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Corruption in Indonesian Health Procurement: Strengthening Integrity Mechanisms for Public Hospital Pharmaceutical Purchasing

Samuel Gabriel Santoso*
Universitas Brawijaya, Malang, Indonesia
s.g.santoso@students.ub.ac.id

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*Corresponding Author

Abstract

Public procurement of medicines and medical supplies involves substantial government expenditure and directly affects the quality and accessibility of healthcare. Corruption in pharmaceutical procurement can increase prices, reduce product quality, distort supplier competition, and ultimately harm patients. This article examines corruption risks in pharmaceutical procurement by Indonesian public hospitals. Using normative juridical and policy analysis, the study evaluates procurement regulation, supplier selection, pricing mechanisms, conflicts of interest, and institutional oversight. The article argues that conventional procurement controls may be insufficient when procurement decisions involve complex technical specifications and information asymmetry between hospitals and suppliers. The study proposes an integrity framework incorporating transparent procurement data, standardized specifications, conflict-of-interest declarations, supplier due diligence, price benchmarking, and independent audits. Particular attention is given to the role of hospital procurement committees and relationships between healthcare professionals and pharmaceutical suppliers. The article concludes that anti-corruption policy in healthcare procurement should integrate financial accountability with patient-centered considerations because procurement corruption has consequences extending beyond public finances to the right to accessible and quality healthcare.

[*Pengadaan obat-obatan dan perlengkapan medis oleh pemerintah melibatkan pengeluaran pemerintah yang besar dan secara langsung memengaruhi kualitas dan aksesibilitas layanan kesehatan. Korupsi dalam pengadaan farmasi dapat menaikkan harga, menurunkan kualitas produk, mendistorsi persaingan pemasok, dan pada akhirnya merugikan pasien. Artikel ini mengkaji risiko korupsi dalam pengadaan farmasi oleh rumah sakit pemerintah di Indonesia. Dengan menggunakan analisis yuridis dan kebijakan normatif, studi ini mengevaluasi regulasi pengadaan, pemilihan pemasok, mekanisme penetapan harga, konflik kepentingan, dan*

pengawasan kelembagaan. Artikel ini berpendapat bahwa kontrol pengadaan konvensional mungkin tidak cukup ketika keputusan pengadaan melibatkan spesifikasi teknis yang kompleks dan asimetri informasi antara rumah sakit dan pemasok. Studi ini mengusulkan kerangka kerja integritas yang menggabungkan data pengadaan yang transparan, spesifikasi standar, deklarasi konflik kepentingan, uji tuntas pemasok, penetapan harga acuan, dan audit independen. Perhatian khusus diberikan pada peran komite pengadaan rumah sakit dan hubungan antara tenaga kesehatan dan pemasok farmasi. Artikel ini menyimpulkan bahwa kebijakan anti-korupsi dalam pengadaan layanan kesehatan harus mengintegrasikan akuntabilitas keuangan dengan pertimbangan yang berpusat pada pasien karena korupsi pengadaan memiliki konsekuensi yang meluas melampaui keuangan publik hingga hak atas akses dan kualitas layanan kesehatan.]

Keywords: Health procurement, pharmaceutical corruption, public hospitals, integrity, Indonesia

Introduction

Public hospital pharmaceutical procurement occupies a distinctive position within the broader system of public administration because decisions concerning medicines simultaneously involve financial, technical, clinical, and ethical considerations. Unlike many ordinary government purchases, a procurement decision concerning pharmaceuticals may affect whether patients receive essential treatment, whether a hospital experiences stock shortages, and whether public health financing produces effective therapeutic outcomes. The procurement process must therefore achieve several objectives at once: public institutions must obtain safe and effective medicines, ensure continuity of supply, maintain competitive prices, comply with legal procurement procedures, and protect decision-making from undue influence. These overlapping objectives create a governance environment in which corruption may be difficult to identify because questionable procurement decisions can be presented as technical or clinical judgments. Research on pharmaceutical governance has consistently demonstrated that the sector is particularly vulnerable to corruption because it combines large financial flows, complex products, specialized knowledge, substantial information asymmetry, and relationships between public institutions and private companies (Kohler and Dimancesco 2020; Kohler, Mackey, and Ovtcharenko 2014).

The consequences of corruption in pharmaceutical procurement are particularly serious because financial misconduct can be translated into direct harm to patients. When corruption increases prices, hospitals may purchase fewer medicines with available resources. When supplier selection is manipulated, competition may be restricted and lower-quality products may enter the supply

chain. When procurement planning is distorted by commercial relationships, hospitals may prioritize unnecessary or excessively expensive medicines over more cost-effective alternatives. These effects demonstrate that pharmaceutical corruption should not be understood merely as a budgetary offense. The diversion or inefficient use of public resources may reduce the capacity of hospitals to fulfill their function as institutions responsible for protecting public health. The relationship between governance and access to medicines is therefore central to the anti-corruption debate: weak transparency and accountability can contribute to financial losses while simultaneously aggravating inequity in access to essential health products (Vian 2008; Mackey and Liang 2012; Kohler, Mackey, and Ovtcharenko 2014).

Indonesia has undertaken significant procurement reform through the development of electronic systems, including e-procurement and e-purchasing mechanisms, as well as the use of electronic catalogues for selected medicines. Government procurement is principally governed by Presidential Regulation No. 16 of 2018 concerning Government Procurement of Goods and Services, as amended by Presidential Regulation No. 12 of 2021. These reforms seek to improve efficiency, transparency, accountability, and competition through standardized procedures and digital transactions. In the health sector, electronic catalogue mechanisms have been expected to reduce opportunities for direct manipulation of prices and supplier selection. Empirical research from Indonesian health facilities indicates that e-catalogue procurement can increase procedural efficiency and transparency but may also encounter practical problems involving supplier responsiveness, stock availability, delivery delays, minimum purchasing requirements, and limited procurement capacity (Saputra, Puspandari, and Kurniawan 2019; Pancasila, Anggriani, and Lesilolo 2020). These findings suggest that electronic procurement is not a self-executing anti-corruption mechanism.

The Indonesian legal framework also places pharmaceutical procurement within a broader public health and anti-corruption architecture. Law No. 17 of 2023 concerning Health recognizes the state's responsibility to organize and support the health system, while Law No. 31 of 1999 concerning the Eradication of Criminal Acts of Corruption, as amended by Law No. 20 of 2001, establishes criminal prohibitions relevant to abuse of authority, bribery, unlawful enrichment, and procurement-related corruption. In addition, Law No. 14 of 2008 concerning Public Information Disclosure provides an important foundation for transparency, while Law No. 30 of 2014 concerning Government Administration reinforces the principles of legality and good governance. Nevertheless, the existence of these legal instruments does not automatically resolve the distinctive vulnerabilities of pharmaceutical procurement. Anti-corruption rules must be translated into operational mechanisms capable of identifying conflicts of interest, evaluating supplier integrity, testing the reasonableness of prices, and distinguishing legitimate clinical discretion from commercially motivated procurement decisions.

This article examines corruption risks in Indonesian public hospital pharmaceutical purchasing through a descriptive-analytical and normative juridical approach. The principal argument is that conventional procurement compliance is insufficient because pharmaceutical purchasing involves specialized information that can be strategically controlled by healthcare professionals, procurement committees, and suppliers. A hospital may formally comply with electronic procedures while procurement outcomes remain vulnerable to collusion, manipulated specifications, hidden conflicts of interest, or inadequate supplier oversight. Effective corruption prevention therefore requires a broader concept of integrity that integrates procedural transparency with substantive scrutiny. The article proposes that procurement decisions should be assessed not only according to whether legal procedures have been followed, but also according to whether prices are reasonable, specifications are clinically justified, supplier relationships are transparent, and purchasing outcomes protect patient access to safe and effective medicines.

This study employs a normative juridical method combined with descriptive-analytical policy analysis. The normative component examines the principal Indonesian legal instruments governing public procurement, healthcare administration, public information, government administration, and corruption prevention. Particular attention is given to Presidential Regulation No. 16 of 2018 concerning Government Procurement of Goods and Services, as amended by Presidential Regulation No. 12 of 2021; Law No. 17 of 2023 concerning Health; Law No. 31 of 1999 concerning the Eradication of Criminal Acts of Corruption, as amended by Law No. 20 of 2001; Law No. 14 of 2008 concerning Public Information Disclosure; and Law No. 30 of 2014 concerning Government Administration. The legal framework is analyzed together with relevant policy mechanisms governing electronic procurement, e-catalogue purchasing, procurement oversight, and pharmaceutical governance. The purpose is not merely to identify formal legal provisions but to evaluate whether they address the institutional conditions that create opportunities for corruption.

The descriptive-analytical dimension draws upon academic literature concerning pharmaceutical corruption, public procurement, conflicts of interest, e-procurement, medicine pricing, health-sector governance, and hospital purchasing. The analysis focuses on the relationship between procedural compliance and substantive integrity. This distinction is essential because a procurement process may satisfy formal administrative requirements while remaining vulnerable to corruption through technical specification design, pre-arranged supplier relationships, inappropriate pricing, or concealed conflicts of interest. The study therefore approaches corruption risk as an institutional problem rather than exclusively as a criminal event. The central analytical questions are: where do major corruption vulnerabilities arise in public hospital pharmaceutical procurement; how effectively do Indonesian legal and institutional mechanisms

address those vulnerabilities; and what additional integrity mechanisms are necessary to protect both public finances and patient welfare?

The analysis is organized around four substantive dimensions. First, the article examines why pharmaceutical procurement presents distinctive corruption risks compared with ordinary government purchasing. Second, it identifies key points of vulnerability throughout the procurement cycle, including planning, specification development, supplier selection, pricing, contract implementation, and delivery. Third, it evaluates the strengths and limitations of Indonesian electronic procurement and legal accountability mechanisms. Fourth, it develops an integrity framework combining transparency, conflict-of-interest regulation, supplier due diligence, price benchmarking, clinical accountability, and independent oversight. This framework is intended to demonstrate that corruption prevention in healthcare procurement requires institutional coordination across financial, clinical, legal, and administrative domains.

The Distinctive Corruption Risks of Pharmaceutical Procurement

Pharmaceutical procurement is structurally vulnerable to corruption because medicines are not ordinary commodities. Their selection and evaluation require specialized knowledge concerning clinical effectiveness, safety, dosage, formulation, therapeutic alternatives, regulatory status, and patient needs. Hospital managers and procurement officials may therefore depend heavily on pharmacists, physicians, or technical experts when defining procurement requirements. This dependence creates information asymmetry because the individuals responsible for technical recommendations may possess knowledge that external financial or administrative oversight bodies cannot easily evaluate. A procurement decision can consequently be presented as clinically necessary even when a particular product is unnecessarily expensive, a cheaper therapeutic equivalent exists, or the specification has been drafted to favor a specific supplier. Kohler and Dimancesco (2020) identify information asymmetry as a major vulnerability in pharmaceutical procurement because technical complexity can conceal corruption from conventional procurement controls. The challenge is therefore not simply to prevent officials from violating procurement procedures but to ensure that technical expertise itself is exercised transparently and independently.

The pharmaceutical sector also involves close and continuing relationships between public healthcare institutions and private suppliers. Pharmaceutical companies may interact with physicians, pharmacists, hospital managers, procurement committees, distributors, and other healthcare professionals through product information, training activities, professional events, research support, and commercial transactions. These interactions are not inherently corrupt; cooperation between healthcare institutions and suppliers can contribute to product information and technical capacity. However, the boundary between legitimate professional interaction and improper influence may become difficult to identify when financial

or institutional relationships are not fully disclosed. Research concerning institutional conflicts of interest has demonstrated that pharmaceutical relationships may influence organizational decision-making even where no explicit bribery occurs, particularly when professional or institutional dependence creates incentives to favor certain products (Ohi et al. 2021). Effective integrity policy must therefore address not only direct bribery but also conflicts of interest capable of distorting supposedly independent clinical or procurement decisions.

Price determination constitutes another significant area of vulnerability. Pharmaceutical prices can vary according to procurement volumes, product characteristics, market concentration, intellectual property conditions, supplier strategies, and negotiation arrangements. Consequently, a procurement officer cannot necessarily identify an unreasonable price merely by comparing one transaction with another. Corrupt overpricing may therefore be concealed within apparently technical pricing structures. International research on medicine procurement has emphasized that transparency concerning prices can improve accountability, but the publication of prices alone does not guarantee that a purchase represents good value because meaningful analysis requires comparable data, standardized units, and information about product quality and contract conditions (Vogler, Haasis, and colleagues 2022). Price transparency must therefore be combined with systematic benchmarking capable of identifying unusual price differences that cannot be explained by legitimate market conditions.

The public health consequences of these vulnerabilities distinguish pharmaceutical corruption from many other forms of procurement misconduct. When corruption affects office construction or routine administrative supplies, the principal immediate harm may be financial. In pharmaceutical procurement, however, distorted decisions may contribute to medicine shortages, delayed treatment, reduced quality, and unequal access to care. This connection between corruption and patient welfare is especially important in public hospitals, where procurement decisions are frequently linked to publicly financed healthcare services and the treatment of economically vulnerable populations. Mackey and Liang (2012) argue that corruption in global health can undermine health outcomes by diverting resources, distorting priorities, and weakening institutional legitimacy. Pharmaceutical integrity should therefore be understood as a component of the right to health and not merely as a matter of administrative efficiency.

Corruption Vulnerabilities Across the Hospital Pharmaceutical Purchasing Cycle

The first significant point of vulnerability occurs before a formal procurement process begins. Procurement planning determines which medicines will be purchased, in what quantities, and according to what technical criteria. If planning is based on inaccurate consumption data, distorted demand estimates, or commercially influenced clinical preferences, the resulting procurement may be

inefficient even when the subsequent purchasing procedure is formally competitive. Corruption prevention must therefore begin with needs assessment. Hospitals should be able to demonstrate the relationship between procurement quantities and verifiable clinical demand, consumption patterns, patient numbers, and formulary requirements. Excessive procurement can create opportunities for waste, diversion, and unnecessary expenditure, while insufficient procurement may produce shortages that encourage emergency purchases under less competitive conditions. A transparent planning process is consequently essential because it establishes the substantive foundation upon which all later procurement decisions are based.

Technical specifications represent a second major point of vulnerability. Procurement rules often require specifications to promote competition and avoid unnecessary discrimination among suppliers. In pharmaceutical purchasing, however, highly detailed specifications may effectively limit competition to a particular product or supplier. Such restrictions can be justified when clinically necessary, but they also create opportunities for hidden favoritism. The problem is particularly difficult because general procurement officials may lack the expertise required to challenge medical justifications. An integrity-based system should therefore require documented clinical reasoning whenever specifications substantially restrict competition. Independent review by pharmacy and therapeutics committees, clinical experts, or external specialists may be necessary for high-value or unusually restrictive procurement. The purpose is not to remove medical expertise from the process but to prevent expertise from functioning as an opaque shield against accountability.

Supplier selection creates additional risks even within electronic procurement systems. E-procurement can reduce face-to-face interactions, standardize procedures, and create digital records that improve traceability. However, digital systems cannot prevent collusion when suppliers coordinate bids, divide markets, or agree in advance on pricing strategies. Nor can they independently identify whether a technically compliant supplier is controlled by undisclosed beneficial owners or has previously engaged in serious integrity violations. Research on public pharmaceutical procurement has emphasized that open contracting and transparency are useful mechanisms, but they must be connected with accountability and verification rather than treated as substitutes for oversight (Kohler and Dimancesco 2020). Supplier selection should therefore include integrity due diligence examining corporate ownership, sanctions history, conflicts of interest, previous contract performance, and evidence of anti-competitive conduct.

Indonesian experience with e-catalogue procurement illustrates both the benefits and limitations of digitalization. The adoption of e-purchasing mechanisms was intended to improve efficiency, transparency, and price control by reducing discretionary negotiations and standardizing purchasing procedures. Research examining medicine procurement at Indonesian health facilities has nevertheless

identified operational difficulties, including delayed supplier responses, stock shortages, variable delivery times, products unavailable in the catalogue, and limited procurement personnel (Saputra, Puspandari, and Kurniawan 2019). Similar research on public health centers has found that e-catalogue purchasing may encounter problems related to planning, system implementation, supplier availability, and procurement performance (Widiyani, Istyastono, and Priyatni 2022). These operational problems are relevant to corruption prevention because a system that cannot meet legitimate hospital needs may encourage the use of exceptional or alternative procedures with greater discretionary space.

The final stages of procurement also require stronger scrutiny. A procurement contract does not guarantee that the medicine delivered corresponds to the agreed product, quantity, quality, price, and delivery schedule. Hospitals must therefore maintain controls over receipt, storage, quality assurance, invoice verification, and payment. Segregation of duties is particularly important because the same individuals should not exercise uncontrolled authority over planning, supplier selection, product acceptance, and payment approval. Internal audit mechanisms should examine not only whether supporting documents are complete but also whether procurement patterns indicate irregularities. Repeated purchases from the same supplier, unusual emergency procurement, substantial price variations, recurring stock shortages, and repeated specification changes may all constitute indicators requiring further examination. An effective anti-corruption system must therefore treat procurement as a continuous process rather than a single event ending with contract award.

Indonesian Legal and Institutional Mechanisms: Progress and Remaining Gaps

Indonesia has established a substantial legal framework for public procurement and corruption prevention. Presidential Regulation No. 16 of 2018, as amended by Presidential Regulation No. 12 of 2021, emphasizes efficiency, effectiveness, transparency, openness, competition, fairness, and accountability as fundamental principles of government procurement. These principles provide an important normative basis for integrity in pharmaceutical purchasing because they require public institutions to organize procurement in a manner capable of being examined and justified. Electronic procurement systems further support these objectives by creating transaction records and reducing some opportunities for informal intervention. However, the effectiveness of these principles depends on their institutional implementation. A transparent digital process may still produce problematic outcomes if the information entered into the system is itself manipulated or if technical decisions are made before the electronic process begins.

Law No. 17 of 2023 concerning Health provides an additional legal context because the procurement and availability of medicines are inseparable from the state's responsibility to support the health system. Pharmaceutical procurement

should therefore be evaluated against broader objectives of accessibility, safety, quality, and continuity of care. A procurement system that formally saves money but produces recurring stock shortages cannot automatically be regarded as successful from a health governance perspective. Similarly, an anti-corruption framework that focuses exclusively on financial documentation may overlook the clinical consequences of distorted purchasing. Kohler, Mackey, and Ovtcharenko (2014) argue that pharmaceutical governance must integrate accountability with broader health objectives because weaknesses in procurement can affect medicine availability and public health outcomes. Indonesian procurement governance should consequently include indicators connecting financial integrity with patient access and service continuity.

The anti-corruption framework established by Law No. 31 of 1999 and Law No. 20 of 2001 provides mechanisms for investigating and punishing completed corrupt acts. Nevertheless, criminal law is predominantly reactive. It becomes effective after suspicious conduct has been identified and sufficient evidence exists to support investigation and prosecution. Preventive governance therefore requires complementary institutional mechanisms. Conflict-of-interest declarations, independent technical review, supplier due diligence, price benchmarking, internal audit, and whistleblowing systems can identify risks before they develop into completed corruption offenses. The United Nations Convention against Corruption also supports a preventive approach by emphasizing public procurement systems based on transparency, competition, and objective criteria. Recent scholarship concerning pharmaceutical governance similarly concludes that legal compliance with anti-corruption standards is necessary but insufficient when broader cultures of integrity, transparency, and accountability are weak (Wong, Perehudoff, and Kohler 2024).

Law No. 14 of 2008 concerning Public Information Disclosure is particularly relevant to hospital pharmaceutical procurement because public access to procurement information can enable external scrutiny. Nevertheless, transparency should not be interpreted as requiring the indiscriminate publication of every document without considering how information will be used. Procurement data should be published in a standardized and intelligible format that allows comparison across hospitals and contracts. Information concerning product prices, quantities, suppliers, contract amendments, and delivery performance can support monitoring by auditors, researchers, civil society organizations, and oversight bodies. Research on transparency has repeatedly demonstrated that disclosure is most effective when information can be understood, compared, and converted into accountability (Lindstedt and Naurin 2010). Data that technically exists but cannot be meaningfully analyzed may provide only symbolic transparency.

Hospital governance also requires attention to the internal distribution of authority. Procurement committees may include administrators, pharmacists, clinicians, finance officers, and technical personnel whose roles overlap at different stages of decision-making. Such institutional arrangements can strengthen decision

quality by combining expertise, but they may also obscure responsibility when accountability is collective and poorly documented. Each significant decision should therefore have a clear record identifying who proposed a requirement, who approved it, what evidence was considered, and whether any conflicts of interest were declared. This is particularly important where high-cost medicines or restricted specifications are involved. Institutional integrity requires not only preventing individual misconduct but also ensuring that decision-making structures do not permit responsibility to disappear into complex committees.

A Patient-Centered Integrity Framework for Public Hospital Pharmaceutical Purchasing

The first component of a stronger integrity framework should be transparent and standardized procurement data. Hospitals should maintain interoperable information systems linking procurement planning, formulary decisions, product specifications, supplier identity, contract value, quantity, unit price, delivery performance, and payment. This information should be capable of generating both internal and external scrutiny. Public disclosure should be designed around usability, enabling comparisons between hospitals and over time. Procurement transparency should also include contract amendments and exceptions because corruption risks may emerge after the initial award through modifications that substantially alter prices or quantities. Open procurement data can therefore function as an early-warning mechanism when combined with analytical tools capable of detecting unusual patterns.

The second component should be mandatory and enforceable conflict-of-interest management. Members of procurement committees, pharmacy and therapeutics committees, clinicians involved in product selection, hospital executives, and relevant technical experts should submit periodic declarations concerning financial, professional, or institutional relationships with pharmaceutical suppliers. These declarations should be updated when new relationships emerge and should produce clear consequences where a conflict exists. Recusal procedures must be operational rather than symbolic. A declaration that remains confidential and has no effect on decision-making provides limited protection. Research on pharmaceutical governance demonstrates that conflicts of interest can distort decisions even when relationships are formally legal, making transparency and institutional management essential (Ohi et al. 2021; Kohler, Mackey, and Ovtcharenko 2014).

The third component should be supplier integrity due diligence. Public hospitals should not assess suppliers exclusively according to price and technical compliance. Due diligence should consider corporate identity, beneficial ownership where legally available, past performance, sanctions, serious contractual violations, competition-law concerns, and integrity risks. Particular attention should be given to suppliers that appear formally independent but are controlled by the

same beneficial owners or participate in coordinated bidding patterns. Digital procurement systems could support this process through risk indicators and data matching. Supplier integrity assessment should not replace competitive procurement rules but should ensure that competition is genuine rather than merely formal. The existence of multiple bidders is not meaningful if the bidders are connected through undisclosed ownership or coordinated commercial behavior.

The fourth component should involve systematic price benchmarking and market analysis. Hospitals should compare procurement prices against relevant national catalogue prices, historical hospital prices, prices obtained by comparable institutions, and other available reference data. Significant price deviations should automatically trigger additional review rather than being treated as evidence of corruption by themselves. Legitimate differences may result from product formulation, purchase volume, delivery conditions, or market shortages. However, the obligation to explain unusual pricing creates a preventive accountability mechanism. Research on centralized medicine procurement has shown that transparent and coordinated purchasing arrangements can improve governance and equity, although effective implementation requires reliable data and institutional capacity (Vogler, Haasis, and colleagues 2022). Indonesia could strengthen this approach by developing analytical tools capable of identifying price anomalies across public hospitals.

The fifth component should integrate financial accountability with clinical and patient-centered evaluation. Procurement success should not be measured exclusively through budget savings. A lower purchase price is not necessarily a successful outcome if medicines arrive late, fail to meet quality requirements, or create treatment interruptions. Hospitals should therefore assess procurement integrity using indicators such as stock-out frequency, delivery timeliness, medicine availability, product quality, price variance, emergency purchasing frequency, and complaints from patients or healthcare professionals. This broader evaluation would recognize that corruption prevention and health-system performance are interconnected. Public resources are protected most effectively when procurement produces medicines that are both economically efficient and clinically accessible.

The final component should strengthen independent oversight and protected reporting. Internal auditors, external auditors, procurement regulators, health authorities, and anti-corruption institutions should have clear channels for exchanging information concerning high-risk transactions. Hospitals should also maintain accessible whistleblowing mechanisms for employees, suppliers, patients, and members of the public. Protection is essential because healthcare professionals or procurement staff may hesitate to report irregularities when the suspected actors possess institutional authority. The effectiveness of reporting mechanisms depends on confidentiality, protection against retaliation, timely investigation, and feedback concerning institutional responses. Recent research on pharmaceutical-sector governance has emphasized that gaps in whistleblower and witness protection can weaken otherwise comprehensive anti-corruption systems (Wong, Perehudoff, and

Kohler 2024). A procurement integrity framework must therefore make reporting both legally possible and practically safe.

Conclusion

Pharmaceutical procurement in Indonesian public hospitals presents corruption risks that cannot be addressed through conventional financial controls alone. The sector combines substantial public expenditure, specialized technical knowledge, complex pricing structures, close relationships between healthcare professionals and suppliers, and direct consequences for patient welfare. These characteristics create information asymmetries that may allow corruption to remain concealed behind formally legitimate clinical or technical decisions. Corruption can occur through bribery and direct financial misconduct, but it may also emerge through manipulated specifications, undisclosed conflicts of interest, distorted planning, supplier favoritism, collusion, overpricing, and weak contract implementation. A comprehensive anti-corruption strategy must therefore address the entire procurement cycle rather than concentrating only on the moment of supplier selection.

Indonesia has developed important legal and institutional foundations through procurement reform, electronic purchasing, public information rules, health legislation, and anti-corruption law. Nevertheless, digitalization should not be treated as a complete solution. E-catalogue and e-purchasing systems can improve traceability and reduce certain forms of discretion, but they cannot independently prevent corruption occurring through technically manipulated specifications, coordinated supplier behavior, hidden conflicts of interest, or commercially influenced clinical decisions. The effectiveness of electronic procurement depends on the integrity of the information, institutional independence of decision-makers, supplier verification, and the capacity of oversight institutions to detect abnormal patterns.

The article therefore proposes a patient-centered integrity framework built upon transparent procurement data, standardized specifications, mandatory conflict-of-interest declarations, supplier due diligence, price benchmarking, clinical justification, independent auditing, and protected reporting mechanisms. This approach recognizes that pharmaceutical procurement is both a public financial function and a component of the health system. Corruption prevention should consequently be evaluated not only by the amount of public money protected but also by whether patients receive safe, effective, affordable, and continuously available medicines. Strengthening integrity in public hospital pharmaceutical purchasing would thus contribute simultaneously to financial accountability, institutional trust, equitable healthcare, and the broader realization of the right to health.

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N/A