Indian J Med Ethics Vol XI (Cumulative Vol XXXIV) No 2 Apr-Jun 2026

RESEARCH ARTICLE

An expanded framework for understanding corruption in healthcare

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Abstract

Corruption in healthcare is ubiquitous across countries but differs in extent and nature based on the socio-political context and historical development of their health service systems. We review various approaches to defining and analysing corruption and examine their application to the health sector. Commonly adopted measures of corruption based on these frameworks, by covering certain actions and excluding others, tend to highlight poor countries as being more corrupt. These frameworks are largely ahistorical, and lack a systems approach, and consequently, miss institutionalised forms and types of corruption at higher levels between and within countries. The failure of anticorruption efforts makes it necessary to interrogate and understand the nature of corruption, its forms, types, and measurement, through a lens that can lead to effectively addressing the phenomenon from the perspective of low-and-middle income countries.

We propose an expanded framework for understanding the systemic pathways of corruption, across the multiple levels and actors in the health system. We then discuss its relevance to low-and-middle-income countries, with a specific focus on India. We argue that historical socio-political structures, with a colonial hangover and elite dominance, legitimising only one health knowledge system (conventional biomedicine) and its medical professionals, have led to a healthcare system design which is unaffordable, unsustainable, unregulated and alienated from the majority of the population even while it creates a dependency on biomedical experts and institutions. The medical industrial complex – the network of providers and industries in healthcare – prioritises profit over health benefits, and contributes to escalating corruption in the healthcare sector, thereby pushing inappropriate solutions and policy choices. Such an ecosystem is fertile ground for corruption as it results in huge unmet needs and unreasonable expectations from the health services, underpaid health workers, weak regulatory structures, and poor accountability.

Keywords: *health sector, corruption, frameworks, medical industrial complex, politics of knowledge*

Introduction

Corruption is defined as the abuse of entrusted power for private gain [1,2], and is conventionally associated with unlawful use of public office. "Misuse of public office" is typically identified using an established legal standard, for example, taking kickbacks in public procurements [3]. This definition excludes misuse of power by private entities. As a social institution, healthcare includes not only public officials in positions of power, but all health professionals and providers of products and services, who wield power in the health system. Moreover, not all abuses of power for private gain are illegal, and a corrupt act might be viewed as "legal" if it does not breach any law, for instance, lobbying parliamentarians for corporate gain [4]. In fact, corruption is not just a legal issue but more importantly, a moral and ethical issue [5]. Further, the commonly used definition above does not provide any clues as to the organisational and systemic drivers of corruption. Thus, the dominant definitions of corruption are too narrowly focused and give rise to frameworks for addressing corruption which have had very limited success.

This paper analyses existing frameworks for understanding corruption in healthcare and proposes an expanded framework that is relevant to low-and middle-income countries (LMIC) with a focus on India.

Methods

We conducted a thematic search for frameworks or theoretical models to understand corruption in the health sector using search engines Google Scholar and PubMed, with key words "corruption in healthcare" and "frameworks for corruption in healthcare", not restricting it to any time period. We examined these frameworks for their strengths and limitations, and their adequacy and relevance for LMICs. Using analyses of development of the Indian healthcare system [6], we formulated an expanded systems framework describing the structural bases of health sector corruption. We analysed multiple levels and actors in the health system, and the socio-political structures which shaped it, to delineate the systemic pathways generating and exacerbating corruption in the health sector.

What is corruption?

Gaitonde et al in their review identify the following key elements from previously existing definitions of corruption.

- The person who abuses power may directly commit the abuse or may be complicit in its abuse.
- It can be by people who are either in private or public positions of power.
- A position of power or authority may be entrusted either by formal systems of governance or by social/cultural systems.
- The abuse may be for the benefit of oneself, a

group, an organisation, a (political) party, or others close to those who abuse their power.

- Benefits can be financial, material or non-material (such as furtherance of political or professional ambition).
- The abuse violates the rights of other individuals or groups [7].

They define corruption as "The abuse or complicity in abuse, of public or private position, power or authority to benefit oneself, a group, an organization or others close to oneself; where the benefits may be financial, material or non-material" [7].

The most commonly cited global index of corruption, the Corruption Perception Index (CPI), assigns a single corruption score to each country [8]. Poor countries consistently rank at the bottom while wealthy countries are always at the top [4, 8]. Corruption is then framed as a major cause of poverty in these countries [9, 10]. This victim blaming — along with the failure of anticorruption efforts — makes it necessary to interrogate and understand the nature of corruption, its forms and types and measurement, through a lens that can lead to effectively addressing the phenomenon from the perspective of low-and-middle income countries.

Yuen Ang provides a useful classification of types of corruption based on the nature of exchange of benefit among transacting parties and the levels at which it involves state actors (Table 1). In Ang's model, corruption may involve exchange of benefit to both the involved parties, for instance, payment of bribes to avail of welfare benefits. In corruption without direct exchange of benefit, state actors rob the citizens and public coffers ie, theft, amounting to a net loss for society [11]. The four categories — petty theft (extortion by street-level officers), grand theft (embezzlement by politicians), speed money (small bribes to overcome bureaucratic hurdles or harassment), and access money (big payoffs in exchange for exclusive, lucrative privileges such as contracts and bailouts) — highlight the different actors involved and levels at which they operate. The four categories often overlap [11].

Ang's typology is useful as it brings together both blatantly illegal forms of corruption (petty theft, grand theft, and speed money) and legalised exchanges of power and profit among the elite[i] (lobbying in the United States, electoral bonds in India) in the category of access money. Ang states that in China both forms exist, embezzlement of public funds and access money, but both are outside the legal framework, indicative of the historical and contextual factors that affect the nature and type of corruption [12].

Corruption that involves high-level/elite actors (the socially/economically/politically/culturally/intellectually powerful) is of different magnitudes from corruption involving low-level / non-elite actors, with a different scope and scale of consequences. The rich, elite and powerful, wielding power through legal instruments and institutional mechanisms, are able to make certain types of corruption legal as well as difficult to capture and measure. Global metrics like CPI systematically under-measure the corruption of the rich as compared to that of the poor. For instance, "access money" used to gain special favours by the elite, and found to be highest in the rich countries, is not accounted for in the CPI. It is by design that the standard methods of assessing corruption make rich countries look clean, excluding all the sophisticated dark-money political operations and financial chicanery that have come to light in recent years [11].

Table 1. A Typology of Corruption

	Lower level/ nonelite actors	**Higher level/elite actors**
Without exchange of benefits	Petty Theft	Grand Theft
With exchange of benefits in transacting parties	Speed money	Access money

Source: Ang YY, 2020 [11].

Hutchinson and colleagues suggest differentiating between different forms of corruption that are:

a) "'survival corruption' constitutes forms of problem solving (eg, by underpaid personnel)

b) forms of corruption that appear 'petty', but which have a profound impact on the health system, (such as commissions to prescribing doctors by the pharmaceutical suppliers)

c) forms of corruption that are well-known about and part of the everyday, informal norms within a health system (eg, private practice by government doctors)

d) more hidden forms of corruption that are underpinned by imbalances in political power". (eg facilitation money for influencing policy decisions)

They argue that this differentiation helps develop and prioritise interventions for targeted approaches [13]. Examples have been added in parenthesis.

Corruption in healthcare

Both Ang and Hutchinson's typologies indicate the importance of historical and contextual factors to address corruption in healthcare. While corruption in healthcare is a deeply entrenched universal phenomenon in the current time, societies differ in the extent of prevalence of corruption, its nature, causes and consequences. A society's healthcare institutions are shaped by its political, economic, social and cultural history. These, in turn, govern how health professionals relate to each other and to other sections, and provide the overall context in which healthcare-related corruption exists in that society.

Healthcare always involves an unequal power relationship between provider and recipient of health services and products, and therefore, the potential for "the abuse of entrusted power for private gain" is huge. The power of the healthcare provider, as the expert, is based on multiple axes — the power to determine what is "correct" health-related knowledge; the power to apply health-related knowledge, while influencing the actions of patients, communities or governments; and the power to obtain material returns for services rendered and advice given. Corruption can thus be in the form of overcharging for services or irrational clinical practice and is often both. Policy and systems design recommendations by experts that create health systems ill-suited to people's contexts and are biased towards provider institutions and experts, which is a higher level of corruption.

Specificities of the health sector

Inelastic demand for healthcare (unlike other consumption goods, the consumer has little choice but to seek healthcare when ill), information asymmetry of health-related knowledge, patients' dependence on healthcare providers' decisions on treatment and choice of technologies, the provider and seller of services and products sometimes being the same — are factors that make dealing with corruption in this sector challenging.

The increasing numbers of actors in the healthcare system, and the relationships between them, have made the system more prone to corruption. This is made more complex by the fact that services are provided through both the public and private sectors. Actors like the recipient of services and payer for those services, the provider of services and payer for those services, the third-party payer and regulator of services, could all be the same or different; thereby the interests of users of services, payers and providers of services could be the same or divergent. Complex health systems with increasing numbers of actors, arguably for mutual oversight and regulation, increase the cost of care and also windows of opportunity for corruption. The larger the number of actors, the greater the complexity and fragmentation of systems. The globalised nature of the supply chain for drugs and medical devices together create the huge potential for corruption in a commercially driven world [14]. Each actor has different objectives and interests and possesses differential powers. The resultant power dynamics between them shapes the structure and culture of health services.

Existing frameworks to understand corruption in healthcare

There are two widely used frameworks to understand corruption in healthcare. Savedoff and Hussman's conceptual model is anchored in the different actors and their potential for abuse of power [15]. The actors identified in this model are patients, providers (public and private), payers (social security, private or public health insurance), government regulators, and suppliers of drugs, equipment, and other materials.

Taryn Vian's model identifies the different processes and functions of the health service system [16] and discusses potential abuses within these. The processes include construction of a health facility; purchase of drugs, equipment and supplies; distribution and use of drugs and supplies in service delivery; regulation of quality in products, services, facilities and professionals; education of health professionals; medical research; and provision of services by medical professionals and health workers. The potential abuse of power in her model happens if there is (1) pressure to abuse (lower wages, incentives and pressure from clients); (2) rationalisation of abuse of power (personality, attitude, moral and ethical belief, and social norms that justify corrupt practices); and (3) opportunities for corruption (existence of monopoly, discretionary powers, lack of accountability, absence of citizens' voices, lack of transparency, absence of an effective detection and enforcement mechanism) [16].

Going beyond financial corruption such as theft and bribes, the understanding of corruption in healthcare has been advanced by Tim Ensor and Antonio Duran-Moreno [17] and by Gaitonde et al [7], bringing in misinformation as an important factor contributing to corruption. Both also combine the models of Savedoff and Haussmann, and Vian, based on actors and processes.

For their review, Gaitonde et al [7] developed a matrix of types of behaviour and types of interactions in the health sector, invoking interactions — between government regulators and suppliers, payers or providers; payers and suppliers; payers and providers; and finally, between suppliers or providers and patients. These interactions are then identified as points where behaviours like theft, bribes and misinformation play out, leading to corruption in the health sector [7].

These conceptual models are very useful for an understanding of the gamut of corruption in healthcare. However, while they are useful in describing corruption in a healthcare institution, they lack a systemic view of healthcare and how its very structure makes it prone to corruption. Even those models espousing a systems approach, such as Glynn's [14], do not help in qualitatively differentiating levels at which corruption is found, the determinants and processes by which it evolved historically, as well as the wider impact of that corruption. These models are ahistorical and insensitive to the nuances of corruption; hence they do not lead to effective anti-corruption interventions. They commonly address the micro and meso levels of health service systems, and are anchored in a management perspective. Consequently, these models fail to enable either evaluation of the health service systems' structure, or interrogation of the technologies used in healthcare as contributors to corruption.

Anti-corruption interventions

Despite corruption in the health sector being an enormous challenge, there is a dearth of existing research on effective

anti-corruption interventions. The comprehensive Cochrane review by Gaitonde et al on corruption in the health sector revealed a serious gap in research studies assessing the effectiveness of anti-corruption interventions using randomised or non-randomised trials, or even controlled before–after studies. Other studies included in the same review on anti-corruption interventions showed very few interventions with significantly successful outcomes or with high certainty evidence of outcomes [7]. The pervasiveness of the problem, and ineffectiveness of the anti-corruption interventions attempted so far, make it necessary to revisit their conceptual underpinnings.

There have been attempts at expanding the framework for understanding and addressing corruption in healthcare. Drawing on a range of disciplines, Zyglidopoulos et al suggest researching corporate corruption at four different levels: individuals; organisations and industries; different countries from an economic development perspective; and different cultural contexts from an anthropological perspective [18]. David Clarke suggests using a public health approach to understand and address the problem of corruption in the health sector. A public health approach would conceptualise corruption in the health sector as a complex problem with a series of determinants and hold upstream determinants to be crucial in anti-corruption interventions. This approach would help us understand and deal with corruption at a population level, going beyond individual behavioural approaches. Commonly used socio-ecological frameworks in public health would enable us to examine the influence of social, cultural, political, institutional and environmental factors that contribute to corruption in health systems [19].

Hutchinson et al (2018) suggest that the multi-dimensional and complex nature of corruption in healthcare necessitates a multi-disciplinary and holistic view to understand it [20]. In their 2020 paper, they propose that clarity on how power operates in different healthcare settings, its historical background, and its political economy are pre-conditions for effective, context-appropriate anti-corruption measures [13].

Building on this body of literature, we propose a framework for understanding corruption in health systems as the "new normal" — a product of structural phenomena at multiple levels. We use the experience of India's health system for specific illustrations of historical processes and pathways leading to corruption.

A systems framework for understanding the "new normal" of corruption in health service systems

Figure 1. An expanded systems framework for the structural basis of corruption in healthcare (Source: Adapted from Priya and Ghodajkar, 2018 [21]) (available online only)

We propose a framework for research on healthcare corruption which recognises the importance of functions included in the four conceptual models above, of Savedoff and Hussman, Vian, Ensor and Duran-Moreno, and Gaitonde and colleagues. Our framework also invokes Ang's broader classification which brings in elite actors and processes operating across levels of institutions. Corruption in healthcare needs to be studied as a systemic problem and not merely described as an institutional feature. Our proposed framework makes a case for understanding the history and context of systemic pathways that lead to corruption in healthcare, which could lead to more effective interventions.

The actors of Savedoff and Hussman's model are universally present in all healthcare systems; however, the level, nature and type of corruption vary across different health services systems or countries. The institutional arrangements and processes in which these actors are placed are also varied. Our proposed framework for understanding corruption is anchored in health service systems structures, with multiple actors operating across multiple levels, making corruption possible. It incorporates the models to place them in an expanded framework which identifies the upstream causal factors and their implications.

Multi-level actors and their interactions

Healthcare at its core involves interaction between the provider and recipient of care involving advice, medical prescription and physical procedures. This interaction confers power on the provider holding expert knowledge and skills. Essentially, in the interaction involving prescriptive advice to the recipient, the provider has the power to control the behaviour of the recipient of care so as to relieve their suffering. Inappropriate and irresponsible use of this power, whether through irrational practice, unethical practice, or malpractice for personal gain, is corruption. Financial or material exchanges for public services meant to be free of charge have conventionally been viewed as corruption. Excess pricing by private providers of services that are unaffordable for the majority also falls within the definition of corruption.

In health services requiring material goods like medicines, equipment and instruments, or herbs, healthcare providers can influence access to these goods, their quality, cost, and sufficiency. These material resources may be freely available to patients or providers, or they may need to be purchased at a high cost from global manufacturers and supply chains. The need for these resources in healthcare delivery brings in a layer of power and shapes the dynamic between recipient and provider, bringing in features of corruption like over-pricing, supply of spurious products and bribes for institutional purchase.

In an institutional setting, the norms and rules of those institutions govern the interaction between providers and recipients bringing in one more layer of power and making it more prone to corruption through the management's decision-making processes. The structure and functioning of healthcare institutions is, in turn, influenced by the suppliers of medical goods, and healthcare financing agencies, including insurance. The healthcare regulatory frameworks

shape the dynamic interaction within and between these levels for the health system's various functions — for medical education and licensing; for manufacturing, storage, distribution, taxation, pricing and consumption of medicines, vaccines, biologicals and sera; for service quality standards and assurance mechanisms; for establishing and running healthcare organisations; specific healthcare regulations on maternal and child health, organ donation, infectious diseases, etc.

These institutional structures and their functions are shaped at the international, national and sub-national levels by the historical context and prevailing politically and economically powerful sections with a combination of self-interest, scientific knowledge and public interest. The national policy and governance frameworks of a sovereign nation are meant to shape the goals and objectives of its healthcare systems, along with their structure and functioning. For example, in India, healthcare roles are divided between the central government and state governments, and some roles are the joint responsibility of both. If healthcare is identified as the right of a citizen of the country, then the national policies and governance frameworks tend to differ from those in countries where healthcare is considered the individual's responsibility. Thus, the defined roles and responsibilities of an individual, state, and market are different in different health systems, shaping their power dynamics and susceptibility to abuse of power, leading to corruption. International agencies like the World Health Organization, private foundations such as the Bill and Melinda Gates Foundation, and other networks, wield enormous power in areas such as healthcare priority setting, choosing health interventions, and establishing scientific standards and norms. These then influence national and regional decision making, thereby impacting the health of millions, intensifying the impact of any abuse of power at the macro level.

The actors/ players at these multiple levels of institutions are governed by the culture and ethos at individual and institutional levels.

Processes relevant for understanding corruption in healthcare

Social context and aspirations of the actors involved

Healthcare providers and professionals working in health-related spheres, like most sections of society, aspire to be more prosperous. The pressure to achieve upward social mobility, or the need to sustain one's standard of living in a highly commercialised social setting, can be a stimulus for corruption. In LMICs where salaries are inadequate to support basic middle-class necessities, corruption is a "coping mechanism" sometimes described as "survival corruption" [22, 23]. We do not believe anti-corruption interventions can succeed unless we understand the incentives for, as well as the rationalisation of, corrupt actions in a society. Health professionals taking policy decisions without considering the context of the majority of the population, uncritically accepting technocratic solutions over addressing social determinants of health, with or without obvious personal gain — whether this is corruption rooted in the politics of knowledge or not is a moot question. Could it be viewed not as individual corruption but as an outcome of the dominance of international and medical-industrial complex (MIC)-led priorities of the system?

Rational and ethical decision making

Institutional mechanisms create conditions and context for better functioning of healthcare institutions and actors. Corruption is currently dealt with largely by punitive action. However, actors too have the responsibility to make rational and ethical decisions, and they have to be encouraged and motivated for this. Such encouragement is of paramount importance to address corruption by all actors in the health system.

Aspirations of world class healthcare

Emphasis on specialised care and recent technologies in the absence of basic primary, secondary and tertiary services put healthcare out of reach of the already underserved, even while those who can afford it become dependent on specialists with aspirations of world class healthcare. When those in positions of power want to emulate the healthcare practices of high-income countries or of the local elites in LMICs, this leads to unreasonable standards being set. Healthcare professionals may also want to use cutting-edge medical technologies which may come at the cost of people's basic healthcare needs. This lack of sensitivity to priorities for people's wellbeing leads to the abuse of power for personal gain among health professionals.

Institutional mechanisms to balance interactions between levels and actors

The degree of power, autonomy, and discretion that each actor and institution possesses affects their functioning and the potential for abuse of power. Mechanisms for monitoring, audit, and grievance redressal are meant to increase institutional and functional transparency, and their lack of effective implementation within the system allows for the abuse of power, and thereby facilitates corruption.

The failure of regulatory mechanisms at higher levels in India is evident from non-implementation of the Clinical Establishments Act [24] and failure of self-regulation of the medical profession by the Medical Council of India [25]. Internationally, one sees this, for instance, in the ever-greening of pharmaceutical patents [26] and the TRIPS agreements [27].

Health policy frameworks

Health policy frameworks determine the organisation and functioning of different levels of institutions and individual actors by setting healthcare priorities, performing health technology assessments, procuring drugs, vaccines and other consumables, deciding human resource policies, and setting

up mechanisms for transparency. Health policies also determine what patients' and citizens' entitlements are, and whether and how these entitlements will be prioritised and fulfilled. Health polices thus shape the power and vulnerabilities of different levels of institutions and actors within the system.

Politics of knowledge

Politics is the process of exercising power and making collective decisions. Collective decisions revolve around ideas about the common good and involve two questions: what are substantive visions of the common good, and what are the underlying procedural principles (rights and responsibilities)? Corruption occurs when competing visions of the common good are not allowed to be articulated and are silenced for the benefit of sectional interests. "Misallocation of public money for political purposes is theft on a grander scale, often for non-financial but nevertheless self-enriching reasons……. Unnecessary induced demand implies expenditure on services that are not clinically effective, appropriate or cost-effective. In addition, those most in need are likely to suffer" [17].

The politics of knowledge plays out in various spheres of healthcare [28] — between patient and doctor, between conventional biomedicine and other schools of medicine (from current advances in systems biology and holistic medicine, to earlier systems such as AYUSH and Traditional Chinese Medicine); between practitioners of codified and non-codified health knowledge; between different types of health workers; between expert and lay knowledge of health; between scientific evidence from the first world and from the third world; between the social sciences and bio-medicine. Those possessing greater power tend to delegitimise, silence or sideline the knowledge of others in the name of public interest. In fact, they may be undermining healthcare for large sections, while furthering their own professional standing and commercial interests. This ignoring of other knowledge systems prevalent in specific contexts does two things. Firstly, it makes the informal go underground so that the patient-provider relationship is made inherently opaque and generates mutual distrust, and thereby justifies power play and dominance by providers, allowing for an easy move to corruption. Secondly, it prevents any challenge to the dominant health system and MIC-led clinical and policy approaches.

Over the 20th century, the dimensions discussed above have all actively come together as systemic dynamics to generate what has become the "new normal" with widely pervasive corruption in contemporary healthcare systems.

Systemic pathways to pervasive corruption in the health service system

Figure 2. Systemic pathways to pervasive corruption in the health service system in LMICs (Source: Developed from the earlier version of this schema in Priya and Ghodajkar, 2018, [21]) (available online only) Determinants of this pervasive corruption and the pathways that lead to corruption emerge from two different sources. Firstly, they come from the social and political context, which has created unsustainable, socially alienated health systems with poor coverage and weak regulatory structures. Secondly, they come from the evolution of the MIC, the network of providers and industries in healthcare whose profit-based character lends itself to corrupt practices in vulnerable health systems.

The social and political context

Healthcare systems are susceptible to corruption if they are developed without making provisions to counterbalance the unequal power relationships in society. Ignoring or undermining non-pharmaceutical interventions is well known as a medical malpractice since it acts as a barrier to patient benefits in favour of medical professionals' personal gain. Absence of effective institutional mechanisms of grievance redressal is another way of ensuring that there is no questioning of medical power.

Healthcare systems have emerged from a colonial[ii] legacy and follow the development model adopted by the national elite of former colonies/developing countries, who have accorded power to biomedicine delivered through hospitals and doctors. They undermined other providers of modern medicine such as licentiates, as well as other healing traditions and health knowledge systems (officially recognised as AYUSH in India) which had already been weakened due to elite capture. The healing traditions of the poor majority were de-legitimised. People were pushed to use health services from a health professional, the doctor, whose language and knowledge was alien to them. Doctors became powerful because of state patronage and international legitimacy.

Medical professionals face challenges to their knowledge power by other professionals and other systems of health, or when any patients raise questions about their treatment. They can abuse their power with impunity in the absence of effective mechanisms to ensure transparency, when there is no dialogue between healthcare professionals practising different knowledge systems, or no efforts are made to demystify health-related knowledge to empower people for self-care or participatory decision-making.

Professional interests push for weak regulatory structures and mechanisms to govern their practice. Constructed on a sense of superiority and alienation from the people, the regulatory frameworks are not accountable to the people. Further, regulations cannot be enforced if the supply of health services is far less than the demand. This huge unmet need contributes to misuse of power by healthcare professionals.

The medical industrial complex

While social context and resultant healthcare systems create fertile grounds for corruption, the medical industrial

complex enables and harvests the benefits of corruption in healthcare.

The medical industrial complex constitutes industries involved in all aspects of healthcare — such as manufacturing and marketing; insurance; corporate hospitals, as well as nursing homes; providers, professional networks; medical information systems; research and publication. Due to the legitimisation in healthcare — by the political leadership and bureaucracy — of industrial technology and professional expertise, they all come together to create powerful institutional structures. This nexus allows the system to legitimise and normalise abuse of power and corrupt practices. It creates "norms" and "standards" of medical practice and systems design that are subservient to the MIC's interests. The MIC's motivation to generate unreasonable rates of profit shapes priorities and decision making at all levels from policies and governance frameworks to institutions and individual healthcare providers.

The nexus between providers, pharmaceutical and other medical product industries, health insurance, medical education and research has contributed to making it a very big market, increasing its scale of economy and the sheer volume of money being available for changing hands at all levels, especially in the higher echelons. As the healthcare industry creates a demand for the products it supplies, professionals promote technologies including medicines irrationally, and in turn, create irrational demand among patients. The overuse and irrational use of expensive technological interventions constitute corrupt medical practice and a consequent abuse of power in pursuit of commercial and professional interests.

The research industry, as the creator of evidence for medical practice, and the publication industry, with its role as arbitrator of that knowledge, hold power over health policies and the practice of medical professionals globally, with the potential for distorting evidence for health policy and medical practice and facilitating corruption in healthcare.

Possible interventions

It is possible to enact safeguards against such a nexus by engaging with the politics of knowledge and creating a space for alternative systems design within modern medicine, with a greater voice for laypeople. Social science research can be used to inform health policy and practice, and people can be empowered by integrating health knowledge systems and healing practices. The demystification and democratisation of health-related knowledge have the potential to reduce power imbalances and misuse of power, along with the use of other anti-corruption governance mechanisms.

In summary, the expanded framework for understanding and addressing corruption in healthcare incorporates — 1) a view of healthcare systems as social institutions with socio-cultural underpinnings; 2) a combination of the micro-, meso-, and macro- levels of the system; 3) a historical understanding of pathways to corruption; 4) the understanding that both top down institutional, and bottom up socio-cultural, processes are important in the construction of systems and corruption within them; 5) the understanding that institutional structures and processes are shaped by the politics of knowledge as well as by governance systems; 6) and that this, in turn, influences the responses of communities to the system, along with the formation and utilisation of the informal system (ie, practices outside the officially recognised healthcare); 7) public and private health services as part of the whole system; 8) all health knowledge traditions and practices as part of the system.

Conclusion

Healthcare has come to be viewed as one of the most corrupt sectors in society [20, 29]. Health systems are particularly susceptible to corruption due to the large amount of resource inputs and lack of access to those in need; the uncertainty of outcomes; the information asymmetry between providers and consumers of healthcare; the large number of dispersed actors; system complexity and fragmentation, and the globalised nature of the supply chain for drugs and medical devices [30]. This necessitates a systems approach to corruption which takes cognizance of all levels of the healthcare sector ranging from the international and national levels to the level of peripheral healthcare providers. Interventions to address corruption must be based on understanding the systemic processes and actors and their potential for abuse of power for personal gain.

This paper presents an expanded systemic framework for understanding corruption and argues that the pervasive corruption in healthcare today is an outcome of the development of health systems within international and national historical socio-political contexts as non-transparent and non-participatory, hierarchical and dependency-creating, and thereby susceptible to high levels of corruption. The powerful network of institutions and industries that make up the medical industrial complex is run on the principle of profit maximisation and is opaque in its functioning. This, along with the power imbalances inherent in the healthcare system, provides the basis for corruption.

The dominant discourse on corruption does not consider the abuse of power by the elite who operate at policy making levels, or those who decide standards and norms, whether in government, corporations, or academic publishers and expert groups. This corruption by the powerful generates institutional structures and practices that result in poor access to health services and products for the marginalised majority. The lack of access then promotes irrational clinical and institutional practices and allows for corruption by lower-level state functionaries and providers of services and products. Without consideration of the public interest, local

contexts, and people's voices in shaping knowledge and institutional structures, the system is geared to encourage corrupt practices.

Currently, the political economy of healthcare services, and the knowledge that underlies them, is alienated from the people. The dependence of societies on conventional biomedicine, generated by the socio-political conditions of the past two-and-a half centuries, along with the dominance of the medical industrial complex, facilitates the structural impunity of those controlling knowledge, technology, services and products. However, regulatory mechanisms remain largely ineffective because of the powerful dominant framework. Unless the regulatory framework incorporates people's voices and diversity of contexts, and addresses both the political economy and the politics of knowledge in healthcare, it cannot be effective in shaping practices on the ground.

For effective anti-corruption interventions, corrupt individuals should be identified and appropriately dealt with. However, a holistic and ethical approach requires that the systemic conditions enabling corruption must be identified and corrected. Decolonising the discourse and evolving systemic measures to minimise corruption, creating participatory oversight at all levels from research to international and national policies, to implementation structures and processes is essential. Anti-corruption interventions need to address several issues: decolonising of knowledge; conflict of interests; decentralisation of management and governance and involving lay people; structures of accountability; regulatory mechanism for pricing; Health Technology Assessment incorporating technical, social, and financial dimensions; and regulation of the MIC keeping people's interests at the centre. Recognising the historical pathways by which corruption becomes normalised, as depicted in the expanded framework, can be a useful lens to develop measures that deal with the root causes of corruption. Thus, adapting this lens to the specifics of diverse contexts and their historical trajectories can help in effectively addressing corruption in health systems.

Notes:

[i]*Elites: those who have disproportionate control over a societal resource and exercise disproportionate power and influence, for instance, the political or cultural elite. "It is customary to distinguish between political elites, whose locations in powerful institutions, organisations, and movements enable them to shape or influence political outcomes, often decisively, and cultural elites who enjoy a high status and influence in non-political spheres such as arts and letters, philanthropy, professions, and civic associations" [31] (https://www.britannica.com/topic/elite-sociology).*

[ii]*Colonialism: the practice of extending and maintaining political, social, economic, and cultural domination over a territory and its people by another people in pursuit of interests defined in an often distant metropole, who also claim superiority. "It implies (1) that one society completely deprives a second one of its potential for its autonomous development; that an entire society is 'remote controlled' and reconfigured an entire society is 'remote controlled' and reconfigured in accordance with the colonial rulers; (2) that the ruling and ruled are permanently divided by a cultural gap; (3) the intellectual 'yoke' of an ideology whose purpose it is to legitimise colonial expansion" [32].*

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Conflict of Interest: None declared **Funding:** None

To cite: Ghodajkar P, Priya R. An expanded framework for understanding corruption in healthcare. *Indian J Med Ethics.* 2026 Apr-Jun; 11(2) NS: 108-116 DOI: 10.20529/IJME.2026.025

Submission received: August 30, 2024

Submission accepted: February 27, 2026

Published online first: April 23, 2026

Theme Editors: Sandhya Srinivasan, Veena Johari

Peer Reviewer: Rakhal Gaitonde

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Thank You, Reviewers!

We are grateful to our committed reviewers for their contribution in evaluating and improving submissions. Besides our core group of editors, we thank members of the Editorial Board and others who reviewed manuscripts during the year 2025-26:

Abhishek Kashyap, Adithya Pradyumna, Akhila Vasan, Akshay S Dinesh, Aleena Sebastian, Alok Sarin, Amarendra Pattnaik, Amol Dongre, Aneesh Pillai, Anindita Majumdar, Anuradha Rose, Aravind Chandru, Arnav Mahurkar, Arun Bhatt, Biju Soman, Carol Lobo, CR Bijoy, Cynthia Arunachalam, Deepa Venkatachalam, Dharmagadda Sreedhar, Dheeraj Kattula, Dhvani Mehta, Dunu Roy, E Premdas Pinto, Fatima Castillo, Gayatri Saberwal, George Thomas, Harihar Sahoo, Harmala Gupta, Hui Siu Tan, Imrana Qadeer, Janelle de Sa Fernandes, Jaya Ranjalkar, Jean Dreze, Jerald Dsouza, Joe Varghese, William Joe, Kahaan Mehta, Karel Caals, Kingsly Robert Gnanadurai Victor, Kiran Kumbhar, Laura Palazzani, Manjiri Phansalkar, Manjulika Vaz, Mathew George, Meghna Haridas, Meryl Antony, Mohamad Iqhbal Bin Kunji Mohamad, Mohan Rao, Mohit P Gandhi, Monica Sakhrani, Monty Khajanchi, Muthu Prathiba, Nachiket Shankar, Nandini Kumar, Nobhojit Roy, Parth Sharma, Prabir Chatterjee, Prasanth SR, Prem Pais, Priya Pais, Priya Sharma, R Srivatsan, R Sukanya, Radhika Jha, Raghu Menon Jayakumar, Rakhal Gaitonde, Raman Kutty, Ranjith Viswanath, Ravi Prasad Varma, Ravi Vaswani, Reetika Khera, Rohin Bhatt, Sabah Siddiqui, Saima Iqbal, Samir Malhotra, Sandip Mukhopadhyay, Sanjiv Lewin, Santosh Karmarkar, Savitha D, Sebin George, Sharachchandra Lele, Shivangi Rai, Shruti Bhide, Siby K George, Soham Bhaduri, Sophia Modi, Srimathi Gopalakrishnan, Sualeha Shekhani, Subhasri B, Sudarshan Kottai, Sujith Chandy, Suptendra Nath Sarbadhikari, Surjeet Kaur Chahal, Tejal Jaitly, Thalia Arawi, Tinashe Goronga, Upreet Dhaliwal, Usha Raman, V Sridhar, Vaibhavi Joshipura, Valerie Luyckx, Varun S Bhatta, Venkatanarayana Motkuri, Vijaya Raghavan, Vineetha K, Walter Fontanini