relieves the institution of the responsibilities and accountabilities of managing public finances. The MoH simply relays to STO what is required in intervals of three to six months and STO places bulk orders wherever possible. The current MoU is for the five-year period of 2021-2026.

According to KIs, the MoH is currently negotiating that the MoU be adjusted to set out clearer obligations and standard operating procedures that STO must follow, for example, supplying directly from an authorized supplier, rather than a sub-supplier or distributor as this can inflate costs. A further concern of the arrangement is STO's profit-driven business model, as it is in part publicly owned. The profit margins that STO earns are said to be very high and this has a negative impact on the value for money of the health budget overall. KIs indicate that "STO can charge any amount they want".

STO is exempt from the Public Finance Act (3/2006) and Regulation (2017). There are MoF guidelines outlining the Procurement Procedures and Guidelines for SOEs that were introduced in 2021 under the authority of The Privatization, Corporatization, Monitoring and Evaluation of Government Businesses' Act (2013).<sup>105</sup> However, STO is not obliged to adhere to these guidelines because the company is in part publicly owned. It is therefore subject to oversight from the Capital Markets Development Authority (CMDA) which has a separate governance code.<sup>106</sup> It was not possible to get a reliable assessment of the relative strength of these codices through KIs, but there was no indication that the CMDA code is considerably less robust than the PCB code.

According to interviews, while all procurement is managed by STO, the company is licensed to procure only about one third of all medical consumables; the other two thirds are licensed to third-party suppliers. Under standard procurement practices, requests for tenders are issued by the CMSD to STO, that then will source both locally and internationally for suitable bids (quotes) through a pre-tendering process. Depending on the threshold amount for the procurement, tenders are to be advertised on the STO's online tendering platform. At the time of writing, there were no current tenders advertised on this platform. Suitable bids received are then submitted to MoH. Most products are sourced from suppliers in India, Indonesia and Thailand under service agreements. STO does not inspect the supplier or carry out quality assurance testing.<sup>107</sup> The MoH will then select the supplier and seek approval depending on the threshold amount from the MoF Bid Committee or NTB. The MoF Bid Committee or NTB will review and make the final decision. Interviews indicate that because of the standing arrangement between STO and MoH, the Committee and Board rarely if ever reject a bid submitted for review. According to interviewees, the MoF is "not worried about how STO is doing their procurement". Once approval has been granted, MoH will issue a purchase order for STO to procure the goods using funds from a credit facility established within the MoH.

Procurement is centralized using an SAP-based public accounting system that is controlled by the MoF. All procurement that is carried out by government institutions is recorded in this system.

There are three different tender portals as follows:

1. [www.gazette.gov.mv](http://www.gazette.gov.mv): Procurement for values below MVR 35 000. i.e., by health facilities directly. Information is in Dhivehi. Data are not machine readable. The portal is owned by the PO and contains only one category, "Procurement".
2. [www.bandeyri.finance.gov.mv](http://www.bandeyri.finance.gov.mv): Procurement with values between MVR 35 000 and 5 million, i.e., by tender committee. Information on bid committee, decision, and awards are available.
3. [www.finance.gov.mv/tenders](http://www.finance.gov.mv/tenders): Procurement with values above MVR 5 million, i.e., through the NTB. Information is available in English. Data are machine readable, searchable, and include summaries.

95 CEIC Data (2021), *Maldives Imports: Medicinal and Pharmaceutical Product - 1995-2020*.

96 World Health Organization (2014), *Medicines in Health Care Delivery Maldives Situational Analysis: 26 May - 5 June 2014*.

97 *ibid*.

98 Maldives Food and Drug Authority (2018), *Essential Medicines List - 2018*.

99 Maldives Food and Drug Authority (2021), *Approved Drug List - Number: MTG/RE-AL/Li 0009/2021-0009*.

100 World Health Organization (2014), *Medicines in Health Care Delivery Maldives Situational Analysis: 26 May - 5 June 2014*.

101 Ministry of Health Maldives (2019), *Maldives National Health Accounts 2015-2017*.

102 World Health Organization (2014), *Medicines in Health Care Delivery Maldives Situational Analysis: 26 May - 5 June 2014*.

103 Ministry of Health Maldives (2014), *Health Master Plan 2016-2025*.

104 Government of Maldives (2019), *Strategic Action Plan 2019-2023*.

105 Ministry of Finance Maldives (2021), *Procurement Procedures and Guidelines for State-owned Enterprises*.

106 Capital Market Development Authority Maldives (2014), *Corporate Governance Code*.

107 *ibid*.

However, where a third-party is charged with carrying out procurement on an institution's behalf, as is the case with procurement of medical consumables, the system will not contain information on the actual entity that is awarded a contract. It will only show that STO was tasked with carrying out the procurement.

According to the aforementioned procurement guidelines for SOEs,<sup>108</sup> single source procurement or direct purchase is a practice that is permitted in the event of an emergency, as well as when the products to be procured are under patent/copyright, where there are exclusive manufacturers, distributors or agents, or where spare parts are needed for existing equipment. Single source procurement does not have to be advertised on open tender platforms. KIs indicate that the use of single source procurement is commonplace and that for most procurements there is a preferred product model or branded product (often under patent). In instances where fair tender processes have been followed and arrived at a supplier that was not the preferred supplier, the tender was reissued.

Private companies are often subcontracted as third-party suppliers by STO to procure commodities. As indicated above, third-party suppliers may be specially authorized or have licenses to source and procure certain commodities that STO is not licensed to procure, thereby obliging STO to procure through specific third parties. Interviewees indicate that it is not uncommon for STO and third-party suppliers to go through wholesalers and other distributors. KIs relate that there are 42 private companies registering and importing medicines. This contributes to longer supply chains and increases the mark-ups on procured products.

Many KIs highlighted a recurring abuse of these provisions by private procurement companies to guarantee themselves supplier monopolies for medical devices. In this scheme, a private company will "donate" medical devices to a health facility, such as diagnostic testing equipment, that requires reagents to operate. It is unclear if the donation of equipment is based on the actual needs of the health facility to carry out its functions and there are no cost-benefit analyses conducted on donated equipment. Companies then send a proposal to the MoH through STO to provide the reagents and secure a long-term supplier contract. This leads to inflated prices and monopolies, as in some cases they have exclusive rights of distribution for the required reagents. There appears to be no rules or regulations for this practice.

Interviewees indicate that some third-party suppliers and pharmacies are in fact owned by current or former ministry staff. Companies also appear to intentionally recruit ministry staff to use their insider knowledge of how the ministry procurement system functions in order to manipulate it. There is no information available on ministry or SOE staff being obliged to a cooling off period before employment with another SOE or third-party supplier. Alternatively, (former) civil servants may start their own companies because they know how to acquire lucrative long-term supplier contracts through the unregulated medical equipment donations scheme.

Throughout the COVID-19 pandemic response, there were cases of the MoH circumventing STO and procuring directly through third parties. In these instances, there was no due diligence carried out on suppliers and no procedures followed to demonstrate how decisions were made. In one specific case in 2020 that led to the resignation of the Health Minister, two third-party suppliers were contracted directly by the MoH to provide ventilators. Faulty documents justifying the purchase on the recommendation of the WHO were found. Due diligence on the supplier was not carried out, advance payment was made to a company based in the United Arab Emirates, and the equipment never arrived in the Maldives.<sup>109</sup>

One health institution, the HPA, responsible for the management of health promotion, such as regular vaccination and diseases such as tuberculosis and HIV, does not rely on STO or MoH for the procurement of medical commodities. Instead, procurement for vertical disease programming is carried out by UN agencies such as UNICEF for vaccines and the WHO for tuberculosis and HIV medications. According to interviewees this is due to the need to ensure that these products are available in the country to prevent a drop in vaccination numbers or treatment failure, and because procurement of the MoH through STO is unreliable.

Another peculiar feature of medical procurement is the arrangement for IGMH. There, requirements and specifications for the procurement of goods is set by the hospital itself and STO is responsible for carrying out the procurement. Procurement for these hospitals does not pass through the MoH CMSD. They have a separate MoU with STO, obliging the hospital to procure through STO. Payment for goods procured is made by the MoF following submission of an invoice.

#### **5.6.4 Distribution**

According to the WHO,<sup>110</sup> the distribution of medical commodities operates on a "pull" system and requests for re-stock to the CMSD, or purchases from procuring entities directly, are typically made when there is already a stock out. There is no system for maintaining buffer stock.

The CMSD is said to be understaffed and the stores for medical supply are insufficient. Included in the government's 2019-2023 Strategic Action Plan are objectives for the MoH to establish a more capable central medical store to ensure there is adequate buffer stock to safeguard against national emergencies.<sup>111</sup> STO is relied upon for product warehousing, and it operates a logistics management system that extends to the pharmacy level. For both the CMSD and STO, maintenance of cold chain can be a challenge and there is considerable wastage of products. It is also common for there to be delays in delivery.

The STO has an extensive network of pharmacies across all atolls and in Malé; many private companies, such as ADK Pharmaceutical Company, also operate pharmacies across the country. In spite of the high number of pharmacies, stock outs of even basic medicines are common. There is no



centralized system to track and confirm deliveries of medical commodities in the Maldives. STO does not maintain its own fleet of air and sea transport for delivering products and instead relies on available public transportation; STO staff do not accompany commodity deliveries. When products are delivered, a confirmation of receipt must be signed by the health worker in charge. In the atolls it can often happen that a health worker is not available receive shipments when they arrive. If the delivery receipt is not acquired, the MoH cannot issue payment to STO resulting in frequent delayed payments. Health professionals interviewed by the WHO at health facilities have reported receiving incorrect or poor-quality products or less stock of a product than was ordered. They also report that stock management supervisory visits occur very infrequently (i.e., less than once every two years).<sup>112</sup>

### 5.6.5 Medicine Regulation

The regulation of medicines and therapeutic goods imported, distributed and sold in the Maldives is the responsibility of the MFDA. It is responsible for the registration, licensing, inspection, pricing, promotion and quality testing of medicines, and is supported by the National Pharmaceutical Board. There are two primary divisions for regulation and enforcement under the Medicines and Therapeutic Goods Division. MFDA is also responsible for enforcement of quality, efficacy and safety standards, including inspection of pharmacies and medical storage facilities, medicines import and port control in Malé.

A comprehensive overview of the stages of medical product regulation is provided below.<sup>113</sup>

**Registration:** All products registered in the Maldives must already be registered with a stringent regulatory authority, such as the USA, UK, Canada, Australia, or Thailand. Most medicines that are registered in India and Sri Lanka are also accepted.

**Inspection:** All imports must officially be registered and all papers, including the import license, bill of lading, certificate of origin and invoice, should be in order. Importers must inform customs 24 hours in advance of batch arrival. Upon arrival, a team of inspectors (national security officer, customs officer, MFDA inspectors and importer) examine the shipment and conduct an examination of 5% of randomly-selected packaged cargo. In each unit opened, 5% of the contents (bottles/packets) are visually inspected to check the name, batch, expiry date, company name, dosage and strength, and detect any damages. In the event that a problem is found,

45 more bottles/packets and cartons are checked. It is not clear how unregistered products and controlled medicines are handled at the ports or how spoiled or spurious products are dealt with.

**Licensing:** The MFDA is responsible for granting licenses to private pharmacies. The MFDA should ensure that all pharmacies are visited once per year in order to retain their licenses. There appears to be no system in place for licensing and accreditation for public facilities and supervisory visits are not conducted.

**Promotion:** Drug promotional activities are generally confined to facilities and professionals in Malé and drug company representatives do visit doctors and provide promotional products and information. Over the counter products are required to have pre-approval status from the MFDA.

**Pricing:** As of January 2022, there is a new regulation setting the retail price of medicines through MFDA. It is yet unclear how this regulation will impact on product prices and whether or not sanctions for failure to comply will be levied. Previous data indicate that some medicines had unit costs that were below international reference prices with no information on product quality.<sup>114</sup>

108 Ministry of Finance Maldives (2021), *Procurement Procedures and Guidelines for State-owned Enterprises*.

109 Mohamed S (2020), *Health Minister Ameen resigns amid strong backlash*, The Edition, 21 October 2020.

110 World Health Organization (2014), *Medicines in Health Care Delivery Maldives Situational Analysis: 26 May - 5 June 2014*.

111 Government of Maldives (2019), *Strategic Action Plan 2019-2023*.

112 World Health Organization (2014), *Medicines in Health Care Delivery Maldives Situational Analysis: 26 May - 5 June 2014*.

113 *ibid.*

114 *ibid.*

## **CORRUPTION VULNERABILITIES: HEALTH PROCUREMENT AND MEDICAL SUPPLY CHAIN**

**With the exception of procurement for the HPA, procurement of medical commodities is outsourced to the STO. The roles and responsibilities included in this arrangement are unclear. There is also no transparency regarding the procedures for medical commodity supply. This creates several accountability gaps and other corruption vulnerabilities in product quantification, selection, procurement, pricing, and distribution.**

**The following vulnerabilities for corruption are identified:**

### **1. Legal and regulatory frameworks**

Existing laws or rules that should govern the procurement process have considerable gaps, for example, outsourcing MoH procurement to STO without a robust accountability mechanism, creating a weak system for preventing and mitigating corruption. This in turn enables corruption, such as undue influence, bribery, and collusion.

It is also possible that the existing legal and regulatory frameworks are the result of manipulation or capture in the favor of private interests, e.g., the third-party medical equipment donation scheme, in order to access or hold monopolies on government contracts.

### **2. Control of supply**

STO or private vendors can exercise undue control over the procurement process. They may allow for delays, shortages in supply or unavailability of certain consumables to allow for non-competitive procurement. They can also choose to extend the length of the supply chain thereby incurring additional price mark-ups by sourcing required medicines through private companies rather than directly importing them.

### **3. Stock forecasting, quantification and management**

Procurement tenders may be rigged based on insufficient or faulty forecasting, quantification and stock management data. There is no system of accountability to ensure that products procured reflect actual need.

### **4. Product selection**

Undue influence, conflicts of interest, bribery, or collusion in the selection of medical products can lead to the selection of more expensive products and/or lower quality products included on the EML/ADL

### **5. Transparency of the procurement process**

The lack of or inconsistent transparency of the procurement process both enables opportunities for corruption and prevents effective monitoring and accountability of corrupt practices, both internally as well as by the public. This can lead to a culture of impunity.

### **6. Procurement data**

Similarly, failure to share or inconsistent sharing of procurement

data both with relevant stakeholders, like the MoH, or with the public enables opportunities for corruption and prevents effective monitoring and accountability of corrupt practices. It conceals conflicts of interest, unnecessary use of single-source procurement, rigged bids, lack of competition, inflated prices, failure to deliver and so on.

### **7. Procurement procedures**

Lack of transparent, competitive tendering, bidding and award processes creates an enabling environment for undue influence, bid rigging, collusion, and bribery to acquire government contracts at inflated prices.

### **8. Single-source procurement**

Single-source procurement procedures may be abused through undue influence, bribery or collusion to permit biased contract awards for branded products or tenders with rigged specifications at higher prices.

### **9. Licenses to procure medical commodities**

It is possible that the issuing of procurement licenses is compromised by conflicts of interest of those involved. It is neither clear how procurement licenses are granted and monitored nor what conditions they permit.

### **10. Sourcing and inspection of product suppliers**

Similarly, conflicts of interest and collusion may drive supplier selection. And inspections may be unduly influenced through bribing of inspectors.

### **11. Conflicts of interest**

There is no regulation for the management conflicts of interest and no transparency of beneficial ownership for ministry, STO, health facility staff and third-party suppliers. This creates an enabling environment for collusion and for procurement tenders and contract awards to be corrupted.

### **12. “Revolving Door” between public and private sector**

Former public staff are explicitly recruited by private sector companies to use their knowledge of government procedures in order to manipulate public procurement. There is no cooling off period. This creates an environment with high risk of conflicts of interest and corresponding corruption risks described above.

# 6 CONCLUSIONS

Despite significant increases in overall life expectancy and positive health outcomes, ensuring consistent and equal access to quality health services across the Maldives has proven to be a considerable challenge and there are significant inefficiencies within the health system. The results of this study suggest that poor governance and corruption within the health sector are both drivers and consequences of these inefficiencies.

By reviewing the available literature and speaking directly with national sectoral experts, this study set out to map the health sector through a governance lens and identify critical corruption vulnerabilities throughout the system. While a number of new vulnerabilities have been uncovered through this research, many of the corruption-related challenges included throughout are well known and have been highlighted by experts for many years.

The study found corruption vulnerabilities to exist across all areas of health system seriously undermining efficiency and quality in service delivery, as well as good value for money. The areas that are particularly at risk of corruption are those where financial resources are greatest, such as health sector procurement and financing of health services through the HA scheme.

Throughout the last two decades, the Maldives health sector has undergone significant change and there are many recent, ongoing and pending reforms to the system that were not able to be encapsulated in this report. This is not a unique

feature, and system evolution is generally encouraged. However, the frequency of both fundamental changes to institutional, legal, and regulatory framework, as well as high rates of turnover of staff and leadership are critical problems. Therefore, while the results of this study are highly temporal and reflect the current status of the sector as of December 2021, it is expected that these main issues will remain and the related corruption vulnerabilities will continue to persist.

Recommendations for improvement based on the findings of this study have been prepared in a sister report. Here the top corruption vulnerabilities are distilled, and suggestions are made for remedial action. The report can be found [here](#). Repeated attempts to engage international agencies such as the World Bank, the WHO and other UN agencies meaningfully in this research were made to no avail. Their engagement in improving health sector governance and anti-corruption efforts is very welcome and it is encouraged that these entities consider the recommendations put forward.

With regards to an immediate way forward, it is highly encouraged to conduct further research, particularly on the situation in the atolls. Due to the COVID-19 pandemic, it was not possible to include this important dimension in this research. It will also be very important to closely monitor the implementation of reforms and assess their effects on health system performance and on corruption vulnerabilities.



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ANNEX

# Annex I:

## Summary of Corruption Vulnerabilities

The following table provides an overview of all key corruption vulnerabilities identified in this report, categorized according to the primary functions of the health system as outlined.

FUNCTION	DOMAIN	VULNERABILITY
<b>I. Health governance and regulation</b>	Institutional structure	Lack of separation between institutions whose roles require independence Undue influence on these institutions prevents them from appropriately discharging their mandate
	Transparency	Lack of publicly-available information on official definitions for mandates, roles and responsibilities, policies, procedures, reports, or action plans Weak capacity to monitor actors and their decision making
	Conflicts of interest	Lack of conflict-of-interest regime (incl. policy and mechanisms to identify, record, manage) for civil servants, healthcare managers and politicians who have ownership of SOEs and private companies Capture of system designs (e.g., procurement procedures) to permit abuse Staff incentivized to not perform duties in the best interest of the people or to exert undue influence on processes
	Human resources	Lack of a merit-based system for appointment procedures (hiring, firing and promotions), including for PAs Undue influence and control over political and financial decision making through nepotism and clientelism
	Accountability	Weak oversight capacity due to the lack of transparency, including internal and external audit functions in key institutions Lack of accountability and sanctioning incentivizes continued or future misconduct, including corruption
	Improvement	Identified systemic inefficiencies and corruption vulnerabilities do not lead to corrective action or improvements in the system Fatigue of watchdog agency staff and disinterest in the general public contributes to further lack of monitoring and accountability
<b>II. Service delivery</b>	Domestic service delivery	Use of personal relationships in lieu of informal payments to jump queues Inequitable access contributes to a high public perception of corruption among citizens
	Medical travel overseas	Referral of medical services: lack of formal mechanisms for selection of patients, facilities, and treatment based on medical needs lack of information of and control over prices for service covered under HA scheme Lack of available criteria for selection and accreditation of empaneled facilities Conflicts of interest or collusion between empaneled facilities and domestic actors (e.g., ACL, MoH, etc.) may influence negotiation of service agreements and overall reimbursement prices
<b>III. Hospital Governance and Administration</b>	System reforms	The continuous, un-strategic changes to hospital administration creates a permanently unstable situation, critically exacerbated by the high turnover of staff and leadership (see section Health Workforce) Exploitation of transformation activities (e.g., additional procurement of equipment, infrastructure development, etc.) leading to capture of systems, processes, or key positions Impeding attribution of accountability
	Governance standard and quality assurance	Lack of institutional and regulatory capacity to ensure high quality services, appropriate hospital management, or compliance Weak institutional capacity to prevent, investigate or sanction corruption
	Management and control	Unclear appointment procedures, reporting lines, and responsibilities of hospital management and board Lack of control over the hospital, to abuse by management or to undue influence on hospital operations
	Transparency	Lack of transparent data on health facility management procedures
	Efficiency	Lack of incentives to optimize operations and performance resulting in, among other things, a shortage of services and long waiting lines
<b>IV. Health workforce</b>	Wages and staff retention	Low wages lead to unmotivated employees that rationalize corrupt behavior, negatively impact on quality of services provided and reduce overall system efficiency High staff turnover prevents the establishment of good governance procedures, preventing good oversight, monitoring and accountability, thereby increasing opportunities for corruption and abuse
	Appointment procedures	Lack of transparent information for the appointment of healthcare professionals (local or foreign) and management of conflicts of interest; nepotism, collusion or other forms of corruption Complicated and lengthy appointment procedures increase both the urgency for staff, which can exacerbate recruitment-related corruption and understaffing at health facilities
	Regulation of foreign health professional recruitment	Poor regulation and lack of transparency of foreign health professional recruitment procedures and safeguards may enable bribery or collusion from applicants and recruitment agencies (incl. for issuing of quotas for entry visas), waste of health sector resources spent on recruitment, and contribute to poor system performance through recruits without proper qualification

FUNCTION	DOMAIN	VULNERABILITY
<b>IV. Health workforce</b>	Management and monitoring of foreign health professionals	Moonlighting (working at both public and private facilities) Foreign, MoH-contracted professionals moving from the public sector to the private sector
<b>V. Health financing</b>	Rational service use	The non-contributory, unlimited HA scheme incentivizes excessive use and abuse of the public health system Vendors and users are not incentivized to scrutinize services or provision of consumables or report wasteful practices
	Service coverage oversight	HA incentivizes upcoding, over medicalization and repeat consultation due to a lack of comprehensive, efficient prevention, detection and sanctioning
	Financing medical consumables	HA incentivizes abuse and fraud by pharmacies, such as provision of overpriced consumables, due to a lack of comprehensive, efficient prevention, detection and sanctioning
<b>VI. Health Procurement and Medical Supply Chain</b>	Legal and regulatory frameworks	Gaps in existing laws or rules that govern procurement create a weak system for preventing and mitigating corruption Possible that existing legal and regulatory frameworks are the result of manipulation or capture in the favor of private interests
	Control of product supply	STO or private vendors can create delays, shortages in supply or unavailability of certain consumables to allow for non- competitive procurement STO or private vendors may collude to extend the length of the supply chain by sourcing through private companies rather than directly importing products creating additional price mark-ups
	Stock forecasting, quantification and management	No system of accountability to ensure that products procured reflect actual need Tenders may be rigged based on insufficient or faulty forecasting, quantification and stock management data
	Product selection	Undue influence, conflicts of interest, bribery, or collusion in the selection of medical products may lead to the selection of more expensive products and/or lower quality products included on the EML/AD
	Transparency	Lack of or inconsistent transparency in procurement enables opportunities for corruption and prevents effective monitoring and accountability of corrupt practices leading to a culture of impunity
	Procurement data	Failure to share or inconsistent sharing of procurement data enables opportunities for corruption and prevents effective monitoring and accountability of corrupt practices Concealment of conflicts of interest, unnecessary use of single-source procurement, rigged bids, lack of competition, inflated prices, failure to deliver, etc.
	Procurement procedures	Lack of transparent, competitive tendering, bidding and award processes enables undue influence, bid rigging, collusion, and bribery to acquire government contracts at inflated prices
	Single-source procurement	Single-source procurement procedures may be abused through undue influence, bribery or collusion to permit biased contract awards for branded products or tenders with rigged specifications at higher prices
	Licenses to procure medical commodities	The issuing of procurement licenses may be compromised by conflicts of interest of those involved
	Sourcing and inspection of product suppliers	Conflicts of interest and collusion may drive supplier selection Inspections may be unduly influenced through bribing of inspectors
	Conflicts of interest	No regulation to manage conflicts of interest and no transparency of beneficial ownership for ministry, STO, health facility staff and third-party suppliers
	Revolving door	Former public staff are explicitly recruited by private sector companies to use their knowledge of government procedures in order to manipulate public procurement No cooling off period
Logistics of medicines deliveries	No centralized tracking system for medical commodity delivery, proof of delivery receipts may be forged for products not delivered	

## Annex II: Responsibilities of Key Health Sector Institutions

### MINISTRY OF HEALTH

There have been considerable changes to the MoH, its internal divisions and spheres of responsibility over the past 15 years. Under the obligations and provisions of the current Health Services Act (29/2015), the MoH is the national responsible authority for the policy direction, regulatory standards and guidelines, as well as the operational management of the country's public health system and its facilities, including their quality assurance. It is also the regulatory body for medical education and sets professional standards in the country. Housed within the MoH are the secretariats for the healthcare professional councils governed by the Health Care Professionals Act (13/2015),<sup>115</sup> the Maldives Medical and Dental Council, Maldives Nursing and Midwifery Council and the Maldives Allied Health Council, which are said to be independent. These councils are responsible for the accreditation and licensing of the local and foreign healthcare workforce.

The MoH is also responsible for determining procurement needs of the public health system and issuing requests to tender to procuring authorities (see section on Health Procurement and Medical Supply Chain below for more details). The Central Medical Supplies Division (CMSD) of the MoH is responsible for the administration of health-related public procurement.

The Regional and Atoll Health Services of the MoH is operationally responsible for the supervision and coordination of public health facilities. Exception to this are the five tertiary hospitals as well as the Malé Group of hospitals including IGMH. They are operationally separate to the ministry. However, the MoH still maintains regulatory oversight of IGMH and its affiliated facilities and is accountable for IGMH to the People's Majlis. No publicly available information regarding the governance structures and procedures of health facilities could be located.

The Quality Assurance Division of the MoH is responsible for the registration, licensing and inspection of private health facilities. According to Article 25 of the Health Services Act, the roles and responsibilities include:

- Formulation of policies and regulations to ensure quality of health services and protect the rights of staff and clients
- Inspection of health facilities and the work of technical staff
- Investigating complaints submitted related to health services
- Establishment and implementation of the national accreditation mechanism

The same is not carried out for public facilities either because it is considered unnecessary or there is no budget made available to do so.<sup>116</sup> The MFDA, the HPA for public health promotion, and the Maldives Blood Service, as well as the National Drug Agency also fall under the regulatory remit of the MoH.

There is general concern from health experts in the Maldives that the MoH functions as both the provider and the regulator.

As civil servants the Code of Conduct of the CSC applies to MoH staff, and they can use its complaint mechanism, but there are no conflict-of-interest rules or regime (see section on Health Workforce). According to interviews, there do exist policies that outline conflict of interest management and whistleblowing within the MoH as well, though no documentation outlining such policies is publicly available. The conflicts of interest policy for MoH staff only considers conflicts related to kinship ties and does not include any interests related to private sector activities, such as company ownership or shares; policies in this regard are not made public. There is also a grievance mechanism for staff to lodge a complaint, as well as a recently established Internal Auditor and Chief Accounts Executive, who according to interviews, are responsible for carrying out internal controls and facilitating the Auditor General's annual audit of the MoH. However, again, there is no publicly available information to support this.

<sup>115</sup> Maldives Medical and Dental Council (2015), *Maldives Medical and Dental Council Fees and Charges*.

<sup>116</sup> World Health Organization (2014), *Medicines in Health Care Delivery Maldives Situational Analysis: 26 May – 5 June 2014*.

## MALDIVES FOOD AND DRUG AUTHORITY<sup>117</sup>

The MFDA is responsible for the regulation of medicines and therapeutic goods imported, distributed and sold in the Maldives. This includes product registration and approval, as well as registration and licensing of pharmacies and medical storage facilities. Registration and approval are supported by the National Pharmaceutical Board. MFDA is also responsible for enforcement of quality, efficacy and safety standards, including inspection of pharmacies and medical storage facilities, medicines import and port control in Malé.

The MFDA is responsible for developing and updating the Essential Medicines List (EML)<sup>118</sup> and the Approved Drug List (ADL).<sup>119</sup> The process for registering medicines is available on the MoH website and once they are approved, they are added to the ADL.<sup>120</sup> No information was found regarding the inclusion of medicines in the EML.

The MFDA is the national regulatory body for food stuffs and medicines. It is responsible for the registration, licensing, inspection, pricing, promotion and quality testing of medicines and is supported by the National Pharmaceutical Board. There are two primary divisions for regulation and enforcement under the Medicines and Therapeutic Goods Division.

The MFDA is an affiliate agency of the MoH and is headed by a political appointee making it non-independent. According to a WHO report from 2014, a Medicines Act was being tabled to the government, but had not been passed at the time of the report. It was not possible to determine if a Medicines Act has since been passed based on publicly available information.

## NATIONAL SOCIAL PROTECTION AGENCY

The NSPA is a regulatory authority formed under the National Social Health Insurance Act in 2011<sup>121</sup> with the mandate to administer the National Social Health Insurance Scheme, Husnuvaa Aasandha (HA). NSPA is also responsible for wider national welfare programs and social protection packages beyond health insurance

There are annual reports done and audits conducted for both NSPA and the SOE responsible for administration of HA, Aasandha Company Limited (ACL), by the Auditor General, but these are not regularly made public, if at all. Actioning recommendations from the Auditor General for ACL is the responsibility of the ACL Board.

HA operates under the Aasandha Scheme Regulation (2015/R-19)<sup>122</sup> and is administered by the SOE ACL that was established in 2011 and became fully state owned in 2015. The MoF's Privatization and Corporatization Board (PTB) is the oversight body for ACL as it is an SOE. According to KIIs, a list of all services covered by HA including their corresponding prices exists and is revised regularly. Unfortunately, this list is not published.

NSPA was formerly relegated under the mandate of the MoH, but since 2018 operates under and is accountable to the Ministry for Gender, Family and Social Service (MGFSS). There are two political appointees at the helm of the NSPA, the Chief Executive Officer and the Deputy Chief Executive Officer.

According to interviews, there is a board for HA that is separate to NSPA and ACL. The details of this board are within the National Health Insurance Act. Board members are appointed by the president upon advice from the Minister for Gender, Family and Social Services. This board is responsible for overseeing the policy/regulation, general functioning of the scheme and making major decisions. The board is also accountable to the Minister for Gender, Family and Social Service. The NSPA CEO is a member of the board. Separate to this board, there is an empanelment committee that makes decisions regarding empanelment of both local and overseas private service providers. The NSPA also has a monitoring function over the committee.

## MINISTRY OF FINANCE

The MoF is responsible for the macroeconomic framework of the country including resource mobilization and management of national debt. It is also responsible for formulating national procurement policy and guidelines through its Procurement Policy Department and the National Tender Board (NTB). Until recently, the Public Enterprises Monitoring<sup>123</sup> division of the MoF was responsible for the oversight of SOEs, their fiscal status, budgets, as well as monitoring and managing their profits. This function is now covered by the PCB described below.

**The MoF acts as a secretariat for several boards<sup>124</sup> and committees. Some of the key committees are listed below:<sup>125</sup>**

**1. National Tender Board** whose members are appointed by the President upon recommendation from Minister of Finance. It approves all tenders over MVR 5 million. This threshold was increased from MVR 2.5 million in June 2020.

**2. Procurement Policy Board** whose members are appointed the same way as the NTB. It was formed in June 2020 as part of the third amendment to the Public Finance Regulation. Before then, the NTB was responsible Policy, leaving it in charge of both, policy and decision on tenders.

**3. Bid Review Committee** whose members are appointed by the Minister of Finance. It is in charge of investigating bids based on complaints from bidders as well as suspension related cases (corruption, collusion, etc.) based on a procuring agency requesting such suspension. KIIs consider it a challenge that this body is supposed to review complaints regarding decisions from NTB whose members are appointed by President, while BRC members are appointed by Minister of Finance.



**4. Privatization and Corporatization Board<sup>126</sup>** whose members are nominated as a group by the President and then endorsed by the People's Majlis. PCB reports to the SOE committee of the People's Majlis. Its functions used to be under the MoF (Public Enterprises Monitoring Division<sup>127</sup>) and have now been transferred to this autonomous body established under the 'Law of Privatization, corporatization, monitoring and Evaluation of Government businesses' (Law no. 3/2013). It oversees SOEs, in particular issues of Privatization, Corporatization and Mergers and Acquisitions – which is the bulk of its work. It inherited staff members of the secretariat who are MoF staff members, reporting to PCB as well as MoF.

#### **5. State Internal Audit Committee**

The MoF has a state internal audit function, and as such has recently (in 2021) conducted an audit of the MoH. Unfortunately, the results are not publicly available.

#### Ministry of Economic Development

The MoED is responsible for the regulatory environment of business operations within the country.<sup>128</sup> Relevant legislation and regulations include those for the Export Import Act, Companies Act, Small and Medium Enterprises Act, as well as the Employment Act.<sup>129</sup> The Business Services Department is responsible for business and employee registration, including issuing hiring quotas and work permits for foreign medical professionals.<sup>130</sup> The Trade and Investment Department is responsible for the regulation, oversight and strategy for SOEs.<sup>131</sup>

117 Maldives Food and Drug Authority (2019), Maldives Food and Drug authority Medicine and Therapeutic Goods, Newsletter 2019.

118 Maldives Food and Drug Authority (2018), Essential Medicines List – 2018.

119 Maldives Food and Drug Authority (2021), Approved Drug List - Number: MTG/RE-AL/Li 0009/2021-0009.

120 MFDA (2021), Guideline on Product Registration and Approval of Medicines MTG/RE-RP/GLN-TE 001.

121 Republic of Maldives (2011), National Health Insurance Act (15/2011).

122 Republic of Maldives (2015), Aasandha Scheme Regulation (2015/R-19).

123 Ministry of Finance Maldives (2021), Organizational Structure - Divisions.

124 Ministry of Finance (2020), Statutory Boards (as of 3 March 2020).

125 The mandates of these entities are outlined in Chapter 17 of the Public Finance Regulation. At the time of this report, further changes to the regulations are imminent.

126 Ministry of Finance Maldives (2020), Ministry Organigram.

127 Ministry of Finance Maldives (2021), Organizational Structure - Divisions.

128 Ministry of Economic Development Maldives (2021), Vision, Mission, Mandate.

129 Ministry of Economic Development Maldives (2021), Resources: Laws and Regulations.

130 Ministry of Economic Development Maldives (2021), Business Services Department.

131 Ministry of Economic Development Maldives (2021), Trade & Investment Department.

## **Annex III: Recent, Ongoing, and Pending Reforms**

**There are several recent, ongoing, or pending reforms to the health sector that have been identified. It is anticipated that these reforms will affect the current state of the health system and the corruption vulnerabilities identified throughout this report.**

### **Maximum Retail Price (MFDA regulation)**

From Jan 2022 there is a new regulation setting the retail price of medicines through MFDA. Based on an average import price and some other measure, such as an international rate, a maximum retail price is introduced. Pharmacies are then allowed a markup of 100% for reimbursement. KIs relate that markup before was up to 500%. Therefore, it is expected that this reform will bring down retail prices – which, in turn could be seen as confirmation that prices before were inflated.

### **Exclusive of import/distribution right (MFDA regulation)**

As of October 2021, no exclusive import rights are issued anymore. Before, a 5-year exclusive license was granted to the first importer of a medicine to incentivize importers to go through the paperwork of registering a new medical consumable. Intention is to end monopoly rights of distributors, which should lead to competition and lower prices.

### **Electronic payments (MFDA regulation)**

Entities regulated by MFDA will make related payments in electronic form. This will make the process more transparent and less susceptible to corruption.

### **Generic Prescription Policy**

According to KIs, a policy is being worked on that will oblige doctors to prescribe generic medicines when they are available. Given the high cost of branded products, this is expected to lower costs and limit opportunities for fraud, such as importing companies bribing doctors.

### **Public Finance Regulation**

KIs relate that a major revision of the Public Finance

Regulation is pending, including to Chapters 10 and 17, respectively, that are most relevant for corruption of public procurement in the health sector. One of the reasons for this revision is that these two chapters are not aligned. This will greatly impact the regulatory and institutional framework including the roles and responsibilities of boards in the MoF described above.

KIs expect that this revision will also bring about significant changes to SOE procurement – which may have significant impact in case it affects STO's procurement practices.

### **National Health Service (Maldivian Health Service, MHS)**

It was reported in KIs that there are advanced plans of introducing a National Health Service in the Maldives, which would change the approach to delivering health, relying more on community health workers going out to patients rather than providing services in health facilities. The role of MoH would then change to that of a regulator only while MHS would be implementer.

### **Decentralization**

In the Maldives, there is a current push for reforms of decentralization, empowering the local level institutions (councils). It is unclear how this would affect the health system, but upgrading of regional hospitals, giving them the right to do their own procurement may be steps in that direction. Impact of decentralization on corruption vulnerabilities is not straightforward and

rather depends on the circumstances. However, in contexts with low technical capacity, education, and civil engagement, additional decision-making powers and budget at the peripheral level are at risk of being captured by local elites a vulnerability for corruption.

### **Privatization and Corporatization Act**

KIs report that significant changes are expected in the oversight of SOEs through the PCB.

# Annex IV:

## Research Methodology and Data Collection

### RESEARCH METHODOLOGY

The results presented in this report are based on a thorough review of publicly available secondary data and publications both in English and Dhivehi language as well as semi-structured Key Informant Interviews (KIIs) with representatives from all key stakeholder institutions in the sector, including the People’s Majlis, Government Ministries and departments, SOEs, Private Sector, and Academia (see Table I below). Key experts were selected based on their position as well as their knowledge or experience in the delivery of healthcare services, or healthcare governance/ regulation in the Maldives and included different levels of the institutions, from working level up to two Ministers and the Public Accounts Committee of the Peoples Majlis as well as external stakeholders from civil society, donor organizations, and academic experts.

The organizations were initially selected based on the findings from the desk review (Phase I). To further corroborate and consolidate findings, the research approach was kept flexible, allowing for recurring interviews with experts and adding key informants (snowballing) to expand data collection.

Interviews were conducted in English without interpretation based on a semi-structured discussion guide. Main issues to be explored were an understanding and mapping of the health sector and the identification of vulnerabilities as well as existing countermeasures and insights on how to improve the system in future.

The interviewers probed and explored emerging findings during the interviews to validate and triangulate claims. The gender of the interviewees was monitored to ensure a gender balanced approach

The interviews were undertaken according to research best-practice and data protection requirements. All interviewees are being offered complete anonymity and confidentiality by default to encourage an open dialogue on corruption vulnerabilities. All interviewees are being given full information about the purpose of the study and how the findings will be used so that they can give informed consent to take part. Interviews are not being recorded. During the interviews it is made clear that this study is an independent assessment made by international experts external to TM.

### DATA COLLECTION

Data was collected from 13 September until 1 December 2021.

#### Phase I: Desk Research

The first phase was conducted remotely from 13 September until 9 November 2021. During this stage, publicly available information in English language were reviewed to the extent available, and 14 Interviews with 21 Key Informants were conducted via teleconference.

#### Phase II: Country Mission

The second phase was conducted in country from 14 November until 1 December 2021. During this stage, additional documentation was translated from Dhivehi and reviewed, and 27 interview sessions with a total of 59 additional key informants were conducted.

#### Collected Data

In sum, 41 interview sessions were conducted with a total of 80 different Key Informants from 21 National Key Stakeholder Institutions as well as individual experts (note that some Key Informants were interviewed several times, they are counted only once here).

The table below provides an overview of entities that were interviewed.

CATEGORY	Entity of Interview Partners
1. Government	1. Anti-Corruption Commission 2. Auditor General's Office 3. Civil Service Commission 4. Health Protection Agency 5. Information Commission 6. Maldivian Food and Drug Authority 7. Ministry of Finance 8. Ministry of Health 9. National Social Protection Agency 10. National Tender Board 11. People's Majlis 12. President's Office 13. Privatization and Corporatization Board
2. State Owned Enterprises	14. Aasandha Company Ltd 15. State Trading Organization
3. Service Providers	16. Indira Gandhi Memorial Hospital 17. Hulhumalé Hospital 18. Private Hospital
4. Civil Society & Academia	19. Transparency Maldives 20. Institute for Research & Innovation 21. Maldives National University
5. Others	22. International Donor Organization 23. Individual Experts

To corroborate findings, all Key Informants were invited to provide additional input as a group during a Feedback Workshop, which was held in form of a half-day closed-door event on 1 December 2021, in Male'. A total of 16 Key Informants from 11 Key Stakeholder Institutions participated.'

#### Limitation

Due to travel restrictions during the COVID pandemic, all interviews were conducted in Malé and Hulhumalé. To corroborate findings and identify any additional vulnerabilities specific to the decentral context on the islands, additional data collection is recommended in future studies.



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