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Corruption in the Health sector

This U4 Issue presents some essential resources for anyone promoting anti-corruption in the health sector, or otherwise wanting to learn about the challenges of corruption in the health sector. The text is originally developed as web pages by U4 based on researcher by Carin Nordberg of Transparency International and were later updated by Taryn Vian (tvian@bu.edu) of Boston University.

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Focus:

Further information on corruption in the health sector:

1 Causes and consequences

1.1 Improving public health is a fundamental precondition to ensure human development

The importance of health for economic growth and reduction of poverty is reflected in the Millennium Development Goals (MDG). Three out of the eight goals refer directly to health. One additional goal refers to access to affordable drugs in developing countries. To ensure universal and equitable access to quality health services, governments must earmark a sufficient share of public revenues for health. While high income countries spend on average 7% of GDP on health, low income countries spend on average only 4.2% on health.[1]

Insufficient health budgets due to deteriorating economic conditions, combined with burgeoning health problems such as the global HIV-AIDS pandemic, have led to an acute shortage of health workers (WHO 2006), shortage of drug and medical supplies, inadequate or non-payment of health workers salaries, poor quality of care, and inequitable health care services in many low income and transition countries. With corruption as both a cause and effect the result has been deterioration of general health and degrading of the health system in developing countries (World Bank 2004).

Global Corruption Barometer 2007

In 2007, 63,199 people were surveyed in 60 countries in the Voice of the People survey conducted by Gallup International. Included in the survey were a series of questions asked on behalf of Transparency International (TI), the responses to which are presented in Transparency International's 2007 Global Corruption Barometer intended to reflect international perceptions, experiences, and expectations concerning corruption. On average, respondents rated medical services as moderately corrupt. The prevalence of bribery when attending medical services is higher in low income countries than in high income countries. 6% of those who had sought medical services the last month in low income countries reported to have paid a bribe. The income patterns are similar within countries, with lower income households reporting bribery in medical services more frequently than higher income households (7% versus 5%). Although it is difficult to draw any conclusion based on the findings from the global corruption barometer, the poor appears to be asked for bribes more frequently than the rich both across and within countries.

Link: http://www.transparency.org/policy_research/surveys_indices/gcb/2007

1.2 Corruption in the health sector

"Corruption in the health sector is a concern in all countries, but it is an especially critical problem in developing and transitional economies where public resources are already scarce" (Vian 2002). Corruption reduces the resources effectively available for health, lowers the quality, equity and effectiveness of health care services, decreases the volume and increases the cost of provided services. It discourages people to use and pay for health services and ultimately has a corrosive impact on the population's level of health. A study carried out by the International Monetary Fund (IMF) using data from 71 countries, shows that countries with high indices of corruption systematically have higher rates of infant mortality (Gupta, Davoodi and Tiongron, 2000). Preventing abuse and reducing

[1] HNPStats – the World Bank's comprehensive database of Health, Nutrition and Population (HNP) statistics: statistics from 2004: Permanent URL for this page: http://go.worldbank.org/1QXEI9FDR0- Latest figures are from 2005.

corruption therefore is important to increase resources available for health, to make more efficient use of existing resources and, ultimately, to improve the general health status of the population.

1.3 High corruption vulnerability in the health sector

Despite limited research, the health sector appears to be particularly vulnerable to corruption. This is the result of many processes with high risks of bribery.

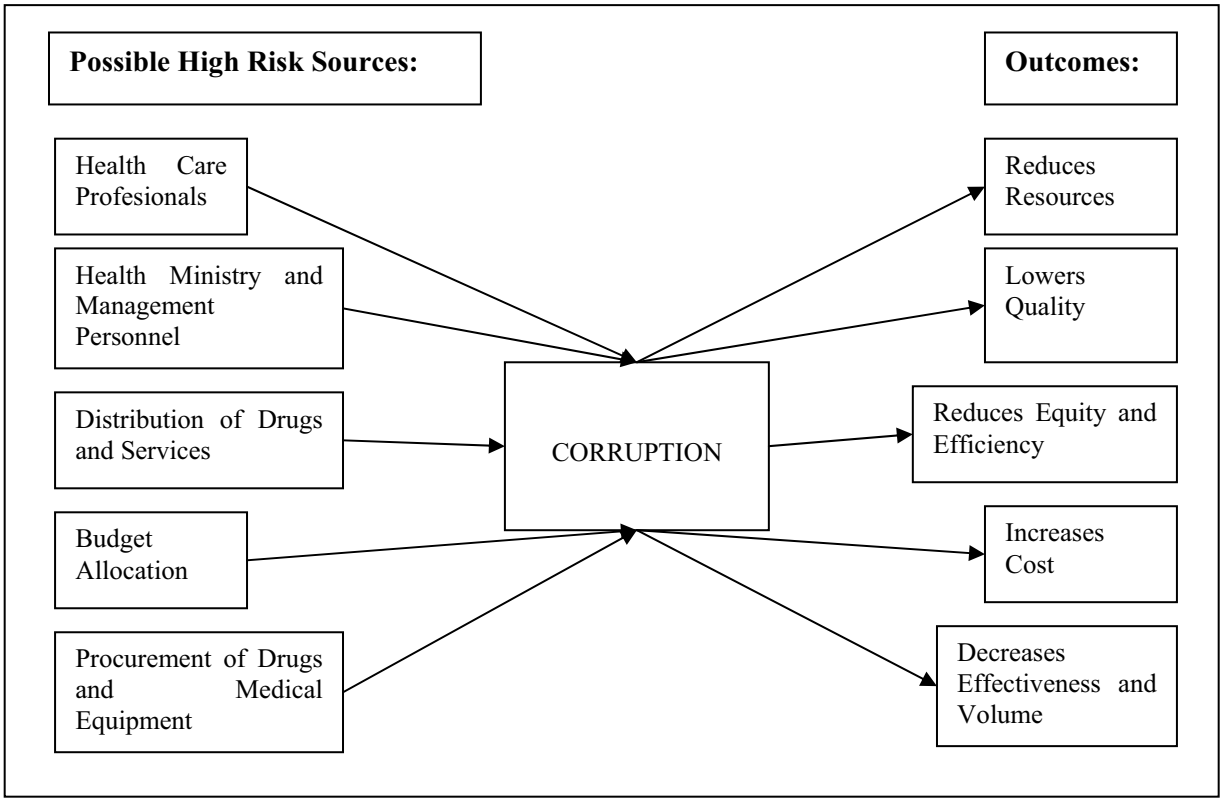
1. The health sector is marked by a high degree of imbalances of information and an inelastic demand for services (Vian 2002, 2007).
2. The high degree of discretion given to providers in choosing services for patients put patients in a vulnerable position. In most countries health professionals have assumed a cultural role as trusted healers who are above suspicion (Savedoff, 2004). We don't like to believe that providers could have conflicts of interest that affect their judgement, but in fact this can be the case. The gap in information regarding various types of services provided is mentioned as a major problem in the study "Voices of Stakeholders in the Health Sector in Bangladesh" (Nilufur, 2003)
3. Systems with direct public provision are prone to low productivity when insulated from competition or external accountability (Savedoff, 2004)
4. Services are also highly decentralised and individualised making it difficult to standardise and monitor service provision and procurement Limited regulatory capacity in many developing countries adds to the problem (UNDP 2003)

The following processes stand out as having a high inherent risk of corruption:

1. provision of services by medical personnel
2. human resources management
3. drug selection and use
4. procurement of drugs and medical equipment
5. distribution and storage of drugs
6. regulatory systems, and
7. budgeting and pricing.

Measuring and documenting abuse and corruption is essential to diagnose, locate and address problems in the provision of basic health services. A series of empirical tools have been developed in the past few years to measure corruption, leakages and efficacy of public spending. Table 1-1 on page 7 lists some of the tools that can be used to assess vulnerabilities to corruption. For example, USAID has produced a handbook titled "Tools for Assessing Corruption & Integrity in Institutions" that looks specifically at several sectors, including health (IRIS 2005). Other empirical tools include Focus Group Surveys, Price Information Comparisons, Public Expenditure Tracking Surveys (PETS), Quantitative Service Delivery Surveys and Firm Level Surveys. The findings of these various studies have produced very valuable data, enabling stakeholders to identify, analyse, and develop effective strategies to tackle the problems.

Figure 1-1 Corruption in the health sector: risk areas and consequences (Weerasuriya, 2004)



1.4 Health finance systems and corruption

How and where corruption appears in the health sector depends partly on the health financing system. Much of the corruption found in the health sector is a reflection of general problems of governance and public sector accountability (Vian 2002, 2007). A health finance system will be more vulnerable to corruption in procurement and abuses that undermine the quality of services. Examples of abuse are illegal fees, theft, absenteeism, and kickbacks in grants procuring medical supplies. A system that relies on billing an insurance institution is generally more vulnerable to diverting funds by inducing treatment not required medically, and billing the government for services not provided. The first system is known as an integrated system, while the other, with a separation between finance and provider, is called a "finance/provider system". Integrated health systems are the most common form of public health systems in developing countries. Countries with social insurance systems can however be found in middle income countries of Latin America and Asia (Savedoff, 2003, 2007). In an essay contributed to Transparency International's Global Corruption Report 2006, William Savedoff, and Karen Hussmann explored how the type of national health financing system can affect the level of corruption (TI 2006).

Table 1-1: Health financing and risks of corruption (Savedoff, 2003)

Method of financing	Characteristics	Corruption risk
Taxes	Normally associated with free or almost free service deliveries. Limitations: raising taxes in low-income countries is problematic. Rich people also get a disproportionately high share of public subsidies	Large-scale diversions of public funds at ministerial level. High risk of informal or illegal payments. Corruption in procurement. Abuses that undermine the quality of services.
Social insurance	Compulsory, not every citizen eligible for coverage and benefits, premiums and benefits described in social contracts (laws or regulations). Only applicable for formal employees.	Most common abuses include excessive medical treatment, fraud in billing, and diverting funds.
Private insurance	Buyer voluntarily purchases insurance (can be done on individual or group basis).	Same as for social insurance schemes.
Out-of-pocket payments	When patients pay providers directly out of their own pockets for goods and services. Costs are not reimbursable.	With weak regulatory capacity, high risk of over-charging and inappropriate prescribing of services. Also risk of employees pocketing official fees collected from patients. No guarantee that all health services are of value to those buying them.
Community financing	Any financing scheme that has community members paying in advance ("pre-paying"). Under most community-financing schemes, the financing and delivery care are integrated.	Problems of same character as under tax system with difference that provider is directly responsible to community thus reduced risk of corruption.[2]

In low-income countries, tax usually funds 4050% of total health expenditure, social insurance finances 1020%, direct out-of-pocket payments from patients finance 2040%, while private insurance funds less than 10%. In transition economies, though, out-of-pocket spending can account for up to 75-80% of total health expenditure (World Bank 2005). A necessary step for many low-income countries is to decide on a national health financing strategy taking into consideration availability of funds, equity and efficiency. Measures to reduce the waste of resources due to corruption should be an important part of any financing strategy.

According to the theoretical framework presented above, public officials will engage in corrupt practices for mainly three reasons: First, officials must have the **opportunity** to be engage in corrupt practices due to some or all of the following: monopoly of services, discretion to make decisions, poor accountability, weak civil society, and poor transparency. Second, individual beliefs, social norms, and eroding public service values may create **an environment** in which corrupt practices appear justified, and third, public officials may feel **pressure**d to engage in corrupt practices due to low salaries, personal financial debt and similar (Vian, 2008). Note that addressing one of these explanations alone is unlikely to lower corruption. Take the example of raising salaries to combat informal payments in the health sector. If informal payments have become prevalent amongst health workers, a culture of acceptance of this way of adding to salaries may influence officials to continue with corrupt practices even after salary increases have been implemented. Also, it is difficult to curb opportunities for corruption if a culture of acceptance exists and health workers and other health officials are sheltering each other.

[2] According to cross-country analysis, fiscal decentralisation appears as a mechanism to improve health outcomes in environments with high levels of corruption. See David A Robalino, Oscar F Picazo and Albertus Voetberg, "Does Fiscal Decentralization Improve Health Outcomes? Evidence from a Cross-Country Analysis" *World Bank Working Paper* 2565, p. 11 (2005):
LINK: http://go.worldbank.org/KPA7QPH7V0

1.5 Consequences of Corruption

On a macroeconomic level, corruption limits economic growth, since private firms see corruption as a sort of "tax" that can be avoided by investing in less corrupt countries. In turn, the lower economic growth results in less government revenue available for investment, including investment in the health sector. Corruption also affects government choices in how to invest revenue, with corrupt governments more likely to invest in infrastructure-intensive sectors such as transport and military, where procurement contracts offer potential to extract larger bribes, rather than social sectors like health and education. Within the health sector, investments may also tend to favour construction of hospitals and purchase of expensive, high-tech equipment over primary health care programs such as immunisation and family planning, for the same reason.

Corruption in the health sector also has a direct negative effect on access and quality of patient care. As resources are drained from health budgets through embezzlement and procurement fraud, less funding is available to pay salaries and fund operations and maintenance, leading to de-motivated staff, lower quality of care, and reduced service availability and use (Lindelow and Sernells, 2006). Studies have shown that corruption has a significant, negative effect on health indicators such as infant and child mortality, even after adjusting for income, female education, health spending, and level of urbanisation (Gupta *et al* 2002). There is evidence that reducing corruption can improve health outcomes by increasing the effectiveness of public expenditures (Azfar, 2005).

A review of research in Eastern Europe and Central Asia found evidence that corruption in the form of informal payments for care reduces access to services, especially for the poor, and causes delays in care-seeking behaviour (Lewis 2000). However, where the payments are cost contributions, they can enhance efficiency because more people can be treated at relatively low additional cost. But generally there are better ways to enhance efficiency, and we find that secret payments are more open to abuse. In Azerbaijan, studies have shown that about 35% of births in rural areas take place at home, in part because of high charges for care in facilities where care was supposed to be free (World Bank 2005). In many countries, families are forced to sell livestock or assets, or borrow money from extended family and community members, in order to make the necessary informal payments to receive care.

Besides informal payments, other types of corruption which clearly affect health outcomes are bribes to avoid government regulation of drugs and medicines, which resulted in the dilution of vaccines in Uganda and has contributed to the rising problem of counterfeit drugs in the world. Dora Akunyili, Director General of the National Agency for Food and Drug Administration and Control in Nigeria, writes eloquently about her struggle to lead Nigeria's battle against counterfeit drugs (Akunyili, 2006). Unregulated medicines which are of sub-therapeutic value can contribute to the development of drug resistant organisms, increase the threat of pandemic disease spread, and severely damage patients' health as counterfeit drugs might have the wrong ingredients or include no active ingredients at all and undermine public trust in important medicines according to WHO IMPACT (2006). In addition to fake and sub-therapeutic drugs on the market, corruption can lead to shortages of drugs available in government facilities, due to theft and diversion to private pharmacies. This in turn leads to reduced utilisation of public facilities. Procurement corruption can lead to inferior public infrastructure as well as increased prices paid for inputs, resulting in less money available for service provision.

Unethical drug promotion and conflict of interest among physicians can have negative effects on health outcomes as well. As documented by Jerome Kassirer, promotional activities and other interactions between pharmaceutical companies and physicians, if not tightly regulated, can influence physicians to engage in unethical practices (Kassirer, 2006). Studies have shown that these interactions can lead to non-rational prescribing (Wazana, 2000), and increased costs with little or no additional health benefit. Patients' health can be endangered as some doctors enrol unqualified patients in trials or prescribe unnecessary or potentially harmful treatments, in order to maximise profit (Kassirer, 2005).

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2 Financial resources management

2.1 The problems

2.1.1 The budget process

The budget process constitutes an important tool for governments to mobilise adequate resources for health, translate policies into pro-poor investments and provide equitable and efficient quality health services. It also sets the targets for which governments can be held accountable. In many countries institutions are weak, budget processes opaque and undemocratic, and public participation opportunities limited. Resources therefore risk being diverted from the country's key social priorities at the very early stage of the budget formulation and resource allocation towards more politically or financially "profitable" sectors. Examples include elite capture such as favouring groups with money or connections. For the poor the consequence can be a comparatively inferior access to specialised or even primary health care than for the elites.

2.1.2 Lack of financial accountability

Allocated resources for health flow through various layers of national and local government's institutions on their way to the health facilities. Financial accountability using monitoring, auditing and accounting mechanisms defined by a country's legal and institutional framework is a prerequisite to ensure that allocated funds are used for the intended purposes. In many developing countries, governments do not have the financial and technical capacity to effectively exercise such oversight and control functions, track and report on allocation, disbursement and use of financial resources. Political and bureaucratic leakage, fraud, abuse and corrupt practices are likely to occur at every stage of the process as a result of poorly managed expenditure systems, lack of effective auditing and supervision, organisational deficiencies and lax fiscal controls over the flow of public funds. Falsification of financial statements is more of a problem in proprietary (private) hospitals. Executives will sometimes exaggerate revenue and misstate expenses in order to meet expectations of industry analysts and shareholders. However, even in public hospitals fraud can present a severe problem. For example, performance based funding is increasingly popular among donor wishing to ensure that money is spent according to objectives. When the objectives are for some reason not met, health facility managers have an incentive to falsify statements in order to receive bonuses.

2.1.3 Budget leakages

Surveys carried out by the World Bank in a series of developing countries to compare budget allocations to actual spending at the facility level have confirmed that resources are not allocated according to underlying budget decisions (Reinikka and Svensson, 2003). In Uganda and Tanzania, local or district councils have diverted large parts of the funds disbursed by central government to other uses as well as for private gains, with leakages affecting up to 41% of the allocated resources. In Ghana, only 20% of non-wage public health expenditures actually reached the service delivery points, with a large proportion of the leakage occurring between line ministries and district levels. In Cambodia, 5-10% of health budgets are said to disappear before they even leave the ministry of health (Transparency International 2006:23). The effect of corruption on health spending is also supported by the findings in a cross-country analysis of 64 countries from 1996 to 2001, in which corruption is found to lower public spending on education, health and social protection (Delavallade, 2006).

Budget leakages could possibly also explain why many studies have failed to identify any effect of health care financing on health outcomes. Gauthier and Wane (2006) suggest that misallocations and abuse of health funds could be the reason why previous research has not identified a linkage. Their study of health spending in Chad employed data collected by the World Bank in 2004, and showed that even though the regional administration is allocated 60% of the ministry's budget, the regions only receive 18% of the funding, and even more disappears on the way to the clinics. Clinics respond

to the low funding by increasing user-fees. The poor may be the most affected by this, as higher fees can prevent them from seeking health care at all. Gauthier and Wane believe the number of patients seeking primary health care would be twice as high if all the funding reached its intended destination.

2.1.4 Multiple funding mechanisms and large influxes of funds

Donor funds are the single most important external resource in many developing countries, particularly in Africa. The trend over the past ten years has been towards pooling resources with governments and other donors in budget funding or basket funding arrangements, moving away from single project funding. This is particularly true for health and education. A considerable share of donor funds continues, however, to be channelled off-budget through international and non-governmental organisations. To give one example: The Global Fund has committed 50% of their resources directly to governments and an almost equally large share to other organisations and the private sector. There is an inherent risk of corruption when large amounts of funding become available and need to be spent quickly, as has been the case with some HIV-AIDS related funding in developing countries under the Global Fund and PEPFAR initiatives (Lewis 2005). Off-budget funding also grants a government discretionary power to reallocate public funding budgeted for health – a reallocation which can be hard to detect as the money received by the clinics could still be similar to what was promised. Thus, increased donor spending could crowd out public spending on health care (Gauthier and Wane 2006).

Suspecting leakages, donors take steps to improve accounting practices and move beyond financial audits when checking the actual use of funds, thereby causing delays in the release of donor funding. Such delays are likely to leave clinics to deal with expenditures outside the normal and formal budgets. Coping strategies include informal partnerships between private actors and regional and district managers. Asante *et al* (2006) suggest that informal mechanisms arising as a consequence of delays in donor funding can contribute to increased corruption.

2.2 What can be done?

2.2.1 Improved resource control and accounting systems

Health systems require a legal and institutional framework that provides clear and simple accounting and procurement standards based on transparency, comprehensiveness and timeliness. They should also have effective supervision and auditing systems to improve fiscal oversight and ensure effective enforcement of rules and sanctions for financial misconduct. Because in corrupt systems people may be benefiting from the lack of transparency, there could be resistance to putting in place better control systems. For example, when reformers sought to control diversion of user fee revenues by putting in place cash registers in one Kenyan hospital, the initiative was resisted by collection agents. The original fee collectors had to be fired and new personnel assigned before the reform could be implemented. Within three months, user fee revenue jumped 50% with no effect on utilisation, and within three years the annual user fee revenue was 400% higher (Stover 2001).

2.2.2 Budget transparency and participation

Accountability supposes that public policies, practices and expenditures are open to public and legislative scrutiny and that civil society is involved at all stages of budget formulation, execution and reporting (Fölscher *et al*, 2000). Budget transparency requires an information system that produces timely, reliable and accurate information in order to hold public officials accountable for the use of allocated resources. Civil society must also be enabled to use the information and take action when irregularities are detected. Participatory budgeting initiatives encourage a wide range of stakeholders to have a voice in allocating budgets according to their community's priorities, monitoring budgets to assure that spending is in accordance with those priorities, and monitoring the quality of goods and services purchased with budgets. Successful initiatives to expand participatory budgeting have been documented in Ireland; Porto Alegre, Brazil; and South Africa (Narayan, 2002). Also, the effects of

corruption on public health spending have been found to be mediated by social accountability in a cross-country study including 64 countries (Delavallade, 2006).

For an interesting case study on Mexico see Robalino *et al* (2001). For more information on civil society participation in the budget process, see The International Budget Partnership website: http://www.internationalbudget.org/.

2.2.3 Decentralisation

Decentralisation is a favoured strategy to improve technical as well as allocation efficiency, with the view to enabling broader public participation, improving local oversight of fiscal resources, enhancing public ability to hold decision makers accountable and enhancing the responsiveness of the health system. Research indicates that in poorer countries, higher fiscal decentralisation is consistently associated with lower mortality rates and appears to improve health outcomes in environments with high levels of corruption (Hofbauer, 2006). However, decentralisation can also lead to corruption and elite capture due to loosened central control, lack of appropriate institutional capacity and inadequate checks and balances at local levels. It can also increase regional disparities between richer and poorer districts. Decentralisation is a risky strategy that needs to be cautiously implemented (Das Gupta and Khaleghian, 2004).

2.2.4 Privatisation of health services

When institutions are weak and accountability for the use of public funds is low, privatisation of health services can be seen as an alternative method of improving the quality and effectiveness of health services. Privatisation reduces the power-monopoly of public providers and limits their opportunity to charge bribes. Many developing countries, particularly in Latin America and some Asian countries, have also witnessed rapid and unregulated private sector development (UNDP 2003). Preventive functions have mostly remained the government's responsibility. The supposed benefits have been elusive. The main problem has been the lack of a regulatory framework to control and monitor the quality, reliability and cost-effectiveness of private care and treatments, ensure equitable and universal access to quality health services and prevent market abuses and illicit practices (Das Gupta and Khaleghian, 2004). The existence of alternative providers was associated with lower rates of informal payments in one study of municipal hospitals in Bolivia (Gray-Molina *et al* 2001). The authors found that competition between the public and private providers was more likely to reduce informal payments when public providers were dependent on user fee income to finance their operating costs.

2.2.5 Tracking resource flows

Measuring resource leakages and efficacy of public spending is important to detect problems. Public Expenditure Tracking Surveys (PETS), Quantitative Service Delivery Surveys, and Price Comparisons can identify places where funds are not reaching beneficiaries or are being used for purposes other than what was intended. For a recent publication on tools for the measurement of service delivery, see Amin *et al* (2008).

2.2.6 Information campaigns

The government capacity as auditor and supervisor in weak institutional environments is very limited. Traditional audit and oversight mechanisms may be an insufficient one-sided approach to reduce abuse and corruption in the health system. Publication of survey findings and information dissemination can increase the visibility of corrupt practices, as well as the ability of the public to monitor and challenge abuses and help combat the general culture of impunity. For example, following a PETS, Uganda started to publish monthly intergovernmental fund transfers in the local media, dramatically reducing the capture and leakage of funds by 78% (Reinikka and Svensson, 2005). These findings are supported by other studies from Uganda, showing that household knowledge

on how to report poor bureaucratic practices had an effect on corruption levels and service quality (Deiniger and Mpuga, 2005).

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3 Management of medical supplies

3.1 The problems

3.1.1 Why the pharmaceutical sector is particularly vulnerable to corruption

1. The information asymmetries between suppliers and users combined with strong economic incentives might induce suppliers to go against legal and ethical norms.
2. In order to ensure drug safety and an efficient allocation of resources the pharmaceutical sector is under government regulation. Although this regulation should improve efficiency it also opens up for bureaucratic corruption at any stage of the regulatory process, i.e. during a) registration of medicines and pharmacies, b) drug selection, c) procurement, d) distribution and e) promotion.
3. It is inherently difficult to differentiate between authentic and counterfeit drugs (Cohen, Mrazek and Hawkins, 2007).

3.1.2 Pharmaceutical corruption and health

In developing countries, pharmaceutical expenditures and drug procurements account for 20-50% of public health budgets (Vian 2002). Of public procurement costs, an estimated 10-25% is lost to corruption (WHO 2008). Making essential drugs available for everyone at affordable prices is a key condition for improving national health indicators. Inadequate provision of drug and medical supplies has a direct bearing on the performance of the health system. Corruption in procurement and distribution of pharmaceutical and medical supplies reduces access to essential medicines, particularly for the most vulnerable groups. Current estimates from the WHO indicate that approximately 2 billion people lack regular access to medicines and the WHO believe that improving access to drugs could potentially save the lives of 10 million people every year (WHO 2004).

3.1.3 Registration of medicines and pharmacies

Market approval and registration of pharmaceutical products is usually granted on the basis of efficacy, safety, and quality. It is a regulatory decision that allows a medicine to be marketed in a given country. Compliance with regulations affecting drug licensing, accreditation, and approvals can be costly for pharmaceutical companies wanting to market their products. Some of them may try to bribe or influence the regulator to get their product registered or simply to speed up the approval process. One form of influence is to offer lucrative industry jobs or consulting assignments to regulatory officials, rewarding them for decisions that are favourable to the industry. Such conflict of interest can also affect the setting of user fees for drug registration, which are often set well below true cost. Thus, the government is effectively subsidising costs of private industry for little public benefit (Kaplan and Laing 2003). The concept of conflict of interest is not always well understood.

Pharmacies and drug stores also require approvals to operate. The process of licensing pharmacies for operation can be corrupted by bribes, leading to unfair decisions (favouring kin or political contacts of government agents), geographic inequities, and facilities that do not adhere to government regulations. As with the registration process, conflict of interest is also a concern if national experts receive compensation from pharmaceutical companies that could influence their judgement.

3.1.4 Drug selection

Once a pharmaceutical product has received market approval, most public procurement systems and insurance schemes have mechanisms to limit procurement or reimbursement of medicines, based on comparison between various medicines and on considerations of value for money. This step leads to a "national list of essential medicines" (WHO 2002). The selection of essential medicines in a given

country needs to use defined criteria and consultative and transparent process. The inclusion of any pharmaceutical on this list will lead to increased market share and if the process is not transparent, special interest groups may offer bribes to the selection committee members to get their product on the list (Baghdadi 2004). Interested parties may also bribe the committee responsible for deciding which products are reimbursed through government social insurance programs.

3.1.5 Procurements

Providing health facilities with drug and medical supplies is a very complex process that involves a large variety of actors from both the private and public sectors. Government health ministries often lack the management skills required to write technical specifications, supervise competitive bidding, and monitor and evaluate the contract performance. Corruption can occur at any stage of the process and influence decisions on the model of procurement (direct rather than competitive), on the type and volume of procured supplies, and on specifications and selection criteria ultimately compromising access to essential quality medicines.

Common corrupt practices in the procurement process include collusion among bidders resulting in higher prices for purchased medicine, kickbacks from suppliers and contractors to reduce competition and influence the selection process, and bribes to public officials monitoring the winning contractor's performance. All of these practices lead to cost overruns and low quality. Other forms of abuse, fraud, and mismanagement can occur due to insufficient management and monitoring capacity. In some cases, supplies do not meet the expected standards, or they are only partially delivered or not delivered at all. In a context where quality controls are difficult to exercise, an increasing lack of funds results in opportunities to sell low quality, expired, counterfeit and harmful drugs at cheaper prices. Corrupt procurement officers can also purchase sub-standard drugs in place of quality medicines and pocket the difference.

3.1.6 Distribution and misappropriation

Due to under-financed and badly managed systems, poor record-keeping and ineffective monitoring and accounting mechanisms, large quantities of drugs and medical supplies are stolen from central stores and individual facilities, and diverted for resale for personal gain in private practices or on the black market (Ferinho, Omar, Fernandes, Blaise, Bugalho and Lerberghe, 2004).

This involves a variety of practices such as record falsification, dispensing drugs to "ghost patients", or simply pocketing the patient's payment. Patients are directly affected in this process as they are forced to supply their own medications or, in the case of hospital inpatient stays, linens and food. This results in considerable leakage of public resources. Distributing medical supplies to the healthcare facilities also involves managing an effective transportation system and preventing misappropriation of fuel and vehicles for private or non-health related uses.

3.1.7 Promotion

Aggressive marketing strategies can also lead to the unethical promotion of medicines or to conflicts of interest that influence a physician's judgement. A range of practices are commonly used by pharmaceutical companies as incentives to encourage the use of their product such as distributing free samples, gifts, sponsored trips or training courses. Although it is sometimes delicate to draw the line between marketing and corruption, such practices are likely to generate conflict of interest whereby a decision on treatment is no longer made in the patient's best interest. Interactions between physicians and the pharmaceutical industry can lead to non-rational prescribing and increased spending on medicines with little or no additional health benefit (Wazana, 2000). Perverse incentives and "money warped behaviour" can endanger patients' health, as doctors enrol unqualified patients in trials or prescribe unnecessary and potentially harmful treatments, in order to maximise profit. Some countries have banned, by law, direct financial incentives by prescribers (Kassirer, 2005).

3.1.8 Counterfeit drugs

According to the WHO IMPACT, "counterfeit medicines are deliberately and fraudulently mislabelled with respect to identity and source: their quality is unpredictable as they may contain the wrong amount of active ingredients or no active ingredients" (2006). Counterfeit drugs are a problem in both developed and developing countries. In the US, up to 15% of all drugs sold are fake, while in some African countries the figure can amount to 50%. Globally, the US Food and Drug Administration (FDA) believe approximately 10% of all drugs to be fake (Cockburn *et al*, 2005). Due to low reporting of discoveries of counterfeit drugs, it is difficult to provide accurate calculations of the health consequences of fake drugs. In the article "The Global Threat of Counterfeit Drugs: Why Industry and Governments must communicate the dangers" (Cockburn *et al*, 2005) nonetheless provide several examples of how counterfeit drugs contribute to increased morbidity and poor health to those affected.

Counterfeit drugs – country examples (Cockburn *et al*, 2005)

A) In Nigeria 88 000 vaccines were provided by Pasteur Meriux and SmithKline Beechan – approximately 60 000 Nigerians were vaccinated with what was later discovered to be counterfeit, and contain to active ingredients
B) In African countries such as Ghana, Nigeria and Sierra Leone - counterfeit paediatric anti-malarials were found on the market, branded GlaxoSmithKline
C) One third of the packets of the anti-malarial drug artesunate which were sold in South East Asia were found to be counterfeit, containing no active ingredients
D) In Brazil, a contraceptive pill were found to be containing wheat flour - information the company Schering kept private for 30 days before notifying the authorities.

The consequence of counterfeit medicine can be severe for those affected - increased morbidity from malaria, HIV, and other diseases when drugs are containing too little, no active ingredients or even harmful ingredients. One example would be the use of counterfeit anti-malaria drugs which may under long term use cause malaria parasite resistance to the drugs - hampering worldwide efforts to curb and prevent the spread of malaria. Because pharmaceutical companies are afraid bad publicity caused by information campaigns might harm the sale of the original product, they are reluctant to spread information about discoveries of counterfeits. This reluctance to provide the public with information might result in counterfeits being sold in neighbouring countries or shipped over great distances, thus effecting people without recourse (Cockburn *et al* 2005).

3.1.9 What can be done

A World Bank research team working in Latin America has identified indicators to measure compliance with standardised processes and decision-making criteria in the sub-systems of drug registration, selection, procurement, and distribution (Cohen, Cercone and Macay, 2002; Cohen *et al*, 2007). For example, using locally collected data researchers measured performance against the indicators in Costa Rica. Overall, Costa Rica received a rating of 7.7 out of 10, indicating "marginal" vulnerability to corruption. The procurement function was rated as "moderately vulnerable" (5.4 out of 10), due to problems such as lack of documentation of prices paid and criteria used for awards. The indicators helped health managers to get a more precise idea of specific interventions needed to reduce vulnerability. Based on this research, WHO recently developed a new Manual for Measuring Transparency to Improve Good Governance in the Pharmaceutical Sector (WHO 2006). It covers the functions of registration, promotion, inspection, selection, and procurement. The manual provides instructions to collect and calculate 51 indicators to monitor transparency.

The WHO Good Governance for Medicines (GGM) programme (WHO, 2008)

In order to help governments to increase transparency and reduce corruption related to public procurement of medicines, the WHO started the Good Governance for Medicines program in 2005. The main objective of the program is to help implement transparent and create clear administrative procedures for the procurement of drugs. In addition the programme works to promote the ethical conduct of health workers. The project has three phases. During the first phase, experts independent of the Ministry of Health are called upon to assess the vulnerability to corruption. Two experts research the pharmaceutical sector and undertake at least 10 interviews with key interviewees and develops a report which forms the basis for a development of a national GGM programme (phase 2). This programme is implanted during phase 3. In 2007, nineteen countries had taken on the Good Governance for Medicines.

http://www.who.int/medicines/areas/policy/goodgovernance/GGM_assessment.pdf

3.1.10 Registration of medicines

National regulatory authorities need to ensure transparency and accountability. Regulatory policies, procedures and criteria for decision-making need to be published and made easily accessible. A formal committee responsible for registration of medicines needs to be established, with clear terms of reference, and whose members will be selected based on clear and technical criteria. Regulatory officials need also to be trained how on to manage conflict of interest (WHO 2003a). Table 3-1 gives additional guidance on components of effective health laws and regulation of private sector providers.

3.1.11 Drug selection

A set of practical measures can be implemented to limit opportunities for corrupt behaviour. The first important step consists in adopting lists of essential medicines that are based on standard evidence-based treatment guidelines at national and sub-national levels. 156 countries have already adopted an Essential Medicines List (WHO 2003a) of generically named products based on WHO principles, with a view to limiting the selection of products to a smaller number of appropriate drugs. From 2007 a separate list also exists for children (WHO 2007). Here also, government officials need to ensure that the selection of these essential medicines is based on clear criteria and a transparent process, with an expert committee responsible for this exercise that will operate according to published terms of reference, whose members will be selected based on technical expertise, and whose decisions will be based on the latest scientific evidence. Training in managing conflict of interest is also valuable.

A recent paper documents experience with implementation of an Essential Drugs Programme in Delhi, India (Chaudhury, Parameswar, Gupta, Sharma, Tekur and Bapna, 2005). The paper describes how implementation of an essential medicines list and transparent procurement processes helped to lower costs and improve quality of drugs.

Improving access to medicines - MeTA

In December 2006, representatives from DFID, the WHO, the World Bank met to discuss the creation of a Medicine Transparency Alliance (MeTA) - the alliance was officially launched in May 2008. The objective of MeTA is to increase access to medicines by creating transparency in all steps of procurement of medicines. Greater transparency will be achieved by bringing together actors from the government, the pharmaceutical industry and the civil society and disclose information about procurement. In particular information about a) the quality and registration of medicines, b) the availability of medicines, c) the price of medicines and d) policies and practices concerning the promotion of medicines. Countries that sign up to MeTA are expected to make formal commitment to the principles of MeTA, and form a national stakeholder group consisting of public, private and civil society actors to decide how to collect and disseminate data between group members. The work undertaken by the stakeholder group will be reviewed by the MeTA International Advisory group (to be formed in the second half of 2008). MeTA also provides participant countries with funding. Currently seven countries have signed up to MeTA: Ghana, Uganda, Zambia, the Philippines, Peru, Kyrgyzstan and Jordan. MeTA is currently funded principally by DFID.

MeTA homepage:

http://www.medicinestransparency.org/

http://www.dfidhealthrc.org/MeTA/index.html

http://www.guardian.co.uk/world/2006/oct/27/outlook.development2

3.1.12 Procurement

The prerequisite for curbing corruption in the procurement process consists in defining clear and transparent procurement rules and guidelines that reduce discretionary powers where they are likely to be abused and to increase the probability for corrupt practices to be detected and sanctioned. The WHO Operational Principles for Good Pharmaceutical Procurement (WHO 1999) can assist governments in developing procedures that increase transparency and efficiency of procurement processes. Promoting transparency in the procurement process can be achieved by publishing the lists of supplies offered in tenders, offering clear documentation and public access to bidding results, if possible using an electronic bidding system as was tried in Chile (Cohen 2001), involving civil society at all stages of the process. Establishing lists of reliable and well-performing suppliers as well as making price information widely available, using a tool similar to as the WHO's drug price information service (WHO 2003b), or the MSH/WHO International Price Guide (MSH/WHO 2007) can help reduce prices and opportunities for corruption. Establishing price reporting systems can allow comparisons for basic medical goods and services and result in a decrease in input prices as demonstrated in an anti-corruption crackdown in Argentina (Tella and Schardgrodsky, 2002). Technical assistance and training for procurement officers can also improve the capacity of governments to manage competitive bidding.

3.1.13 Distribution

Measures to reduce illegal practices at the distribution stage of medical supplies include establishing efficient inventory control systems, improving record keeping and control procedures, fortifying security against robbery in central warehouses, etc. These are actions to be taken by the ministry at national and/or provincial/district level. The means of promoting a competitive market or using it, where it exists, are other avenues to improve efficiency and reduce corruption in distribution. The USAID-funded DELIVER Project (DELIVER) has provided many tools for improving drug

distribution systems, including guidelines for forecasting, supply chain management, process mapping for improved health logistics system performance, and warehousing of health commodities. A complete library of DELIVER publications is available on CD Rom (DELIVER).

3.1.14 Promotion

Other possible measures include banning practices of gift and sponsorship, following WHO ethical guidelines on medicines promotion (WHO 1998), and promoting codes of ethics in marketing through trade and professional organisations. Training physicians and students on how to critically read and analyse promotional materials from the pharmaceutical industry and raising their awareness on conflict of interest can also be effective. Better delivery of the "powerful medicine of information" on the benefits, risks, and cost-effectiveness of specific drugs is critical to influencing how drugs are used and protecting patient interests (Avorn, 2004). The practice of "academic detailing" or user-friendly educational outreach programs sponsored from a medical school base can help provide non-commercial sources of drug information and has been proven effective at influencing prescribing patterns in a way that benefits public health objectives (O'Brien *et al* 2003).

3.1.15 Fighting counterfeit drugs, what can be done?

In 2006 the WHO launched the International Medical Products Anti-Counterfeiting Taskforce (IMPACT), to promote cooperation between the pharmaceutical industry, governments, NGOs and the WHO to combat counterfeit drugs. According to this initiative the following priority actions should be undertaken by governments:

1. Strengthen legislation on counterfeit drugs
2. Strengthen regulatory initiatives
3. Improve collaboration among government entities
4. Develop a communication strategy

Cockburn *et al* (2006) argue that in addition the industry should be required or at least encouraged to report knowledge about counterfeit drugs.

A possibly important tool in the fight against counterfeit drugs are technological devices such as radio frequency identification (RFID) - which will allow for a check on the authenticity of the product. However, such devices are costly, and consequently IMPACT is recommending changes in the regulatory institutions in developing countries as a means to combat counterfeit drugs.

WHO Western Pacific Region has also created a rapid alert system in order to promote the spread of information about counterfeit drugs between the industry and governments in WHO member states. The electronic information network was created as part of the Regional Strategy for Improving Access to Essential Medicines in the Western Pacific Region, 2005 – 2010.

Table 3-1 - Elements of Laws to Regulate Private Practice of Medicine

Area of law	Requirements or Main Elements of Law
State licensing of physicians	Law must state it is illegal to practice medicine without license; specify what is "practice of medicine", if licensing by specialty, then specify categories, definitions
Minimum qualifications for eligibility to practice medicine	Approved training, competency testing, character and criminal record
Ownership of facilities	Disclosure of ownership; limits on types of ownership allowed and locations; restriction on ownership of affiliated facilities such as pharmacies, laboratories or radiology facilities; and required financial standing for ownership
Physical facility requirements	Minimum floor space and structural requirements, utilities, hygiene, equipment, other approvals, and inspection and enforcement requirements (how violations will be detected and corrected, what will happen if corrections are not made)
Staffing	Minimum levels, levels in relation to volume, training or experience
Use of public facilities in private practice	Options/issues: 1) allow private practice, specify hours, types of procedures, quality assurance mechanisms, 2) charge for rent or services in the public clinic, 3) admitting privileges (criteria for granting, barring)
Price regulation	Price controls (are they desirable, how to set); balance billing (billing in excess of insurance payment); posted charges (requirements to list); non-discrimination (barring differential pricing)
Capacity Regulation	Permission to practice in a geographic area, limits on investment and equipment (required certificates of need)
Professional liability	Defining physician's liability for professional negligence; define standard of care; measure of damages; dispute resolution procedures; financial guarantees
Patient rights	Disclosure and information; informed consent; right to refuse treatment; right to medical records; obligation to treat; non-discrimination; complaints about violations
Establishment/termination of physician-patient relationship	Defining point at which relationship is established; defining obligations for continuity of care or referral
Public health reporting requirements	Reportable diseases and vital statistics, case finding, abuse reports, immunisation
Advertising	Bans or limits; requirements on content; system for adjudicating disputes; sanctions
Maintenance of medical records	Positive obligation to maintain; privilege requirements (limits to confidentiality)
Prescribing authority	Links between pharmaceutical law and physician licensing law; special authority for highly dangerous substances; specialty regulations, if desired; written prescriptions (requirements); generic prescribing; permission to sell drugs
Physician extenders	Process for qualifying physician extenders (nurse-practitioners, physician assistants)
Registration and re-registration: license renewal	Continuing medical education rules; competency testing; availability of licensing data (public release)
What body sets the rules?	MOH or independent body? (If MOH, need to control for possible MOH abuse of power over private licenses in order to punish doctors who are critical of MOH action.) Inclusion of public members on independent board (to balance physician interests); national or regional
Suspension and revocation of license	Procedures for revoking or suspending license; action in emergencies; cause for license action; drug/alcohol abuse (impaired physicians); poor quality medical care (method of proof)

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4 Health worker/patient interaction

4.1 The problems

Corruption flourishes at the service delivery points affecting the interaction between health workers and patients when the following conditions arise: staffs is underpaid as a result of constrained health budgets, when exceptional performance of health providers is not noticed or adequately rewarded, and when rules and sanctions are not enforced due to lack of oversight and supervision. Most common abuses include informal charging of patients, theft of drugs and medical supplies, illegal use of public facilities for private practices, self referral of patients, and absenteeism. All these practices undermine the quality, access and use of health services.

> "My son was vaccinated with water because we were too poor to pay the health worker the extra fee." (Man, Uganda)
>
> CIET International
> www.ciet.org

4.1.1 Informal payments

An informal payment is a payment in cash or kind for services in excess of official user fees (Mæstad and Mwisongo, 2007). Health workers respond to inadequate salaries and difficult living and working conditions by developing individual coping strategies, many of which can be seen as "survival corruption" (Van Lerberghe *et al*, 2002). Patients pay unofficial fees to gain access to health services, which are supposed to be free of charge, to reduce waiting time, receive drugs, treatment or hospital meals, as well as to ensure better attention and improved quality of treatment. Such practices are widespread in developing and transition countries. Informal payments have been consistently associated with massive reduction in the use of services in Poland and Uganda, due to financial accessibility of care. In the long run, they also compromise the quality of the health system by channelling out-of-pocket payments outside of the public health system. Many studies have been conducted in the past several years exploring the motivations behind informal payments, which is an essential step in order to design effective strategies to prevent them (Vian *et al* 2004).

> **"Pilfering for survival"**
>
> A 2004 study – "Pilfering for survival: how health workers use access to drugs as a coping strategy" – confirms that health workers in Mozambique and Cape Verde do take advantage of their privileged access to pharmaceuticals, and that this abuse has become a key element in the coping strategies health personnel develop to deal with difficult living conditions (Ferrinho *et al* 2004). Based on a self-administered questionnaire addressed to a sample of health workers, it identifies the reasons given for misusing access to drugs, shows how the problem is perceived by the health workers, and discusses the implications for finding solutions to the problem.

4.1.2 Informal payments and the quality of health care

Ottar Mæstad and Aziza Mwisingo (2007) conducted focus-group discussions with health workers in Tanzania to explore effects of informal payments on the quality of health care provided by health workers.

A key finding was that even though patients may expect to improve his/her chances of receiving care by paying a bribe, it is by no means certain that a system with informal payments will deliver higher

quality health care than a system without informal payments. The FGDs suggest at least three ways in which informal payments may reduce the quality of care.

1. The opportunity to extract bribes may increase rent-seeking behaviour. For example clinicians may create queues or artificial shortages in medicines or indicate that the best quality medicines cost more in order to increase the willingness to pay. Artificial queues may lower quality by increasing waiting time and time available for treating patients. Indicating a shortage of drugs is often coupled with an offer to buy from his or her private outlet, or one where the doctor takes a commission. In so far as these strategies also increase waiting time and available time for treatment, quality may deteriorate. Or, patients who are not willing pay bribes will receive lower quality care.
2. As the quality of a consultation often depends on more than one health worker, a practice has emerged where health personnel demand a share of the payment before proceeding with treatment. Rudeness towards patients is a common practice in these processes. It is also found that where health workers suspect that bribes have been distributed unfairly, this may cause them to instil sanctions by withdrawing the quality.
3. A further unfortunate scenario is where high quality health care may be seen as a sign of bribe-paying, hence prompting health workers who want to appear incorrupt to withhold quality in order to signal this to colleagues.

However, Mæstad and Mwisongo (2007) also identified mechanisms through which informal payments can increase the overall quality of care. Firstly, a health worker mainly motivated by monetary incentives may increase the quality of care only if compensated directly for the cost associated with providing health care. Note that this health worker would only increase quality in areas observable to patients. If patients are unable to judge the quality of the consultation the payment is unlikely to increase quality. Secondly, the opportunity to extract bribes may create a competition for these payments and, therefore, lead to increased quality of care – also here limited to areas that patients can observe. However, such competition may again undermine the cooperation between cadres necessary for achieving high quality in service provision. Thirdly, the opportunity to obtain informal payments from patients may reduce absenteeism, which can again increase quality, since one certain prerequisite for quality is that the health worker is actually present at the health clinic.

Because the focus-group discussions provide evidence of informal payments having both positive and negative impacts on the overall quality of care, Mæstad and Mwisongo cannot conclusively say that informal payments increase or reduce the quality of care. Other overview studies undertaken by Azfar and Gurgur (2005) and Lewis (2006) on the effect of corruption in health care delivery suggest that corrupt practices are correlated with poorer health outcomes. Nevertheless, several studies have indicated that even though it is difficult to prove that the overall quality decreases as a consequence of informal payments – these payments may reduce the quality of care provided to the poor (Szende and Culyer, 2006).

4.1.3 Private practices / self-referral / absenteeism

Doctors working for government have been increasingly allowed to open private practices as a strategy to supplement their meagre salaries. This has produced mixed results, with doctors spending official time in private practices, using public facilities and equipment to treat private patients, or merely utilising the public system to channel patients to their private practice. This often leads to high rates of absenteeism which represents a significant loss of funds and public resources. In Bangladesh, unannounced visits to public health facilities showed that doctors were absent more than 40% of the time (Chaudhury and Hammer, 2003). Another study showed that absenteeism in primary health care clinics in non-HIV/AIDS afflicted countries ranged from 28-42% (Lewis 2005). Looking at averages across countries as different as Bangladesh, Ecuador, India, Indonesia, Peru and Uganda, Chaudhury *et al* (2006) found worker absence to be 19% of teachers and 35% of health workers. Absenteeism is often associated with low salaries, lucrative opportunities for selling services privately and lack of sanction or punishment.

4.1.4 Training and selling of accreditation or positions and licensing

Political influence, nepotism and favouritism can occur in the selection of candidates for training opportunities, appointment, hiring, and promotion and licensing of health personnel. Training is a particularly vulnerable area with trainees paying bribes to gain a place in a medical school or passing exams, jeopardising the competence of trained health workers. As noted in Nataliya Rumyantseva's (2005) article on "Taxonomy of Corruption in Higher Education", higher education has a critical influence on young people's values and beliefs about right and wrong, and thus, on the nation's leadership. Corruption in professional education is therefore of very great concern.

4.1.5 Health care fraud

In countries where governments or health insurance companies can be billed for services rendered, a large range of fraudulent practices can occur, including billing for services that were not rendered, for more expensive services than were rendered, over-prescribing or performing unnecessary interventions. Losses can be substantial: the U.S. government has estimated that improper Medicare fee-for-service payments, including non-hospital services, may be in the range of $11.9 billion to $23.2 billion per year, or 6.8 to 14% of total payments (Becker *et al* 2005). Due to complicated procedures, such practices are often difficult to monitor, detect and sanction.

4.1.6 Conflict of interest

Pecuniary gains can influence a physician's decision and induce unnecessary interventions or over-prescriptions, whereby performed interventions or prescribed drugs are based on the remunerative aspect of the treatment rather than a patient's medical needs. In Peru, for example, studies have shown that in private hospitals 70% of births were caesarean deliveries against 20% in public hospitals (Savedoff, 2003). Physicians' medical practices can be influenced by questionable relationships of a financial or non-financial nature between doctors, firms and pharmacies.

4.2 What can be done?

For anti-corruption regulations to be effective, the patients' rights must be clear and well known, channels of complaints simple and well defined and regulatory agencies strong and trusted. Moreover, successful strategies must not only focus on prohibiting corrupt practise and enforcing sanctions against transgressors, but also address the underlying causes of corruption and provide incentives for good performance and honest behaviours.

4.2.1 Salaries and living conditions

Prohibition of corrupt practices cannot succeed if health workers' wages remain low, but increasing salaries is not always a realistic option in many developing countries. It is also pertinent to ask if wage increases by themselves are sufficient – research from other sectors such as customs indicate that corrupt officials will continue collecting bribes despite substantial wage increases. However, a decent salary scheme does seem to be a precondition for other measures to work. An experiment carried out in Buenos Aires showed that the effectiveness of anti-corruption wage policies is largely dependent on the accompanying monitoring and auditing measures. Downsizing the public service in order to divide resources available for salaries among a smaller workforce meets much resistance in the public sector. Promoting contractual relationships between government and health workers rather than public service salaried status could be an alternative strategy to investigate further.

4.2.2 Official user fees

The introduction of official user fees in health centres has been promoted as a strategy to eliminate unofficial payments, generating revenues that can be channelled back into operational costs or used to finance adequate salaries for health workers. This approach has produced mixed results in many

countries in terms of financial accessibility and equity of health care and has been consistently associated with reduction of the use of services, especially preventive measures such as immunisation. User fees are clearly not an option for prevention, education or disease surveillance functions (Sachs 2001). At the same time, hospitals and health centres in Cambodia have had success in reducing informal payments by formalising user fees, and promoting professionalism among staff (Soeters and Griffiths, 2003). For example, one hospital created individual contracts with personnel and increased pay scales while enforcing accountability and sanctioning poor performance (Barber *et al* 2004). Similarly, reforms in Kyrgyzstan[3] have shown some reduction in informal payments through the introduction of formal co-payments. Another hospital in Albania also has used formal user fees to try to decrease informal payments, and succeeded in raising physician salaries five-fold while increasing utilisation (Vian *et al* 2004).

4.2.3 Hierarchical accountability and improved management

Monitoring performance of civil servants has great potential to reduce corruption when associated with higher wages. This strategy involves defining clear performance expectations as well as job descriptions, transparent and enforced rules and behaviour standards as well as introducing fairly implemented merit based promotion policies. It also requires effective monitoring instruments that are insufficiently developed at present. Internal supervision can be complemented by external audits, unannounced visits to health facilities and evaluation of services by clients and beneficiaries. Innovative technology and management procedures at the facility level can also enhance efficiency and quality of service provision, reduce long waiting times and opportunities of bribery to gain or speed up access to medical care. External monitoring can be improved by providing channels for whistle blowing and legal support to citizens who feel they have been treated unfairly or harmed through corruption (Vian 2003).

4.2.4 Code of ethics

Informal payments lower the quality of care as health workers elevate their own monetary interest over the welfare of patients. For this reason, instilling norms of professional behaviour through a code of ethics could cushion some of the more harmful effects and induce health workers to provide better health care. A code of ethics could possibly increase the intrinsic motivation of health professionals to do a good job. Codes of ethics regulating the medical profession can be adopted and promoted through professional organisations and associations to address conflict of interest issues. The promotion of cost-effective evidence-based clinical treatment guidelines at the national and sub-national levels can also limit opportunities for abuse.

Hong Kong – Integrity in Practice

In addition to providing other profession-specific corruption prevention materials, the Independent Commission Against Corruption (ICAC) in Hong Kong produced a practical guide for medical practitioners in cooperation with the Hong Kong Medical Association. Aiming to promote a high ethical standard in medical practice, the guidebook "*Integrity in Practice - A Practical Guide for Medical Practitioners on Corruption Prevention*" (ICAC not dated) was distributed to all doctors in Hong Kong and made available on the internet. The guidebook contains information on the anti-corruption laws and on the corruption prone areas in the practice of medicine, illustrated by cases or hypothetical cases from both the public and private

[3] Manas Health Policy Analysis Project Kyrgyzstan
http://www.globalforumhealth.org/filesupld/forum9/CD%20Forum%209/papers/Akunov%20N.pdf

4.2.5 Access to information

When seeking health services, patients should be in a position to make informed choices and select appropriate providers at appropriate prices and standards of quality. This requires consumers to be informed of their rights, of the services available, prices and conditions of access. Making information public also tends to have a direct effect on providers by holding them up to scrutiny by peers – making it more difficult to conceal dishonourable activities, etc. (Savedoff, 2004). An assessment of vulnerabilities to corruption in Albania suggested several initiatives to increase patient information, including a strategy to disseminate official price information (conduct trend analyses of drug prices in private pharmacies being reimbursed by the government, and affordability for patients), creation of consumer guides to health regulation, and establishment of a Citizen's Advocacy Office for Health Concerns (Savedoff, 2004).

4.2.6 Voice based strategies

Information and voice-based strategies that involve the community in decisions affecting them, as well as in monitoring activities, have proven to be very effective in regulating health services. Community participation can be achieved through the constitution of local health boards or committees, in which civil society is represented and involved at all levels of the decision-making process as well as in monitoring activities. Because they are not of visible and immediate value for the community, such strategies may need to be adapted to preventive or educational public health services (Das Gupa and Khalegian, 2004). Effective citizen oversight boards were associated with lower rates of informal payments and lower input prices paid in municipal hospitals in Bolivia (Gray-Molina *et al*, 2001). Efficient complaint mechanisms must also be in place to provide opportunities to report and prosecute abuse and restore the public trust in institutions.

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5 Good practice –Examples

> "The issues: salaries, budget process, and procurement are national issues, not a particular health issue. We cannot deal with the salary issues isolated."
>
> Lise Stensrud, Norwegian Health Adviser in Mozambique,
>
> Best Practice work shop on health and corruption in London, Sept, 2004

Corruption risks in the health sector have only marginally been addressed in the past. As donors are increasingly moving towards budget support in the health sector, the potential risks of corruption and budget leakages have moved higher on the donor agenda.

Four donor supported health sector programmes have been selected as examples of good practice because these display a consideration to the risk of corruption in the preparatory phase leading up to the decision to support the programme. The emphasis is on prevention rather than on sanctions against a detected corrupt act.

The general lessons to draw from these examples are:

- Due attention must be given to the general corruption environment - the National Integrity System - of each country
- Corruption risks associated with the health system itself have to be identified and acted upon, and
- The general financial management system including the audit and procurement functions must be analysed and, if necessary, reinforced

The "Bangladesh Social Sector Performance Survey", has been selected as an example because it provides a model for an investigative methodology adapted to the social sectors, including health. Emphasis is on evaluating the impact of reforms.

5.1 Tools to address corruption in the health sector

5.1.1 National Health Accounts (NHA)

An internationally recognised framework that measures and tracks the use of total health care expenditures in a country (public, private, and donor)

LINK: http://www.who.int/nha/en/

5.1.2 Public Expenditure Tracking Surveys (PETS)

Track the flow of resources on a sample survey basis, in order to determine how much of the originally allocated resources reach each level.

LINKS:

http://www.u4.no/themes/pets/main.cfm

http://www.transparency.org/content/download/4815/28500/file/Part%201_2_scale%20of%20problem.pdf

http://www.transparency.org/publications/gcr

5.1.3 Service Delivery Surveys (SDS)

Collect data on inputs, outputs, quality, pricing, oversight, and so forth. Can detect absence rates among e.g. health care workers. Read more on SDS at Governance Resource Centre. World Bank.

LINKS:

http://www.grc-exchange.org/g_themes/servicedelivery_finance.html

http://www.worldbank.org/research/projects/publicspending/tools/newtools.htm

5.1.4 Report Cards

Provide an instrument for civil society to assess and highlight dimensions (including corruption) of public service delivery in a community. Read about the use of Report cards in India in part 7 of Transparency International's Corruption Fighters' Tool Kit 2001.

LINK: http://transparency.org/tools/e_toolkit/corruption_fighters_tool_kit_2001

5.1.5 TI National Integrity System Surveys country studies

Assess the National Integrity System and its components, the NIS pillars, which is the sum total of the laws, institutions and practices in a country that maintain accountability and integrity of public, private and civil society organisations.

LINK: http://transparency.org/policy_and_research/nis/regional

5.2 Programme Support to the Zambian Health Sector

Table 5-1: Zambian Health Sector

Responsible	Sida (Sweden)
Project no	Sida 2001-00735
Partners	Netherlands, DFID, World Bank, EU, USAID, Danida, Ireland Aid, Unicef, UNFPA, JICA, GTZ, WHO and UNFPA (15 collaborating partners signed a MOU 1999 with the Zambian Ministry of Health outlining the vision of the health sector reform process)
Implementer	Government of the Republic of Zambia
Period	2002-2005
Amount	(Sida) SEK 240 million
Document	Assessment Memorandum, at http://www.u4.no/themes/health/zamssessmentmemorandum.pdf
Contact persons at Sida	Britta Nordstrom, Health Division (britta.nordstrom@sida.se) Pär Eriksson, Swedish Embassy, Zambia (par.eriksson@sida.se)

5.2.1 Project description

The Assessment Memorandum proposes a continued Sector Programme Support (SPS) to the Zambian health sector for the period 2002-2005 in the order of USD 6 million annually.

The Swedish support is by definition flexible in nature and a main objective is to continue the process of strengthening the SWAp process itself. The support is based on the Zambia National Health Strategic Plan 2001-2005, which has been assessed and apprised by a large number of stakeholders.

Since SPS is a long term commitment, very close attention is being paid to the political and economic development in Zambia. The memorandum emphasises the external context in which the SWAp takes

place with a risk analysis including a possible alternative strategy. It is argued that SPS is the only sustainable way of supporting the Zambian health sector and the memorandum outlines a strategy on how to do this in a difficult political environment.

5.2.2 Anti-corruption aspects

The memorandum, Chapter 3, "Assessment of the external context", includes a section on corruption stating that:

"[T]here are a number of reports indicating that corruption and misuse of power at a very high political level is widespread and there are numerous examples of supposed corruption and/or misuse of public funds in almost all sectors, including the health sector."

Following Chapter 4 "Risk analysis and alternative strategy: Risks related to good governance and corruption". Corruption is assessed both from a technical and a political perspective. The overall view is that sector support increases the possibility to address corruption risks properly:

"Working with the framework of a SWAp, means that Sweden and other collaborating partners (PC) have an overview of all resources including GRZ, to the health sector. This implies that Sweden may be more aware of mismanagement of funds and corruption than would otherwise be the case. Within a SWAp environment corruption can be better dealt with than in a traditional project environment and it is getting increasingly difficult for politicians and public servants to misuse funds, regardless of whether it is GRZ funds or CP funds".

The political perspective, by which is meant the willingness from the political elite to seriously deal with corruption is "much more complicated". "This perspective is closely interlinked with democracy, human rights and good governance".

A Review of the National Health Strategic Plan was published in February 2004. The report indicates that the health sector has been in receipt of rising budgets. It is however also noted that no exercise has been undertaken to determine if trends of disbursements and expenditures have been in the desired direction. The partners are therefore recommended to attach high priority to tracking resource flows within the health sector for the next period, and to design and implement a revised allocation formula to individual districts to reflect relative mortality/morbidity and poverty situation. There is no specific reference to corruption risks.

5.2.3 Recommended reading

Zambia National Health Accounts 2002: Main Findings, September 2004, by Felix Phiri and Marie Tien, funded by USAID/REDSO, Sida and WHO.

LINK: http://www.phrplus.org/Pubs/WP007_fin.pdf

This study also includes a study of the sources and uses of funding for HIV/AIDS. The National Health Accounts methodology is a tool that allows countries to track the flow of all health spending from financial sources to end users. It includes estimates of household expenditures, spending that governments have not historically considered when looking at national health expenditures.

5.2.4 Other relevant anti-corruption projects in Zambia from U4 database:

Payroll management and establishment control project, DFID, 2000.

LINK: http://www.u4.no/projects/project.cfm?id=295

Office of the Auditor General, NORAD, 2003.

LINK: http://www.u4.no/projects/project.cfm?id=613

Support to Auditor General of Zambia, Ministry of Foreign Affairs, the Netherlands, 2001.

LINK: http://www.u4.no/projects/project.cfm?id=66

5.3 Common Fund for Support to the Health Sector, Mozambique

Table 5-2: Mozambique Health Sector

Responsible	NORAD (Norway)
Project no	MOC 2473 Common Health Fund
Partners	DFID, Ireland Aid, CIDA, Finland, the Netherlands, EU, Danida, Swiss Agency for Development Co-operation and the World Bank
Implementer	Government of the Republic of Zambia
Period	2003 – 2006
Amount	(Norad): NOK 175 million
Document	Assessment Memorandum at: http://www.u4.no/themes/health/mozassessmhealth.pdf
Contact person	Lise Stensrud (lise.stensrud@mfa.no), the Norwegian Embassy in Maputo

5.3.1 Project description

Through the establishment of a common health fund all Norwegian funding to the health sector with the exception of one programme (UNFPA) is channelled as a core contribution to the Ministry of Health. The justification for moving towards program support rests in the understanding that this will lead to improved health services, by providing a better overview of available resources and by creating a common framework for setting priorities, articulated in an annual cost plan, with common reporting, monitoring, accounting and audit of all activities. The performance of the health sector will be assessed through a joint annual review, using the national list of indicators, which will be subject for discussion with other partners and the Ministry of Health in the preparations of the annual reviews. All contributing partners have signed a MOU, setting out the conditions for the common fund.

5.3.2 Anti-corruption aspects

The change from a project approach to a programme approach has been difficult. Identified risk areas have been:

- Resistance within the Ministry of Health from those who are losing direct control of funds
- Resistance to expose the various topping up schemes for salaries (extremely high salary levels partly created by abundant donor funding)
- Costs related to training and/or participation in seminars, and
- Procurement, partly because the various donors have different requirements and partly because this is a "traditional" corruption risk area.

The process is simultaneous with the development of a new public financial management system, SISTAFE. The establishment of a common planning and budget system, and the connecting financing mechanism, is expected to improve not only government ownership, but also increase transparency and accountability.

The Ministry of Health is expected to be the first ministry to have the new financial system implemented. The elaboration of a new procurement law and its regulations, including assets, is another important parallel process. The work in this regard has unfortunately been slow even if some progress can be noted as from beginning of 2005. The partners in the Health Sector have taken an initiative, recommended by the UN Special Envoy on Human Rights, to assess the possibility of abolishing user fees. The purpose is to increase access to health services and to reduce corruption. The study will most probably be done in cooperation with the education sector (for school fees).

5.3.3 Recommended reading

Primary Health Care in Mozambique by Magnus Lindelöw, the World Bank, Patrick Ward, OPM, Nathalie Zorzi, consultant, July 2003, the World Bank.

LINK: http://www.opml.co.uk/docs/Primary_Health_Care_in_Mozambique.pdf

Health Sector Expenditure Tracking and Service Delivery Survey for primary health care services in Mozambique funded by DFID in collaboration with the World Bank and Oxford Policy Management (OPM). It assesses the flow of monetary and non-monetary inputs to, and service outputs from, a sample of primary level health facilities. It also collects information on compliance with reporting and control systems at the facilities and at higher administrative levels. The distribution and utilisation of key inputs are being assessed in terms of equity and efficiency.

5.3.4 Other relevant anti-corruption projects in Mozambique from U4 data base:

Combat Corruption, NORAD, 2002.

LINK: http://www.u4.no/projects/project.cfm?id=251

Etica Mocambique, the Netherlands, 2002.

LINK: http://www.u4.no/projects/project.cfm?id=544

Civil Society Participation in the PRSP process, DFID, 2001.

LINK: http://www.u4.no/projects/project.cfm?id=339

5.4 Health, Nutrition and Population Sector Programme, Bangladesh

Table 5-3: Bangladesh, Health, Nutrition, and Population

Responsible	Sida
Partners	Partners Netherlands, DFID, World Bank, EU and Sida are pool financiers with the World Bank as lead
Implementer	Government of Bangladesh
Period	2005 – 2010
Amount	(Sida): SEK 500 million
Document	Minutes Project Committee at: http://www.u4.no/themes/health/pkbangladeshhealth.pdf
Contact persons	Anna Kari Bill, Health Division (Anna-kari.bill@sida.se) Syed Khaled Ahsan, Swedish Embassy, Dhaka (khaled.syed@sida.se)

5.4.1 Project description

Sweden has supported the health sector development of the Government of Bangladesh since 1972. In 1998 Sida, joined four other so called pool financiers led by the World Bank to support a sector wide approach initiative called the Health and Population Sector Programme (1998-2003).

Based on the lessons of this programme, the Ministry of Health and Family Welfare (MOHFW) has developed a successor programme, the Health, Nutrition and Population Sector Programme (HNPSP). It is based on a Strategic Investment Plan for the health sector lasting until June 2010. The HNPSP aims at improvements of basic health services to cost-effective, equitable and accessible levels.

Alternative financing mechanisms will be developed to reduce demand side barriers like staff absenteeism and informal payments that negatively affect utilisation of public services, especially by the poorest segments. Collaboration between the MOHFW and its development partners will be

strengthened in order to gain and share better understanding of how to improve governance in the health sector, reduce system loss and strengthen accountability mechanisms.

The MOHWF will support the mechanisms of community and stakeholder participation in monitoring the programme. A Health Service Users Forum will be set up at national level, linked to community and district level monitoring groups. A demand-side financing mechanism as a way of transferring purchasing power to poor people to choose their services providers will be piloted.

5.4.2 Anti-corruption aspects

The assessment memorandum for the Swedish participation in the Health, Nutrition and Population Sector Support Programme in Bangladesh was presented to Sida Project Committee (PC) on April 7, 2005. It was the first of four health sector support programmes to be presented during 2005 with a special focus on anti-corruption measures.

The PC recommended that anti corruption should be part of the policy dialogue as elaborated in the Specific Agreement. The PC further asked the Swedish Embassy to provide an analysis of the corruption situation in Bangladesh in general and in the health sector in particular to be included in the final assessment memorandum.

In the following discussions the Embassy highlighted that financial risks had been analysed and presented in an annex to the memorandum, Assessment of Financial Management and Audit Systems.

The Swedish contribution is suggested to be pooled with other financial resources. Annual program reviews will be co-ordinated by the World Bank. Sida will sign a trust agreement with the World Bank outlining the responsibilities of the World Bank towards Sida regarding monitoring and reporting. The agreement will be a tool for regulating joint responses to suspected corruptive behaviours, transparency within the donor group and procedures for sanctions and withdrawals.

5.4.3 Other donor supported activities in Bangladesh of relevance for reducing the risk of corruption in the health sector:

The World Bank is the lead agency in the health sector and complementary information regarding the risks and measures taken to counter these risks can be found in their Project Appraisal Document (latest version Jan 14, 2005). Corruption risks are not mentioned directly. There is however a number of issues of direct relevance for reducing the risk of corruption presented in the document: governance issues, the public sector's capacity, financial analysis, fiduciary aspects with focus on the necessity to strengthen the procurement and distribution of health sector goods. Report No: 31144-BD.

DFID is supporting a Financial Management Reform Programme in co-operation with the Royal Netherlands's Embassy. The goal of the programme is to improve the efficiency and effectiveness of the allocation of resources and to achieve more equitable and improved public service. It will further strengthen line ministries role in resource allocation and management as well as the management capacity of the Financial Management Academy and Auditor General.

See also DFID support to "Social Sector Performance Surveys" in Bangladesh.

Transparency and Anti-Corruption in the Public Service Sector Management of Water and Sanitation Services, South Asia Ministry of Foreign Affairs, Netherlands, 1999-2002.

LINK: http://www.u4.no/projects/project.cfm?id=2

5.5 Social Sector Performance Surveys, Bangladesh

Table 5-4: Bangladesh Social Sector

Responsible	DFID (UK)
Partners	Oxford Policy Management at http://www.opml.co.uk/
Implementer	Oxford Policy Management
Period	2003 – 2005
Amount	(Sida): SEK 500 million
Relevant website	Health and Population Sector Annual Performance Review (Oxford Policy Management) at: http://www.opml.co.uk/social_policy/health/sh3622.html

5.5.1 Project description

Over the period 2003-2005 DFID is funding three sector surveys in Bangladesh, one each in secondary and primary education and one in primary health.

In the case of Primary Health the survey is intended to stimulate policy debate and support the public sector in becoming more performance-oriented and accountable, with the ultimate objective of increasing the effectiveness and equity of public spending on priority services.

The survey focuses on the lowest tier of service provision in health care, since this tier is essential for the effective delivery of primary services to the population.

Oxford Policy Management conducted the surveys along with a counterpart national survey organisation. The final report for the Primary Health survey was released in November 2005. A summary of lessons learned from implementation of the Bangladesh PETS survey is available on the OPM website. The dissemination of the survey results will be conducted in co-operation with the Ministry of Finance.

LINK:
www.opml.co.uk/docs/qgux_Lessons_from_a_Health_PETS_in_Bangladesh_November_2005.pdf

5.5.2 Anti-corruption aspects

Areas covered by the surveys included resource flows in formal and informal management systems, resource control and accounting, utilisation of essential inputs at the facilities, outputs and their relationship with inputs, equity and the demand for services. The following research questions are particularly relevant for future anti-corruption initiatives:

- What is the actual public spending at the primary level?
- Are provisions reaching the frontline service provider? What are the blocks and leakages?
- How important are informal resource flows and how do they relate to leakages of formal flows?
- How are informal payments financed?
- What is the level of absenteeism?

During the process, government expenditure was tracked from the Directorates through to the service providers. In a similar manner the flow of goods (e.g. drugs) was tracked from the Directorates to the service provider. At the facility level researchers reviewed staffing, training, supervision, equipment and other provisions as well as assessments of the quality and volume of the services being provided. The factors that affected service uptake by different groups were assessed. The survey indicated how

commonly users make unofficial payments for services and what the effects are of these fees on uptake.

5.6 Improving Health in Malawi: Sector wide approach including essential health package and emergency human resources programme

Table 5-5: Improving Health in Malawi

Responsible	DFID (UK)
Partners	World Bank and Norway/Sida as pool financiers Global Fund, USAID, JICA, GTZ and UN agencies through project funding
Implementer	Government of Malawi
Period	2005/6 - 20010/11
Amount	(DFID): £ 100 million
Document	Programme Memorandum, November 2004 at: http://www.u4.no/themes/health/dfidmalawifinalreport.pdf
Contact persons	Julia Kemp (J-Kemp@dfid.gov.uk), health advisor Debbie Palmer (d-palmer@dfid.gov.uk), assistant governance advisor

5.6.1 Project description

In December 2004 DFID agreed to provide £100 million to the Malawi Government for support to the health sector over a period of six years (2005/6 to 2010/11). DFID is pooling its contribution to the Sector Wide Approach (SWAp) in health with the World Bank and Norway/Sida.

A Memorandum of Understanding (MoU) governs the relationship between the Government of Malawi and collaborating partners and sets out the different undertakings, governance procedures for the SWAp and capacity building requirements.

The three main components of the DFID support are:

- An Essential Health Package designed to deliver a prioritised package of services that focuses on the major causes of morbidity and mortality, particularly those that affect the poor;
- An Emergency Human Resources Programme that aims to double the number of nurses and triple the number of doctors in Malawi by expanding training capacity and improving incentives for health workers to stay in the profession;
- And capacity building in financial management, procurement, human resources, monitoring and evaluation, and health services planning and management.

DFID intends to set up a joint health office with Norway/Sida to improve the effectiveness and lower transactions costs for the Government and other collaborating partners.

5.6.2 Anti-corruption aspects

The programme is rated "high risk" by DFID not because of programme design, which is viewed as "medium risk", but due to factors exogenous to programme design. Overall sector funding is below recommended levels and may be inadequate to produce significant impact on health outcomes. It has been assumed that more aid will become available in due course.

Malawi has begun a reform process under its new government, but future governments may not sustain it. The new government has demonstrated determination to impose greater fiscal discipline and

fiduciary reforms, which are seen as necessary to enable the programme to achieve its objectives. A new public procurement system is being implemented.

Donors are supporting Government plans to institutionalise political reform in the hope that stronger institutions will make backsliding more difficult. Financial management and procurement procedures have been developed for the SWAp, offering safeguards while simultaneously building capacity at central and district levels. These include time bound Financial Management and Procurement Improvement Plans, a commitment to fill accountant vacancies, independent financial and procurement audits, and long-term Technical Assistants with mentoring, management and supervisory responsibilities.

World Bank procedures will be used for international competitive bidding until Government systems become fully and effectively operational.

Corruption was a major problem under the previous government, especially in the drugs and the supply chain. A condition precedent for DFID disbursements is an agreement on an action plan to improve the effectiveness and integrity of the Central Medical Stores and drugs supply chain.

To retain and attract health workers one aim of the human resources programme is to raise health workers salaries. The proposed salary top-ups are affordable only if fully funded by donors. DFID recognises that the Government is vulnerable to the withdrawal of donor funding and has undertaken to give notice of two financial years, in the unlikely event that the UK Government felt it necessary to withdraw or reduce its contribution to salary support.

5.6.3 Other donor supported activities in Malawi of relevance for reducing the risk of corruption in the health sector:

Financial Management, Transparency and Accountability Project (FIMTAP), World Bank, 2003. This ongoing project aims to improve an effective and accountable use of public expenditures through capacity building and institutional strengthening for budget implementation and oversight, and increase transparency of government institutions, as well as improve human and institutional capacity for expenditure accountability. Project assessment documents can be downloaded from the World Bank web site.

LINK:
http://www-ds.worldbank.org/servlet/WDS_IBank_Servlet?http://web.worldbank.org/external/default/main?pagePK=64027221&piPK=64027220&theSitePK=355870&menuPK=355907&Projectid=P078408

6 Budget transparency

> Donors should focus their aid at the poorest countries and on the achievement of the [Millennium Development Goals]. Effective aid needs to be untied, as tied aid is less efficient for the recipient and invites corruption. It is essential that aid should be provided to finance local as well as recurrent expenditures especially in the health and education sectors. Moreover, donors need to harmonize procedures with those of partner country systems to improve the effectiveness of development assistance.
>
> World Commission on the Social Dimension of Globalization, ILO, 2004 *co-chairs presidents T. Halonen (Finland) and B.W. Mkapa (Tanzania)*

6.1 Opportunities for Corruption in the Allocation and Management of Health Budgets

6.1.1 The budget cycle

Breaking down the budget process into consecutive stages is a helpful way to understand the various steps of the budget cycle. The cycle starts with governmental policy inception, which involves an analysis of the previous fiscal year, the setting of priorities, and estimates of income. It is followed by the government's budget formulation, including setting the resource framework, objectives and priorities. Upon enactment through the legislature, the budget is actually executed (or implemented) during the fiscal year: Revenues are collected, funds released, personnel are deployed, and planned activities are carried out. The budget cycle ends with the monitoring and evaluation of achievements: Expenditures are accounted for, the achievement of targets is measured, and the audit institutions provide their feedback to the legislature. Their information is used to analyse and formulate the next year's budget.

Figure 6-1 illustrates the various stages of the budget cycle.

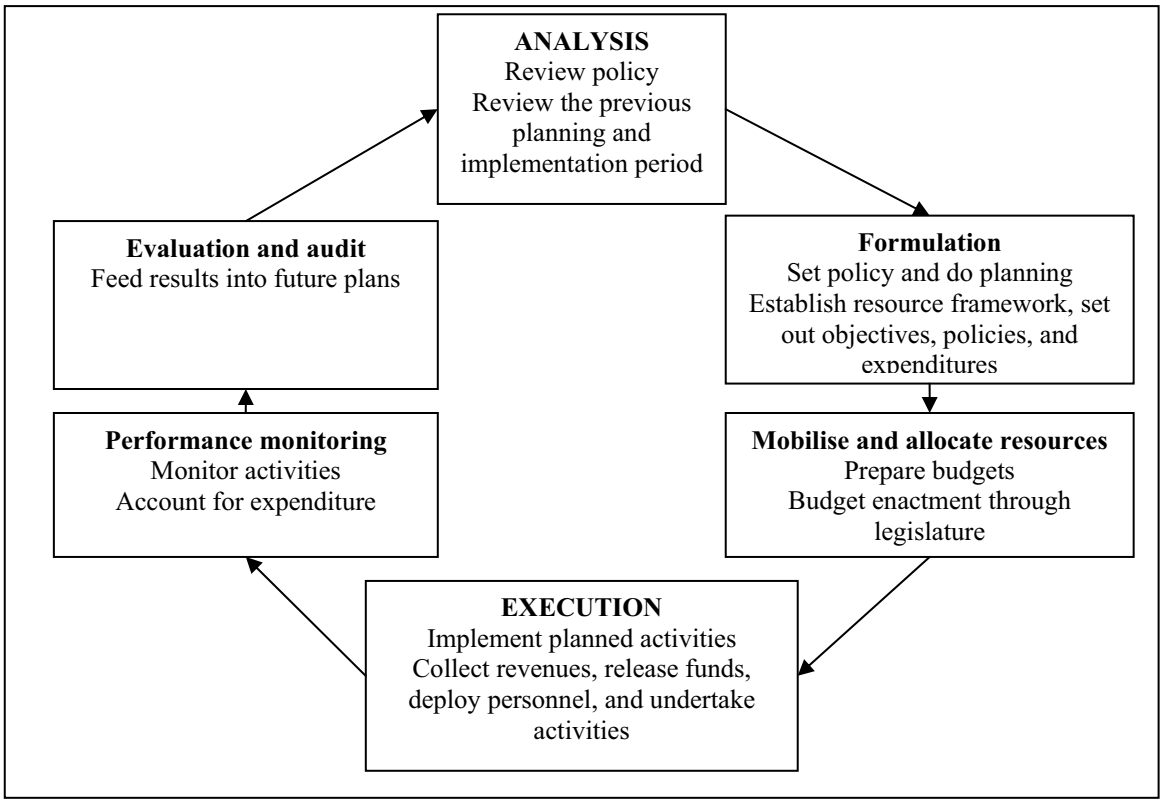

Figure 6-1: The Budget Cycle

6.1.2 Opportunities for corruption in the budget formulation process

The budget is the main policy instrument of the government. However, policy objectives and priorities often do not find expression in annual budgets. For example, even though government policy documents may pledge commitment to social goals, sectors like defence and large infrastructure projects often receive a disproportionate share of the budget, because they provide more opportunity for kickbacks and pay-offs to politicians.

Budgets are frequently built on unrealistic estimates, either over- or underestimating tax income, which makes it difficult to understand and act on a budget proposal. A comprehensive budget analysis therefore needs to look at both the revenue and the expenditure side of the budget. These distortions and manipulations of the budget can constitute acts of corruption in that they favour the political and economic elite of a country. Analyses of the health sector indicate that public expenditure tends to disproportionately benefit the rich in a majority of nations. It is common that priority is given to tertiary hospitals using costly equipment while smaller primary care clinics may be left without both staffing and equipment. This could be the result of officials being influenced to allocate funds to benefit a supplier or to benefit a particular group. Officials could also be influenced to insert specific subsidies or tax exemptions in the budget.

> **Budget Approaches to the Right to Health**
>
> In April 2004 the World Health Organisation (WHO) organised a meeting in Geneva to bring together different research initiatives on monitoring government compliance with the right to health. The Mexican non-governmental organisation (NGO) Fundar discussed its work to evaluate the right to health systematically through budget analysis. Fundar explained that the two core requirement for the realisation of social and economic rights - progressiveness and using available resources - could be examined by analysing the availability and accessibility of health services.
>
> LINK: http://www.internationalbudget.org/resources/newsletter21.htm

A problem in the budget formulation process is that significant portions of resources may not appear in the budget: they are off budget. This is often a consequence of donors who do not trust a country's financial management system, and that often compete for projects. As a consequence, substantial expenditures may simply not appear in the government's budget. Ministries may also prefer not to disclose donors' project grants and internally generated funds because they fear that this may decrease their share of government funds. The lack of information is common in the health sector judging from studies in Uganda. The fact that the private sector is a major player in health care in many low-income countries may contribute to the poor data collection. Off-budget activities create non-transparent, parallel systems that make comprehensive budget analysis and monitoring of expenditures difficult. Delays in donor disbursements also cause difficulties in estimating the full resource envelope.

6.1.3 Opportunities for corruption in budget execution and evaluation

Once the budget has been approved by the legislature, the executive has to ensure that it is implemented in line with what was enacted into law. However, in many countries, budget management systems are so poor that it is difficult for the executive to monitor how resources are spent. Financial information on expenditures is frequently late, often incomprehensive and inaccurate. Crucial data are often non-existent, and the data that are available are plagued by problems of timeliness, accessibility and frequency.

In practice, therefore, budgets are not always implemented in the exact form in which they were approved. Funding levels in the budget are not adhered to and authorised funds are not spent for the intended purposes. These practices are not necessarily corrupt. However, if for example trips abroad

for high level public officials are well over budget, whereas the budget allocated for recurrent charges, such as medical supplies, is not spent, then corrupt behaviour of public officials may have played a role.

Once the fiscal year is over, the public (and the legislature who represents them) should be able to measure whether public resources have been spent effectively. Again, this is often hampered by delays in providing information and a lack of access. Even when data and statistics are accessible in time, they may be inappropriate, faulty and organised (e.g. aggregated) in a way that readers cannot draw any conclusions from them.

6.2 Transparency: standards and promotion

6.2.1 Transparency standards

Regulation for budget transparency exists on national and international levels, and applies to all sectors of the public services. Many developing and transitional countries have legislated, and, to a lesser degree, provided greater availability of budget information in recent years.

The International Monetary Fund's (IMF) Code of Good Practices on Fiscal Transparency developed in the context of the collapse of the Asian financial system and adopted in 1998, provides a coherent framework to assess the transparency of public finances, to identify priorities for reform, and to monitor progress. The Code defines:

1. Clarity of roles and responsibilities in public finance
2. Public availability of information
3. Open budget preparation, execution and reporting
4. Independent assurances of integrity (external audit)

The IMF also issues country reports on fiscal transparency that measure country performance against the Code. The OECD has developed Best Practice on Budget Transparency (2001) that also provides a benchmark for government performance. On the national level, some countries have enacted specific regulations for fiscal transparency. Budget transparency is defined as "full disclosure of all relevant fiscal information in a timely and systematic manner" in the OECD Best Practices for Budget Transparency.

LINKS:

http://www.imf.org/external/np/fad/trans/code.htm

http://www.oecd.org/LongAbstract/0,2546,en_2649_33735_1905251_1_1_1_1,00.html

6.2.2 Measures to Promote Budget Transparency

If the budget were open to public and effective legislative scrutiny, there would be less scope for deviation from policy decisions and reversal of budget allocations. There would probably be fewer distortions between the sub-sectors, and the ruling elite would be less likely to manipulate the budget. Budget transparency, while not a goal in itself, is a prerequisite for public participation and accountability: A budget that is not transparent, accessible and accurate cannot be properly analysed. Its implementation can also not be thoroughly monitored, and its outcomes can not be evaluated. There are a variety of measures and tools that enhance budget transparency.

- **Avoiding off-budget activities:** In the budget presentation, the full picture of the governments' financial status must be given. Many developing countries have lost control over their financial affairs due to the segregation of budgetary execution data, and/or ad hoc budgetary execution records. Donors should be particularly aware that off-budget programmes should be avoided or, if deemed necessary, be fully transparent: Aid practices can otherwise distort the budgetary process and undermine government accountability.

- **Sound budget and expenditure management systems:** Ideally the budget system should be built in such a way that it is transparent and open to public scrutiny. Improved public expenditure management systems are currently put in place in many developing countries in the context of the Poverty Reduction Strategies (PRS). They are part of an overall "reform package" consisting of macro-economic and budget reform, civil service reform, and changes in the legal and regulatory structures, and often appear as conditions attached to International Monetary Fund (IMF) and World Bank lending and debt relief. Many recipients budgetary systems have much better data on the input mix for domestically financed expenditures than they do on donor projects, which are sometimes treated as single lines in the budget.
- **Making information available:** The budget system should be designed in such a way that it "produces" comprehensive, timely information. Communication technology can play a crucial role in this. Electronic records of all transactions can contribute to avoiding expenditures without previous authorisation and proper justification. For example, in Peru, an Internet Portal of Fiscal Transparency has been providing free access to detailed budget information since 1999. Pro-active government or NGO information campaigns can generate public interest in monitoring spending and thus prevent leakage of funds.
- **Build budget literacy:** Understanding and analysing budgets is not an easy task. However, if citizens are to hold their leaders to account, they have to be able to understand the budget. The legislature is more likely to effectively monitor the budget process if there is widespread public interest in budget issues. The media and NGOs play a particularly important role in regard to generating interest and sparking public debates about the budget. In recent years, many NGOs have specialised in budget analysis and offer training for other civil society organisations.
- **Develop capacity of parliamentarians:** Budget literacy is particularly important for Members of Parliament (MPs) who should be able to analyse and comment on the budget proposal, and to monitor expenditures and evaluate the budget outcomes at the end of the fiscal year. MPs have an important role to play: They can initiate public hearings and debates, establish special committees and request further information from the executive. Aid agencies seldom hold a dialogue with parliamentarians, who sometimes view the donor emphasis on civil society as undermining the legitimacy of elected representatives.
- **Public Expenditure Tracking:** In the budget execution phase, transparency can be enhanced through expenditure tracking, a method of finding out how expenditure is being made, and how and at which level of the system the money is disappearing. It examines the flow of public funds and the extent to which resources actually reach the target group. Public Expenditure Tracking Surveys (PETS) measure the transformation of public expenditure into public goods and service delivery. The World Bank website on PETS provides links to several papers that describe this methodology, as well as results from some countries. Other resources include a publication by Ritva Reinikka and Nathanael Smith, Public Expenditure Tracking Surveys in Education, produced by the United Nations Education, Scientific, and Cultural Organization (UNESCO) International Institute of Education Planning (IIEP) in 2004; and the web site of Oxford Policy Management where consulting teams have participated in PETS studies in several countries, including Mozambique and Bangladesh. Reports and lessons learned are posted on the OPM web site, including Lessons from Bangladesh and the Mozambique summary. The full Mozambique expenditure tracking and service delivery survey in combination with quantitative service delivery surveys of specific facilities can yield useful information on the contours of corruption and identify entry points for reform. The World Bank and the IIEP offer training courses on the PETS methodology.
- LINKS:
    - http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTPUBLICSECTORANDGOVERNANCE/EXTPUBLICFINANCE/0,,contentMDK:20235447~pagePK:148956~piPK:216618~theSitePK:1339564,00.html
    - http://www.unesco.org/iiep/PDF/pubs/Reinikka.pdf

- http://www.opml.co.uk/
- http://www.opml.co.uk/docs/qgux_Lessons_from_a_Health_PETS_in_Bangladesh_November_2005.pdf
- http://www.opml.co.uk/docs/02_Aug_2005_Mozambique.pdf
- http://siteresources.worldbank.org/AFRICAEXT/Resources/ww11888final201.pdf.pdf

- **Strong and independent audit institutions:** It is unfortunately not always the case that professional bodies that review and evaluate fiscal activities, such as audit institutions, are able to do their job. Means to enhance budget transparency should therefore also aim to strengthen the effectiveness of audit institutions. To effectively monitor and assess public spending, they need political independence as well as adequate financial and human resources that allow them to produce accurate reports in a timely manner. Another prerequisite for effective audit institutions is a strong legal framework that is able to enforce regulations for spending as well as the fiscal relations between central and local government.

6.2.3 National Health Accounts and the Budget process

National Health Accounts (NHA) is an internationally recognised framework that measures and tracks the use of total health care expenditures in a country. NHA tracks the flow of funds from one health care dimension to another, such as from the Ministry of Health to each health provider and health service program. Expenditure data is presented in a standard set of tables intended for use by country policymakers and other stakeholders, including donor representatives. Thus, NHA allows for greater fiscal transparency of country health systems and fosters an anti-corruption approach NHA requires health care spending information from all health sector stakeholders. This need for transparency allows NHA to serve as an anti-corruption tool, especially when implemented on a regular basis; governments, insurance companies, and other stakeholders remain more vigilant about distribution of their health funds in anticipation of sharing such information each year.

Donors play a critical role in initiating government interest in and commitment to NHA. One source of information about donor NHA activities in Africa is the WHO/AFRO, the elected co-ordinating body of African NHA regional network. In addition, the USAID-funded Partners for Health Reform plus Project has a special section on NHA analysis, links to regional networks, and reports from many countries.

The Commonwealth Regional Health Community Secretariat is an additional source of information on Anglophone countries, see Brief for Donors: National Health Accounts: Supporting NHA in Africa. See also NHA information on Latin America.

LINKS:

http://www.who.int/nha/en/

http://www.phrplus.org/nha.html

http://www.phrplus.org/Pubs/sp7.pdf

http://www.iadb.org/sds/specialprograms/lachealthaccounts/index_en.htm

6.2.4 Public Participation in the Budget Process

Public participation is one important component of a more accountable public sector. Corrupt use of resources cannot be prevented through regulation, good management and transparency alone. The public needs to actively use the budget information that is available to them. The information that is produced through budget transparency should be used for public debate and formulation of policy; otherwise budget transparency has no effect. Civil society and the media should engage in budget debates. Ultimately, it is the citizens who finance the budget and therefore they should be benefiting from public spending. The public can actively be included in all stages of the budget cycle.

- **Participatory budgeting:** Participatory budgeting is an innovative financial practice that involves people in priority-setting and resource allocation. It has become increasingly popular in the context of decentralisation that creates opportunities for greater citizen and local legislative involvement. Participatory budgeting helps improve transparency in finance administration of local authorities; contributes to a more equitable distribution of resources and to eliminate "party politics" in local decision-making. It breaks with the tradition that the budget process should occur exclusively in the executive, with the input only of budget technicians and a few politicians. Participatory budgeting tools have been widely applied in Latin America and Europe.

  LINK: http://hq.unhabitat.org/cdrom/TRANSPARENCY/html/2d_7.html

- **Budget monitoring by Non-Governmental Organisations (NGOs):** An increasing number of NGOs carry out independent research and training with the aim of building public awareness on budget issues. NGOs are involved in budget analysis, providing comprehensive information to the public and to the media and often enabling them to comment on budget proposals and to monitor expenditures. NGOs also carry out surveys to compare budget transparency across countries, thus putting pressure on governments to improve budget systems.

- **Public hearings and citizen score cards:** Two examples of tools that generate public awareness and citizen engagement in budget processes are public hearings and score cards for public services. Public budget hearings at local level raise citizens' awareness on goods and services that are supposedly delivered to them. Presenting expenditure records in easy language to the public and confronting local politicians with the discrepancy between policy statements and actual delivery can trigger civic action against corruption and contribute to accountability. Report cards for public services measure both quantitative and qualitative indicators of service delivery through direct citizen feedback. If they are widely disseminated amongst the public, together with budget information, they provide an opportunity for citizens to get involved in the budget allocation process, and to ensure that the budget addresses their needs.

  LINK: http://www.adb.org/Governance/Pro_poor/Civil_society/default.asp

The Uganda Debt Network

"In May 2000, UDN established Poverty Action Fund Monitoring Committees (PAFMCs) in 12 districts in Uganda. PAFMCs are voluntary civil society groups participating in monitoring of Poverty Action Fund (PAF), performance of the budget, anti-corruption campaign and advocacy for accountability and transparency. The committees are composed of persons selected from the civil society sections including women, youth, people with disabilities, men, religious leaders, and the elderly. In order to make monitoring more participatory, UDN introduced community based monitoring and evaluation system approach. Through this the communities are engaged in continuous monitoring and evaluation of government programmes and pertinent intervention activities. So far, there is no doubt, UDN model of PAF monitoring is hailed as a success story."

From "Monitoring of Poverty Action Fund: Lessons from Uganda" by Basil Kandyomunda, Deputy Executive Director, Uganda Debt Network, 2003

6.3 Development assistance and transparency

6.3.1 Aid Modalities

Donors and the different modalities of aid affect the recipient's spending patterns and budgetary process in many ways. The last chapter of the World Bank, World Development Report (WDR) 2004, "Donors and Service Reform", provides an interesting discussion on the subject. The main recommendation is that in country environments where there are genuine reforms, donors should integrate their support in the recipient's development strategy, budget, and service delivery. According to WDR, this is not the case today. Most donors keep a close eye on their contributions, afraid that misuse of funds and open corruption may de-legitimise the domestic political support for development assistance.

6.3.2 Proliferation of funding mechanisms for health

There has recently been a development of public-private partnerships channelling financial assistance to health. These funds could pose huge opportunity for corruption because of the conscious structuring to circumvent national bureaucracies and speed the process of disbursement. The Global Alliance for Vaccines and Immunisation (GAVI) has disbursed over US$ 1 billion during the period 2001-2005 and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), also started in 2001, has awarded $3.1 billion to 128 countries in the first two years of operation. The latter organisation uses accounting agencies as Local Funds Agents rather than channelling funds through national governments or international organisations. To assure accountability, both GAVI and GFATM use performance-based grant mechanisms. The health sector seems to raise particular challenges in applying performance-based mechanisms. One reason is that too much focus is placed on easy-to-quantify indicators to the exclusion of important health activities harder to measure and a risk that low-cost verification system can not be made corruption-resistant.

LINK: http://www.u4.no/themes/health/bugetandoda.cfm#_ftn1

Corruption and The Global Fund

The Global Fund to Fight AIDS, Tuberculosis, and Malaria (known as GFATM or The Global Fund) temporarily suspended five grants to Uganda due to concerns about corruption. The suspension was imposed in August 2005 because of "serious mismanagement of the grants" that was first reported by a Ugandan whistleblower. The suspension was a dominant story in the Ugandan media when it first happened, pushing the government to set up a formal commission of inquiry led by the country's chief judge. The Ugandan government said that if necessary it would recover lost money by selling the property of those found guilty of misappropriating it.

Uganda has already received $USD 79 million of the $USD 213.6 million in grant funds approved by the Global Fund since June 2003 for scaling up national response to HIV/AIDS, tuberculosis, and malaria; expanding access to treatment; and for care and support of orphans and other vulnerable children.

The Global Fund lifted the suspension in December 2005 after it reached agreement with the Principal Recipient (PR) of the grant (the Ministry of Finance, Planning, and Economic Development), and the Country Coordinating Mechanism (CCM) on new oversight structures, steps towards CCM restructuring, and measures to evaluate the quality and efficacy of all sub-recipients of grant funds. The Global Fund Country Coordinating Mechanism is a key governance structure whose role is to facilitate public-private collaboration in the development of grant proposals and monitoring of implementation.

Source: Global Fund Observer, Issue 53, 11 December 2005, and Issue 50, 7 September 2005 (A newsletter produced by Aidspan, an independent watchdog of the Global Fund), and the Global Fund's website, accessed 30 Dec. 2005

LINKS:

http://www.aidspan.org/

http://www.theglobalfund.org/

6.3.3 SWAps and Budget Support

In countries where donors have agreed to pool their resources for a specific sector this process is often guided by a so-called Sector-Wide Approach (SWAp). SWAps are expected to address problems of "project" modality, increase aid effectiveness, and establish greater coherence between policies, programs and budgets. SWAp is first and foremost a policy co-ordinating mechanism and not a financial mechanism. SWAp thus, in principle, applies to budget as well as project funding arrangements even if they many times are seen as primarily a management tool for disbursement and accounting of funds. SWAp covers public funding for the sector including project type aid, technical assistance, earmarked funds and pooled funds.

According to studies by WHO, SWAPs provide an improved diagnosis of barriers to service utilisation and improvement, including better understanding of corruption and incentives problems. SWAPs also help to create common procedures for planning, disbursement, accounting, audit, and review, all of which can help reduce the costs of dealing with donors, and increase coherence of programmes.

Also studies by UNFPA indicate that SWAps place government squarely in charge, increase predictability of funding, increase transparency of resource use, improve accountability, and achieve more value for money.

See also "Experience of Sector Wide Approaches in Health - A Simple Guide for the Confused", European Community Paper No 25, 2000.

Health Sector Support to Zambia/Risk Analysis and Alternative Strategy

"Corruption could be regarded from both a technical and political perspective. From a technical perspective, corruption is adequately dealt with within the health sector. Working within the framework of a SWAp, means that Sweden and other collaborating partners (CP´s) have an overview of all resources, including Government of the Republic of Zambia (GRZ), to the health sector. This implies that Sweden may be more aware of mismanagement of funds and corruption than would otherwise have been the case. Within a SWAp environment corruption can be better dealt than in a traditional project/project environment and it is getting increasingly difficult for politicians or public servants to misuse funds, regardless of whether it is GRZ funds or CP funds. The political perspective, meaning the willingness from the political elite to seriously deal with corruption, is much more complicated. This perspective is closely interlinked with democracy, human rights and good governance. As outlined above, the good governance situation is far from satisfactory."

Assessment memorandum, Sector Programme Support to the Zambian Health Sector 2002 - 2005, Sida 2001-05-28

The usual concern with SWAps is that they increase the chance of corruption. When donor funds go through a SWAp, the idea is that government assume responsibility for resource allocation decisions in pursuit of agreed objectives. This reduces the scope for donor external control and audit of government's use of funds. If it leads to improved control by the public sector of its own spending, then it is all the good. But if it allows public officials to divert donor funds the same way they may be diverting taxpayer money, then it is not much of an advance at all. Great care thus must be placed on arrangements for financial management, external and independent audits, and other checks and balances such as Basket funding committees, etc.

6.3.4 Tied aid

Some bilateral aid is tied. It must be used for procurement of goods and /or services from the donor country. Studies used by the World Bank show that tied aid reduces the value of that assistance by about 25%. It is not clear whether tied aid is more or less prone to corruption; however, there is evidence that tied aid projects may pay higher prices for supplies due to price discrimination. For example, Mozambique is reported to have been charged up to 50% more for drugs procured from multinational companies using tied aid, compared to a state purchaser using public budget financing who purchased drugs from the same multinationals.

6.3.5 Funding through NGOs

A substantial share of external funding today is channelled through international and/or local non-governmental organisations. In these cases donors need to apply accountability and transparency rules similar to those that have been recommended for countering corruption in the budget process. Before taking a decision to grant funds to a particular organisation it is advisable to look at the competence and capacity of the organisation. The following checklist is from a capacity study of the charity organisation Save the Children (UK) that was commissioned by the Swedish International Development Co-operation Agency (Sida) in 2001.

- Organisational structure (clearly documented sub-unit structures with defined terms of reference and operating protocols for each sub-unit).
- Management of activities (publicly available mandate and operating procedures of governing board, decision making and order of delegation, defined mission, vision, goals, activity plans and policies, indicators for performance)

- Administrative systems and routines (transparency, fairness, and documentation)
- Personnel administration (transparency, fairness, and documentation)
- Financial control (promotion of good administration, transparency in the financing picture and handling of means, and anti-corruption measures).

7 Salaries

Low salaries have been used as an explanation for bribery and informal payments in health care delivery. However, the process of obtaining salaries and promotions may in itself involve corruption. For example, absenteeism and ghost workers constitute a severe problem in many developing countries as patients find clinics empty or with too few health workers. Also, paying for health workers who are present or non-existent can constitute severe wastage. Pay reform should take both effects into account.

The purpose of this section is to survey the existing literature on salaries and pay reform, and to discuss how donors supporting health service delivery can take these concerns into consideration in order to reduce opportunities for corruption.

7.1 The importance of salaries in fighting corruption

The situation regarding pay and health worker motivation has been particularly dramatic in Eastern Europe and Central Asia after the fall of the communist regimes. Informal payments have emerged as a fundamental aspect of health financing in these countries, creating an informal market for health care within the confine of the public health care service network. In some countries such as Azerbaijan and Armenia, out-of-pocket expenditures account for 75-80% of total health expenditures.

The importance of adequate remuneration to ensure an honest civil service is widely debated. Some see raising wages as sufficient to reduce corruption, while others regard raising wages a necessary but not sufficient condition for corruption reduction. Finally, there are those that consider raising wages to be unimportant (or difficult) relative to other policies. Most researchers see complementary mechanisms as necessary.

Salaries and corruption

"A main cause of corruption is still attributed by all those interviewed to low salaries and delay in payment of salaries. This is however coupled with other factors that include the need for politicians to recoup election expenses when they get into power and profiteering by some from situations of insecurity. It was also clear from participatory community appraisals that there is a climate of **tolerance towards corruption** that is difficult to combat. Those who have built houses with large amounts of embezzled monies are viewed as successful achievers. There is also an attitude of sympathy towards those who augment meager wages with small bribes, while the misuse of official resources, such as vehicles for private purposes is seen as the norm rather than a breach of regulations."

Uganda Inspectorate of Government

Second National Integrity Survey

Final Report, March 2003

http://www.igg.go.ug/pdfs/Final_Integrity_Report.pdf

When government positions are paid less than other, comparable jobs, the financial incentives to act corrupt increase and public employees find it easier to rationalise their actions. Poorly paid public officials may find it less reprehensible to accept bribes than officials receiving a comparatively fair salary.

Simple links between payment and corruption can however be **misleading**, as increased salaries not necessarily reduce corruption (Fjeldstad, 2003). Also, several studies have found that better paid employees in the health sector engage more frequently in corrupt practices than their colleagues with lower salaries (Miller et al 2000).

7.2 Salary and corrupt practice - Theoretical backdrop

For public officials to engage in bribery, they must:

a) Have an opportunity to engage in corrupt practices, e.g. due to monopoly of services, discretion to make decisions, poor accountability, weak or non-existent civil society, and poor transparency (Vian 2008 2).

b) Be willing to accept a bribe. This willingness may be influenced by social norms and cultural traits that approve or does not frown upon the acceptance of gifts and bribes.

c) Be provided with an incentive to engage in corrupt practices, i.e. that the expected revenue from engaging in corrupt practices must be positive.

The level of salaries can have an effect on both the willingness to accept a bribe, and on the economic incentive of doing so. For example, low pay can affect the willingness to accept a bribe if people feel more justified in engaging in corrupt activities.

Theoretically, high salaries can also have an effect on the expected economic output from engaging in corruption. High salaries might deter an official who is both willing and able from engaging in corrupt activities if, and only if, the probability of getting caught is present.

According to the Becker-Stiegler model (1974), salaries can deter corruption when the expected gain from engaging in corrupt practices is lower than what is on offer from abstaining. This can happen when the salary held by the public official is sufficiently higher than the salary the official can get in another job,[4] and when the official stand a chance of losing this salary if caught. It is difficult to determine what amounts to a high enough salary, as this depend on the amount of bribes the official will have to forfeit if s/he decides to stop engaging in corrupt activities. For example the Tanzanian Revenue Authority (TRA) increased salaries with 18% for their staff. At first the level of corruption was reported to go down, but soon the level of corruption increased again, and stabilised on the original level. The salary increase appears to have had little effect on corruption. Fjeldstad have indicated that the salary increase might not have been large enough to compensate for forfeited bribes (2003).

The above does not imply that we can expect people with higher salaries to be less corrupt than people with lower salaries. It only shows that people who are paid a wage above the market clearing rate can be deterred from engaging in corruption when they stand to lose this salary. Hence, it is the relative salary that matter for whether the official decides to engage in corruption or not. For example a medical attendant with a pay significantly lower than that of a medical doctor may still be paid above the market wage, while the medical doctor might not be. In this case the medical attendant might be deterred from engaging in corrupt practices while the medical doctor is not.

Attempts have been made to test the salary hypothesis in the Becker-Stiegler model. Findings by Di Tella and Schargrodsky from a Buenos Aires study support the argument that the degree of audit intensity is crucial for the effectiveness of anti-corruption wage policies. When auditing intensity is very high, salaries have no effect on corruption. However, an intermediate intensity of auditing leads lower salaries to become associated with higher corruption (2003).

Examples from studies of corruption and salaries:

a) A study from Indonesia, comparing government pay at different salary ranks to compensation offered by a sample of private establishments, showed that public officials are sometimes comparatively well paid at the lower end of the scale (close to three-quarters of all civil servants). These findings undermine the commonly held view that widespread corruption in the Indonesian government is a result of a “low paid” civil service.

[4] I.e. the official is paid an efficiency wage- a wage above the market clearing level.

b) A study in Venezuela demonstrated that higher wages for purchasing managers at public hospitals were positively correlated with their level of corruption. Similar results were presented in a study on purchasing managers in Colombia. Higher income was associated with more corruption in cases where purchasing was done without bids, but with less corruption where purchasing was done competitively.

c) Miller *et al* (2000) found similar results in a cross-country study from Ukraine, Bulgaria, Slovakia, and the Czech Republic. They interviewed 1307 public officials including 293 health staffers, and found that higher paid health workers were reported to be more corrupt because it was easier for them to extract bribes from patients. Although this does not falsify the low-salary hypothesis, it certainly suggests that the opportunity to extract informal payments is most important.

d) A comparable case study on reforms of salaries schemes comes from the work by Fjeldstad on the TRA. The TRA was sectioned out of the civil service leading to increased salaries for 18% of their officials. Initially this raise, together with other measures, was thought to lower corruption in the TRA. However, the level of corruption was soon on the rise again. In an analysis of processes, Fjeldstad argued that a salary increase can be ineffective as a means to combat corruption even when the increase in salary is large – it may still be much smaller than forfeited income from bribes, and it is found that in countries such as Tanzania an increased pay rate may simply increase the obligations on the employee to extract bribes and share those (2003).

The main challenge seems to be to sustain a high level of auditing over time. Exposing acts of corruption may be a positive move for a new government, but exposing corruption can become damaging in the long run, indicating failure and mismanagement of public funds. Also, if governing authorities is involved in corruption and unwilling to detect and punish corrupt activities, then citizen voice (e.g. public participation and scrutiny) and transparency might increase the willingness to audit corrupt activities.

7.2.1 Performance based pay and the risk of corruption

Performance based pay has become increasingly popular as a means to reach the health related millennium development goals. In order to reduce infant and maternal mortality, the Global Campaign has launched a program which will employ monetary incentives to influence health worker behaviour. According to the campaign: "The evidence suggests that small financial incentives targeted at the right level, such as those described above, are enough to change behaviour significantly and achieve results" (NORAD, 2007). Health workers are to be compensated for actions thought to lower maternal and infant mortality on a team basis. However, a recent report from the Norwegian Knowledge Centre suggests that implementing performance based pay might have adverse effects, some of which might include bureaucratic corruption:

a) Increased bureaucracy which could increase the opportunity for corruption.

b) Financial incentives might be abused and increase the opportunity for patronage.

c) Gaming - employing financial incentives for achieving targets might induce health workers to change reporting rather than practices.

(Oxman and Fretheim, 2008)

7.2.2 Absenteeism and salaries

Absenteeism is a special type of corruption which involves claiming a salary which one is not legally entitled to because of unauthorised absence. García-Prado and Chawla define absenteeism as "the unjustifiable or unexplained absence of workers" (2006). When workers profit from absenteeism, for example by collecting income from a second job, absenteeism also falls within the World Bank definition of corruption as "abuse of public power for private gain."

Recent studies from developing countries have found absenteeism to be high among health workers, ranging from 25-40% across the countries: Bangladesh, Ecuador, Indonesia, Peru, and Uganda (Chaudhury *et al*, 2006). Such high rates of absenteeism are likely to have a severe effect on the quality of health care in countries which already experience a shortage of health workers. Possible consequences of absenteeism include reduction in the production of health care, lower productivity, increased cost per paid hour (due to overtime, temporary adjustments, etc.), and lower quality of health care which in turn can have severe effects on patient welfare (García-Prado and Chawla, 2006). Also, absence patterns have been found to be erratic, meaning that patients cannot plan around absenteeism, and absenteeism can result in a lower demand for health care because of the cost involved in walking to a health care facility and finding it closed.

Theoretically absenteeism has been explained by wages, flexibility of contracted hours, and the expected cost of detection (Allen, 1981). Consequently, low wages in developing countries could contribute to higher absenteeism as the cost of losing the job is lower when wages are lower. In addition, opportunities for alternative employment are thought to be important when explaining absenteeism (Shapiro-Stiglitz, 1984). When it is easy to get new employment, absenteeism is thought to be higher. This could possibly explain absenteeism in developing countries as these countries are currently experiences an acute shortage of health workers.

Note that if health workers who are absent from public health facilities are in fact working in private facilities, reducing absenteeism by stronger supervision might not increase the human resources available for health care. However, ensuring an adequate number of health workers in the public might still be important for equity concerns as the poor normally relies on the public health sector for health care.

Studies on **absenteeism** in the health and education sectors have questioned the importance of higher pay to reduce absence among public servants. What seem to be more important are:

a) More frequent inspections.

b) Improved work environment.

c) Measures to increase accessibility such as housing nearby or good transport facilities.

d) Sanctions against health workers who are absent without permission.

Examples of projects implemented to reduce absenteeism:

a) **Peer supervision to prevent absenteeism:** In the 1990s reforms of the health sector were implemented to reduce absenteeism among health workers in Costa Rica. One of the main objectives of the reform was to reduce absenteeism by non-replacement of absent health workers. Peer pressure was supposed to make health workers refrain from being absent. According to Garcia-Prado and Chawla, this reform did not reduce absenteeism, possibly because the high workload on those remaining at work meant they had an incentive to be absent as well in order to escape the heavy work burden (2006).

b) **The effect of supervision to prevent absenteeism amongst teachers in India:** In order to reduce teacher absenteeism in the rural Udaipur District in India, teachers were required to document attendance with children on camera twice a day. Teachers received a salary consisting of a fixed part and a part dependent on valid attendances. The project was evaluated in a randomised experiment, and absence were found to drop from 36% to 18% in treatment schools (Banerjee and Duflo, 2006)

c) **Supervision and paying for presence in India:** In a randomised field experiment in India, the presence of government nurses was recorded by an NGO, and reported to the local government. The government then took steps to punish absenteeism and reward presence. The program was extremely effective during implementation and led to an increase in presence with about 50%. However, a few months later the effect had worn off and no difference could be detected between the trial group and the control group. Local administration no longer appeared to support the project (Banerjee, Duflo and Glennerster, 2008).

7.2.3 Pay reform in the context of civil service reform

Though increasing salaries have been considered by some as an important step in the fight against corruption, health worker salaries and pay should be seen in the context of a **broader civil service pay reform** because public salaries in the health sector are generally ruled by fairly rigid civil service codes that make it legally and politically difficult to change salaries for health workers without changing salaries for everyone else in the public service. In countries where private providers are contracted to provide public services, payment mechanisms and fees may be relevant policy instruments for addressing corruption, in addition to salaries.

Corruption and patronage can also prevent pay reforms from being implemented effectively. Reforms which have been implemented to prevent patronage related to hiring, firing, and promoting staff have had modest success according to a recent report (IEG, 2008). The report demonstrates that the success of such reforms has been mixed. In countries such as Bulgaria, Bolivia, and Albania, the reforms have worked well. However, in Guyana, Indonesia, Republic of Yemen, Cambodia, and Sri Lanka, reforms of compensation schemes have had little or no impact. Other practices of which the World Bank has undertaken with some success has been technical support in gathering data of health workers, compensation, and attendance where management of civil service has been weak (IEG, 2008).

Reform of civil service pay is especially vital for the rehabilitation of Government, particularly in terms of realising improvements in capacity and the delivery of public goods and services. Among the emerging features which came out of the IEG evaluation, the World Bank supported public sector reforms where:

Supply-side interventions

a) Prosecuting and firing those who take bribes

b) Establishing a code of conduct for public officials

c) Requiring public officials to disclose their assets

d) Investigate and prosecute when unaccounted for wealth is discovered

Demand-side interventions

e) Increase the opportunity of citizens to monitor and complain about practices

(IEG, 2008)

It is critical to note that "technical solutions to public sector service pay policy without due attention to a country's political context are not sustainable." According to McCourt, donors need to take the following factors into consideration:

a) Political will versus political feasibility

b) Political priorities

c) Trade unions as stakeholders

d) Donors as political actors

Donors need to be more aware of how the design of aid can influence the character of pay reform. One particular aspect of donor assistance which has drawn criticism is the establishment of Project Implementation Units (PIU). Civil servants in the PIUs are normally far better paid than their colleagues, and this breeds discontent and low moral among the latter. This problem is also mentioned in the World Bank's World Development Report 2004. Advocates of project implementation units recognise that the arrangements can undermine local capacity building, create salary distortions, and weaken the compact between policymaker and the provider organisation. Whether or not PIUs induce corruption through the de-motivation of staff can probably only be judged country by country and project by project.

The DAC/OECD Governance network group in Oslo, June 2004, discussed a draft report on "Pay Policies in Sub-Saharan Africa". The report covers eight countries and offers a useful definition of

"pay" including four different elements: salary, retirement or post-employment benefits, allowances, and in-kind benefits. It is observed in general that an **increasing usage of allowances and in-kind benefits** to compensate the staff in public services in these countries often indicate a budding crisis in the management of pay policies and practices.

The argument that **low pay de-motivates personnel and stimulates corruption** in the public service is strengthened in a recent survey by the Ugandan Inspectorate General of Government. Public officials were asked about the extent to which their salaries affect their job performance and as a possible consequence encourage corrupt practices. 70% of the respondents reported that their performance is affected negatively by low salaries, while 29% claim not to be affected negatively. It should however be noted that the sample included only a small minority of police, teachers and health workers who have seen only minimal increases in their remuneration packages, which were reported to be below subsistence.

7.3 The problems in the health sector

In the previous section the general problems of pay and corruption in the context of civil service reform has been addressed. It is also important to consider that some issues of pay and corruption are **different in the health sector** and that there is room for ways to address corruption and incomes in the public health sector.

Budget constraints in many developing countries make it difficult to raise salaries to competitive levels with the private sector, at least in the short term. The linking of public pay scales in the health sector to other public sectors is an additional obstacle. Improving salaries may also not be enough to break the vicious circle. Other important elements include social responsibility, self realisation, professional satisfaction, prestige, and access to medical technology. It is also important to understand the social context in which corruption takes place.

An example from Tanzania

In Tanzania, according to the Warrioba Report, the health sector was ranked third in the list of sectors with the highest incidence of corruption. Poor salaries were indicated as one of several causes… It is commonly perceived that salaries for health workers are very low. Health workers have also won the sympathy of many who see them as deserving more for what they do…The Government of Tanzania decided to allow doctors working in Government to open private clinics and engage in private medical practice after their official hours of service in a bid to increase their income while retaining them in Government Service.

M.J. Mwaffisi, PS Ministry of Health

Corruption in the Health Sector

9th IACC October 1999, Durban

Allowing health workers to have dual employment might have increased health worker salaries in Tanzania and in other countries in which it has been implemented. However, recent qualitative research from Tanzania suggests that dual jobs might have introduced higher absenteeism rates in public health facilities (Lindkvist *et al*, 2008). If health workers profit from unauthorised absenteeism, then the overall effect of the policy to allow health workers to work in both private and public health facilities might have increased bureaucratic corruption rather than reduce it.

In contrast to the example from Tanzania, health reformers in Cambodia rejected the idea of allowing private practice by government health workers because "it would mean that health workers are 'competing with themselves', have a *de facto* fuzzy monopoly, and will not be fully dedicated to their work in the public sector" (Soeters and Griffiths, 2003). Instead, policies were designed to charge official user fees and use development bank loan funds to provide additional performance-based staff financial incentives to replace traditional fixed salaries. After three years of operation in five districts,

utilisation of health services improved significantly, while family health expenditures actually decreased due to reductions in informal payments.

7.4 Project examples and some lessons learned

The issue of salaries has been addressed by donors in various ways. First through their support for civil service reform processes and second through direct support to pay reform programme and individual key government departments. U4 donor support to these programmes can be found in the U4 project database. Below is a selection of general civil service reform approaches:

LINK: http://www.u4.no/projects/main.cfm

a) Civil Service Reform and Retrenchment, DFID, 2000, in Kenya includes a study on pay policy. The Government now wishes to refocus the civil service reform and to increase the pace of implementation in order to achieve better control of the wage bill, to further improve the balance of spending between operations and maintenance spending and to promote improvements to service delivery. A medium term strategy will therefore be developed which addresses issues such as controlling the future size of the civil service; the development of realistic and affordable targets for the wage bill, and for pay reform. Concentration of Government on core priority functions and the divestment or abolition of low priority and redundant activities improves performance and builds capacity to enhance service delivery. LINK: http://www.u4.no/projects/project.cfm?id=368

b) Payroll management and establishment control project, DFID, 2000-2003, in Zambia is aiming at reducing opportunities for corruption, and releasing recurrent resources to boost operational budgets or contribute to the decompression of salaries. LINK: http://www.u4.no/projects/project.cfm?id=295

c) Uganda Public Service Reform 2002, DFID, 2002-2003. Through this project pay structures have been rationalised, allowances monetised and pay levels increased by around 100%. LINK: http://www.u4.no/projects/project.cfm?id=303

d) Personnel Controls and Information Systems Project, phase 2, DFID, 1988-2003, in Tanzania. The purpose is to generate bill savings to enhance payroll and to support the improved delivery of public services. LINK: http://www.u4.no/projects/project.cfm?id=479

These are some examples of pay reforms in the health system:

7.4.1 MSF in Cambodia. Sotnikum New Deal, the first year

Better income for health staff; better service to the population, May 2001. Staff earned an increased official income, commitment of the field staff has increased substantially, and utilisation by the population increased in parallel. A similar experience is documented in Soeters and Griffiths article (2003).

LINKS:

http://www.msf.be/fr/pdf/cambodia.pdf

http://www.u4.no/themes/health/healthsalaries.cfm#_ftn2

7.4.2 Albania, Tirana Maternity Hospital, 2001, strengthening the formal payment system

The result was increased revenues and increased utilisation and some evidence of decreased informal payments (Vian, Gryboski, Sinoimeri, and Clifford, 2004).

LINK: http://www.u4.no/themes/health/healthsalaries.cfm#_ftn2

7.4.3 Formalizing under-the-table payments to control out-of-pocket hospital expenditures in Cambodia

(Barber, Bonnet, Bekedam, 2004)

This study documents how a referral hospital reduced informal payments by introducing formal user fees and performance incentives for medical personnel. The more transparent pricing system increased utilisation. While hospital managers found it hard to actually punish employees for bad performance, they were able to withhold bonus payments from poor performers, thus creating more accountability.

LINK: http://www.u4.no/themes/health/healthsalaries.cfm#_ftn4

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8 Literature review

8.1 General information

8.1.1 World Development Report 2004: Making Services Work for the Poor

LINK: http://econ.worldbank.org/wdr/wdr2004/

The 2004 edition of the World Bank's World Development Report focuses on basic services, particularly health, education, water and sanitation, and discusses ways to make them work for poor people. In light of widespread failure to make services accessible, affordable and of high quality, the report also points to success stories and concludes that services can be improved by putting poor people at the centre of service provision by enabling the poor to monitor and discipline service providers, by amplifying their voice in policymaking and by strengthening the incentives for providers to serve the poor.

This text provides a practical framework for making the services that contribute human development work for poor people. It is aimed at citizens, governments and donors who wish to take action and accelerate progress towards poverty reduction, as specified in the Millennium Development Goals. Of particular interest to development workers active in the health sector are chapters 8, 10, and 11. Chapter 8 focuses health and nutrition services, in particular the health of poor people, market and government failures, strengthening client power and the voices of poor citizens, and provider incentives to serve the poor. Chapter 10 discusses public sector underpinnings of service reform, especially the importance of strengthening the foundations of government, wise spending, decentralisation, policy making, management and implementation, curbing corruption, and transition management. Chapter 11 concludes the report with a consideration of the role of donors in service reform, including aid and accountability, strengthening of the compact, management by provider organisations, increasing client power, promoting the voice of the poor, aligning aid delivery with service delivery, and the challenges of reforming aid.

8.1.2 Human development Report 2003 Millennium Development Goals: A Compact Among Nations to End Human Poverty

LINK: http://hdr.undp.org/reports/global/2003/

The 2003 edition of the **United Nations Development Programme's Human Development Report** is devoted to the eight Millennium Development Goals that have transformed development and led to the reorientation of the work of governments, aid agencies and civil society organisations throughout the world. While welcoming commitments that have been made to reducing poverty and advancing development, the Report makes clear that the world is falling short of meeting these goals, in some areas much further than in others.

The central part of the report is devoted to assessing where the greatest problems are, analysing what needs to be done to reverse the setbacks, and offering concrete proposals on how to accelerate progress. The Report sets out a Millennium Development Compact which aims, not to propose another one-size-fits-all solution to the problems of the developing world, but to highlight the key areas of intervention that should guide national efforts and international support for the Goals.

Of particular interest to those working with development agencies in the health sectors of developing countries are chapters 4 and 5. Chapter 4, entitled Public Policies to Improve People's Health and Education, focuses on setting the right policy priorities and includes an in-depth examination of the Goals related to hunger, education, health, and water sanitation. This chapter also includes an action plan intended to boost the level, equity and efficiency of public spending, as well as the quantity and quality of official development assistance for basic services. The following chapter considers the private financing and provision of health, education and water services, and considers issues of privatisation of public services.

8.1.3 The World Health Report 2000 - Health systems: Improving performance

LINK: http://www.who.int/whr2001/2001/archives/2000/en/

The 2000 edition of the **WHO's World Health Report** is devoted entirely to health systems and represents an extension of the organisation's traditional concern for people's physical and mental well-being to emphasise the important elements of goodness and fairness within organisations, institutions and resources devoted to producing actions to improve people's health. It takes account of the roles people have as providers and consumers of health services, as financial contributors to health systems, as workers within them, and as citizens engaged in responsible management or stewardship, of them. It also considers successes and failures in addressing inequalities, how they respond to people's expectations, and how much or how little they respect people's dignity, rights and freedoms.

The report also provides an index of member states' national health systems' performance in trying to achieve three overall goals: good health, responsiveness to the expectations of the population, and fairness of financial contribution. As the WHO's members include developed countries, the focus is not exclusive to developing and transitional economies.

8.1.4 The World Health Report 2006 - Working together for health

LINK: http://www.who.int/whr/2006/en/

The 2006 World Health Report addresses the current global shortage of health workers as one of the main challenges in improving global health outcomes. According to the report, life expectancy has collapsed in many developing countries, and both maternal and infant mortality remains high. The report argues that we have enough financial resources but lack political will to address these poor health outcomes. The current shortage of motivated and qualified staff is the bottleneck which needs to be addressed.

The report provides a profile of the global health workforce and defines health workers broadly including *"all people primarily engaged in actions with the primary intent of enhancing health"* (p. xvi). The WHO estimates a global shortage of four million health workers, with the most acute shortage found in Sub-Saharan Africa and South-East Asia.

The report suggests three strategies to increase the number of motivated and skilled health workers in areas where the shortage is most acute:

1. Improve entry into the workforce (by better planning, increase educational institutions and recruitment)
2. Enhance the performance of the current workforce (through supervision, compensation, systems support and lifelong learning)
3. Manage exit and attrition from the health workforce (migration, career choice, health and safety and retirement)

The report stresses that the current shortage of health workers is global, and that global cooperation is necessary in order to solve the human resource crisis in the health sector.

8.1.5 Good practice in the development of PRSP indicators and monitoring systems: Integrating PRSP indicators into policy formation processes

Booth, D., Lucas, H., ODI Working Paper 172, 2002

LINK: http://www.odi.org.uk/publications/wp172.pdf

This paper is based on a desk study of good practice in the development of PRSP (Poverty Reduction Strategy Paper) indicators and monitoring systems commissioned by DFID for the Strategic Partnership with Africa (SPA) in 2001. The report is divided into two sections reflecting the two phases of the study. Phase 1 was a critical review of PRSP documentation for sub-Saharan Africa, including four full PRSPs, 17 Interim PRSPs, and 19 Joint Staff Assessments. Phase 2 involved a

wide-ranging search for experiences and examples that might be drawn on in improving the way PRSPs handle monitoring and indicators. The key findings include the object, methodology, and purpose of monitoring activities.

Country-specific information, as well as survey results and data used in the study are presented as annexes. In addition to more general information on poverty reduction and service delivery, the following health sector specific information is provided.

Annex 7 considers the cooperation between public health officials in a district in Siem Reap province of Cambodia and Médecins sans Frontières (MSF) in introducing a performance-based salary system, covering not only the hospital and health centres, but also the district administration and deliberately opting to "purchase" the cooperation and good will of local staff.

Annex 8 describes an approach to the supply-side problem of administrative data within the health system of China, proven to be similar to the situation in sub-Saharan Africa despite the fact that their situations appear to be radically different.

Annex 9 considers the attempt pioneered by Save the Children and Johns Hopkins University and funded by USAID to promote effective provider-community partnerships through the generation, analysis and use of information in Bolivia in developing a community health information system.

8.1.6 What Works and Why? An IEG Evaluation of World Bank Support

LINK: http://go.worldbank.org/1C817NN930

In a World Bank commissioned report released in 2008, the Independent Evaluation Group (IEG) studied the effectiveness of World Bank support to reforms of the public sector from 1999 to 2006. Four different areas of the public sector have been targeted: public financial management, administrative and civil service, revenue administration, and anti-corruption and transparency. An effective and efficient public sector is thought to be vital for economic development, and one sixth of World Bank support goes to such reforms.

The IEG found that of the four areas of the public sector which was targeted for reforms, reforms of the civil service achieved the least success with improvement in fewer than half the borrowing countries. More was achieved in the other areas, although direct anti-corruption laws and commissions had little success.

The IEG findings regarding the civil service are of particular relevance for the health sector. Policies aimed at reducing the civil service wage bill by retrenchment and salary adjustments were not successful because, according to the evaluation, these reforms had little real political support. The World Bank has however had more success with personnel reforms such as merit-based recruitment and promotion aimed at improving performance and prevent patronage. The IEG recommends a strengthening of the civil service and administrative components of PSR.

8.1.7 USAID Anti-corruption Strategy

United States Agency for International Development (USAID). January 2005. Washington, D.C.

LINK:
http://www.usaid.gov/our_work/democracy_and_governance/publications/pdfs/ac_strategy_final.pdf

This document outlines the United States government's strategy for reducing opportunities and incentives for corruption as an important foreign policy objective. Corruption weakens the legitimacy and effectiveness of democracies, undermining social cohesion and broad participation in economic and political life. It also distorts allocation of resources in ways that harm the poor. It is a huge challenge for countries around the world.

Four core actions comprise USAID's new strategic direction for anti-corruption. These are:

1. Confronting the dual challenges of grand and administrative corruption. In past years, USAID's anti-corruption efforts have focused more on administrative (petty) corruption,

rather than high-level, or grand corruption. While efforts to reduce administrative corruption alone can be effective, a more comprehensive and sustainable development solution must deal with the constraints of grand corruption. This includes developing tools to assess and measure grand corruption.

2. Deploy resources strategically to fight corruption. USAID plans to improve assessment frameworks and methodologies to determine priorities and better target programmatic responses considering the nature, location, and impact of corruption. USAID will also seek out partnerships to maximise the impact of anti-corruption investments.
3. Incorporate anti-corruption goals and activities across agency work. Anti-corruption goals will be integrated into missions and programs across multiple sectors, rather than concentrating them in the democracy and governance sector alone. Cross-team, interagency, and donor coordination mechanisms will be established to promote collaboration.
4. Build anti-corruption knowledge. More resources will be dedicated to evaluating the impact of anti-corruption programs, to document "best practice", and to promote synergies between anti-corruption programs and programs to support gender equality.

8.1.8 Poverty and Health

DAC Guidelines and Reference Series, OECD/WHO, 2003

LINK: http://www1.oecd.org/publications/e-book/4303051E.PDF

This DAC Reference Document, jointly published by the OECD and WHO, presents a set of policy recommendations aimed at a broad range of development agency staff, policy makers and planners in partner countries. Its goal is to further increase the effectiveness of development cooperation in improving health for poor people as a means of reducing poverty and achieving the health-related Millennium Development Goals. The first chapter discusses the importance of investing in health to achieving poverty reduction. The second chapter focuses on supporting pro-poor health systems by strengthening the capacity of the public sector, developing effective and equitable public and private-sector services, strengthening public-private partnerships, and achieving equitable financing systems. The third chapter focuses on key policy areas involving actions outside of the health sector, such as education, food security, safe water, sanitation and energy. Country-led strategic frameworks are the topic of the fourth chapter, which emphasises the importance of long-term relationships between donors and partner countries to achieving sustainable health improvements that benefit the poor. In conclusion, this report discusses the health problems of the poor in the contexts of a globalised world and, in particular, the promotion of development of Global Public Goods for health, and the increasing influence that trade in goods and services and multilateral trade agreements have on the health of the poor.

8.1.9 Macroeconomics and health: investing in health for economic development

Sachs, J.D/Commission on Macroeconomics and Health, WHO, 2001

LINK: http://www.cmhealth.org/

The key message of this WHO report is that the world community has the power to save the lives of millions of people a year and bolster development in the world's poorest countries and that this can be achieved by an increase in resources spent in the health sectors by developing countries and donors, and by investing these resources more wisely. The report outlines the current state of health sectors and health indicators for developing countries and the linkages between health and development. Current government and donor spending are detailed and a series of financial, structural and organisational recommendations are made that are aimed at improving the state of health care and services in low and middle income countries.

The key findings of this report include detailed data on the amount by which government and donor spending on health needs be increased and what impact this increase would have, which health

conditions should be focussed on in order to prevent and treat conditions for which there are tried and tested interventions, that local service delivery should be prioritised and complemented by nationwide programmes for some major diseases, and that greater investment in research, development, surveillance and data collection is necessary for diseases that are concentrated in poor countries.

In addition to calling for an increase in spending, the report recommends that each low and middle income country establish a temporary National Commission on Macroeconomics and Health (NCMH) to formulate a long-term programme for scaling up essential health interventions, that the international community establish a Global Fund to fight AIDS, TB and Malaria and a Global Health Research Fund, and that the international pharmaceutical industry ensure access of the low-income countries to essential medicines through commitments to provide such drugs at the lowest possible price in developing countries. Appendix 1 includes material on the 6 different working groups, whose group reports are available as separate documents.

The report of Working Group 3, "Mobilization of Domestic Resources for Health", is particularly relevant as it assesses the economic consequences of alternative approaches to resources mobilisation for health systems and interventions from domestic resources. It focuses on how health systems can best be financed at country level, including by reallocation of public sector budgets and by expanding the role of the non-governmental sector.

8.1.10 Sector-wide approaches for health development: a review of experience

Foster, Mick, Adrienne Brown and Tim Conway WHO, Geneva, June 2000

LINK: http://whqlibdoc.who.int/hq/2000/WHO_GPE_00.1.pdf

In 1999, the health-oriented Inter-Agency Group on Sector-wide Approaches and Development Cooperation commissioned five country case studies to review the experience with sector-wide approaches to date. This report provides the synthesis of the case study findings from Mozambique, Uganda, Tanzania, Cambodia, and Vietnam, as well as an exploratory visit to Ethiopia, all of which are involved to some degree with a sector-wide approach to health development. Although there were marked variations between the countries in their commitment to a SWAp and in progress in implementation, it was possible to draw some conclusions about the value of the approach as an aid co-ordination mechanism. Before presenting these conclusions, this report provides detailed information on the development, content, financing and implementation of health sector programmes.

Current issues in sector-wide approaches for health development. Individual case studies. Papers in PDF-format, WHO, Geneva, June 2000:

Uganda case study (A. Brown) LINK: http://whqlibdoc.who.int/hq/2000/WHO_GPE_00.3.pdf

Mozambique case study (A. Brown) LINK: http://whqlibdoc.who.int/hq/2000/WHO_GPE_00.4.pdf

Tanzania case study (A. Brown) LINK: http://whqlibdoc.who.int/hq/2000/WHO_GPE_00.6.pdf

Viet Nam case study (T. Conway) LINK: http://whqlibdoc.who.int/hq/2000/WHO_GPE_00.5.pdf

Cambodia case study (T. Conway) LINK: http://whqlibdoc.who.int/hq/2000/WHO_GPE_00.2.pdf

8.1.11 Health Financing Revisited: A Practitioner's Guide

Gottret, P., and Schieber, G. The World Bank, 2006

LINK: http://siteresources.worldbank.org/INTHSD/Resources/topics/Health-Financing/HFRFull.pdf

This guide addresses the major changes in global health and financing policy that have occurred over the past 10 years. As a result of the global focus on poverty reduction, new global health threats from HIV/AIDS, SARS, and avian influensa, and the international community's adoption of the Millennium Development Goals (MDG), global health policy has now become a development, national security, and humanitarian issue for all countries. Significant amounts of increased resources for development assistance, much of it targeted to health, have subsequently been forthcoming. This report assesses

health financing policies for their ability to improve health outcomes, provide financial protection, and ensure consumer satisfaction, in an equitable, efficient, and financially sustainable manner. It is intended to equip policy-makers at global and country levels with the tools for navigating this extremely complex domain by providing an overview of health financing policy in developing countries and is a primer on major health financing and fiscal issues.

8.2 Corruption in the Health Sector

8.2.1 Review of corruption in the health sector: theory methods and interventions

Vian, Taryn (2008) "Review of Corruption in the Health Sector: theory, methods and interventions" *Health Policy and Planning* 23

LINK: http://heapol.oxfordjournals.org/cgi/content/abstract/23/2/83

This article by Taryn Vian provides an overview of current literature on corruption and health care, including explanations and definitions of specific types of corruption in the health sector, a theoretical framework for explaining corruption in the health sector, and suggestions on how this framework can inform the design of interventions.

Public officials are thought to engage in corruption mainly out of three reasons. First, officials may feel pressured to engage in corrupt practices. Such pressure could arise due to poor living conditions, e.g. a very low salary. Second, a culture of acceptance for corruption may exist or emerge, leading officials to feel justified when engaging in corrupt practices. And third, officials may have an opportunity to engage in corruption. Due to the monopoly enjoyed by the public health sector in most developing countries, many such opportunities exist. Lack of competition leaves the health sector with full discretion in terms of whom and how to treat and what medicines to prescribe, effectively limiting the patient's options.

The key message of this article is that good interventions are both informed by theory and current empirical research. Vian also provides concrete examples of how such interventions can be designed.

8.2.2 Corruption and the Provision of Health Care and Education Services

Sanjeev Gupta, Hamid Davoodi and Erwin Tiongron, IMF Working Paper, 2000

LINK: http://www.imf.org/external/pubs/ft/wp/2000/wp00116.pdf

This paper reviews the relevant theoretical models and users' perceptions of corruption in the public provision of social services. Reports based on public service delivery surveys are found to confirm the pervasiveness of corruption and bribery in the public provision of health and education services. Evidence that reducing corruption can result in significant gains as measured by decreases in child and infant mortality rates, percent of low-birth weight babies, and primary school dropout rates are provided.

The purpose of the review is to determine whether a link between corruption and the outcome of public provision of social services can be established. However, the question of what causes such links and how to approach the problem of corruption receives less attention. Suggested policy implications appear rather conventional and devoid of contextual considerations.

8.2.3 Transparency and Corruption in the Health Sector: A Conceptual Framework and Ideas for Action in Latin America and the Caribbean

Savedoff, William D. (2007) "Transparency and corruption in the health sector: A conceptual framework and Ideas for Action in Latin America and the Caribbean" *Health Technical note 03/2007* Sustainable Development Department, Social Programs Division, Inter-American Development Bank

LINK: http://www.iadb.org/sds/doc/CorruptionHealthFrameworkSavedoff.pdf

Why it is important to tackle corruption in the health sector:

Limits the resources available for the health system

Reduces the effectiveness of health services

Has an important impact on population health status

Corrosive impact on trust in public institutions

Objective: to study what can be done about corruption in health systems of Latin America and the Caribbean

8.2.4 Corruption and the Health sector

Taryn Vian, USAID/MSI, 2002

LINK: http://www.usaid.gov/our_work/democracy_and_governance/publications/ac/sector/health.doc

In this volume of the Sectoral Perspectives on Corruption series prepared by MSI and sponsored by US Agency for International Development, Taryn Vian describes the important areas of vulnerability to corruption within the health sector and identifies tools and approaches for prevention. Although it is acknowledged that corruption is of concern to all countries, the focus of this work is on developing and transitional economies in which public resources are scarce and inadequate systems are crippling their growth and development. Two areas of special focus are the supply of drugs and medical equipment, and informal economic activities of health providers. These areas account for large losses in resources and have direct effects on health by reducing quality of care and access to services, especially for the poor.

Following a detailed analysis of the types of corruption that occur in the health sector, Vian discusses the procurement and management of medicines, equipment and supplies, including the selection process, promotion, and distribution. She then discusses the informal economic activities of health personnel and health reform in connection to global funds before orienting strategies for health within overall anti-corruption activities at the national level. In addition to stressing the importance of approaching the problem of health sector corruption within a broader multi-sector anti-corruption strategy, it is emphasised that commitment should be built by demonstrating how reducing corruption can result in better health outcomes, improved quality and expanded access. The paper is concluded with an agenda for further research and an extensive bibliography. The paper has since been published in Bertram I Spector, ed. Fighting Corruption in Developing Countries (Bloomfield, CT: Kumarian Press Inc., 2005).

8.2.5 Corruption and the Delivery of Health and Education Services

Azfar, Omar, USAID/MSI, 2002

LINK: http://www.usaid.gov/our_work/democracy_and_governance/publications/ac/sector/IRIS.doc

Another volume of the Sectoral Perspectives on Corruption series prepared by MSI and sponsored by USAID, Omar Azfar starts by reviewing the literature on the effect of corruption on health and education outcomes. Drawing on data collected in a study in the Philippines, he cites a significant and clear effect of corruption on the knowledge of required immunisations by physicians, even after controlling for variables such as income levels, voting rates, media exposure, delays in salary payments and the supply of medicines. The estimated the impact of corruption on patient satisfaction and waiting times was in the right direction (i.e. corruption lowered satisfaction and increased waiting times), but was not statistically significant. The author discusses the nature of corruption in the health sector in terms of relationships: patient-doctor, payer-hospital, hospital-supplier, and within the ministry of health or any particular facility. Causes of corruption are reviewed, as well as emerging empirical data sets and ongoing research (i.e. public expenditure tracking surveys, quantitative service delivery surveys). As with Vian's paper, this paper has since been published in Bertram I spector, ed. Fighting Corruption in Developing Countries (Bloomfield, CT: Kumarian Press Inc., 2005).

8.2.6 Diagnosis Corruption

Di Tella, Rafael and William D. Savedoff, 2001, Source : Book (only selected parts available online)

LINK: http://www.iadb.org/publications/book.cfm?id=419382&lang=en

One area not much discussed in the literature on corruption, particularly in Latin America, is health care. Health expenditures represent more than 7% of Latin America's GDP, with about 3.5% of GDP spent by the public sector alone. More than two-thirds of the public expenditures go to build, maintain, and operate public hospitals and provide related services, creating wide latitude for potential corruption.

Using studies of public-sector hospitals, this book addresses several issues. First, it demonstrates that objective data on corruption can be collected, analysed, and used to stem corruption. Second, it measures and characterises the abuse found in Latin America's public hospitals that drains government resources and compromises the health system's ability to serve the people. Finally, it identifies what features in the structure of incentives, accountability, and transparency can be used to reduce the scope and costs of this corruption.

The editors emphasise that this study is only a first step in analysing a very complex and hidden phenomenon. Because the case studies in this book were designed to focus on fraud and misuse of funds within hospitals, they exclude much of the corruption related to the ministries and institutes that build, maintain, and operate hospitals. Looking at bribes, theft, absenteeism, and overcharging for supplies in public hospitals in various countries, this volume shows that it is possible not only to measure corruption in new ways, but to identify systemic factors that encourage or discourage malfeasance in the health sector. The studies provide policymakers, researchers and public sector administrators with insight and tools in the struggle to reduce corruption, strengthen democracy, and build public trust.

8.2.7 The characteristics of corruption in different health systems

Savedoff, William D., WHO, 2003 (draft - not available online)

This paper is based on the conviction that tackling corruption requires an understanding of the various forms of abuse, and that health care corruption is not exclusive to one kind of health system. It begins by looking at definitions of corruption and fraud and how they manifest themselves in particular ways in health systems. It then discusses how the different structures of health systems lead to different kinds of abuse, and provides a review of the evidence regarding the kinds, magnitudes and effects of corruption and fraud. It concludes with a discussion of some of the mechanisms and policies that show promise in fighting this problem. Although this paper is not limited to developing or transitional economies, it reflects the fact that the majority of the available evidence is focused on such countries.

8.2.8 Global Corruption Report 2006: Corruption in Health

Transparency International

LINK: http://www.globalcorruptionreport.org/index.html

The Global Corruption Report is published annually by Transparency International. In 2006, the theme of the report is health and corruption. The report includes chapters on risks of corruption according to health system and governance structure; the scale of the problem, including problems in both developed and developing countries; costs and consequences of corruption in the health sector, including corruption in hospitals, drug supply systems, and informal payments, and corruption in HIV/AIDS programs.

8.2.9 Accountability and Health Systems: overview, framework and strategies - Health systems called to account: a framework and guidelines for exploring accountability issues in the health sector

Brinkerhoff, D. (2003) "Partners for Health reform plus" *PHRplus*

LINK: http://www.phrplus.org/Pubs/Tech018_fin.pdf

All health systems contain accountability relationships of different types, which function with varying degrees of success. Often it is the perception of failed or insufficient accountability that furnishes the impetus for reform. This paper provides a framework and guidance in reinforcing accountability in government service provision.

The author addresses: definition and clarification of accountability, analytic framework for accountability and health service delivery systems, role of health sector actors in accountability, and accountability-strengthening strategies. The paper describes three accountability-enhancing strategies: reducing abuse, assuring compliance with procedures and standards, and improving performance/learning.

Using an accountability lens can help to generate a system-wide perspective on health sector reform and identify connections among individual improvement interventions. These results can support synergistic outcomes, enhance system performance, and contribute to sustainability.

8.2.10 Accountability, Transparency and Corruption in Decentralized Governance

World Bank, 2006

LINK: http://www1.worldbank.org/publicsector/decentralization/admin.htm#4

This short article describes how decentralised governance is strengthened through citizen participation and accountability. Citizen participation allows the public to influence the direction and content of government services, while accountability provides "validation of participation" by holding government authorities responsible for their actions.

Two types of accountability are discussed: the accountability of government workers to elected officials and the accountability of elected officials to citizens. The first type of accountability is seen as more problematic and difficult to achieve because of the strong incentives government workers have to evade control by local authorities and maintain relationships with their "parent" ministry. Means of ensuring accountability of elected officials to citizens are discussed at more length, including elections (seen as a blunt tool), political party and NGO activities, informational strategies (including local media and public meetings), and formal complaint procedures.

The article notes that increased transparency may not reduce corruption in the short-run, but will increase citizen awareness of corruption. Beyond transparency, accountability mechanisms are needed to actually reduce corruption.

8.2.11 Service accountability and community participation in the context of health sector reforms in Asia: Implication for sexual and reproductive health services

Ranjani K. Murthy and Barbara Klugman, 2004, *Health Policy and Planning*; 19(Suppl.1)

(Online purchase only!)

Community participation is often promoted as a strategy to increase government accountability for provision of services. But does it work? In this article, the authors review the experiences of 18 health sector reform initiatives in Asia, exploring the relationship between community participation and accountability. They conclude that community participation is often not effective in ensuring accountability due to lack of capacity of the communities. The authors recommend investments in building the power of civil society representatives as stakeholders.

Common strategies to increase accountability include increasing competition from the private sector; decentralisation; and community financing. The first strategy works by increasing options or citizen choices, while the second and third options increase citizen voice and influence in decision making: strategies which increase the "answerability" of those who hold power to citizens. According to the authors, it is this latter function of accountability that is most important, figuring out how citizens can make sure that governments explain or justify what they actually do.

The article analyzes four different types of community participation in program management, including operations planning, monitoring of health delivery, managing infrastructure, and user fee collection and management, explaining how each type of participation can enforce accountability of health managers and workers. The article also suggests ways central governments can enforce accountability of decentralised units in the implementation of national policies. Suggested improvements for accountability include formalising "participation contracts" between civil society and government, and capacity building of civil society stakeholders in terms of better leadership models, and advocacy training.

8.2.12 Public Management and the Essential Health Functions

Das Gupta, M, Khaleghian, P. (2004) World Bank Policy Research Working Paper 3220

LINK: http://econ.worldbank.org/files/33192_wps3220.pdf

This paper provides an overview of how various approaches to improving public sector management relate to the so-called core or essential public health functions (EPHFs) such as disease surveillance, health education, monitoring and evaluation, workforce development, enforcement of public health laws and regulations, public health research, and health policy development (IOM 1987; PAHO 2002). Its purpose is to summarise key themes in the public management literature and draw lessons for the EPHFs. Section I summarises "new public management" approaches. Section II reviews traditional approaches to public administration and their relevance to the EPHFs. Section III summarises lessons in point form.

8.2.13 Governance and Corruption in Public Health Care Systems

Maureen Lewis, Centre for Global Development, 2006

LINK: http://www.cgdev.org/content/publications/detail/5967%20

This excellent working paper looks at factual evidence to describe the main challenges facing health care delivery in developing countries, including absenteeism, corruption, informal payments, and mismanagement. The author concludes that good governance is important in ensuring effective health care delivery, and that returns to investments in health are low where governance issues are not addressed. The paper provides policy options for promoting better governance.

8.3 Health-related documents from the International Anti-Corruption Conferences (IACCs)

8.3.1 Global Integrity: 2000 and Beyond - Developing Anti-Corruption Strategies in a Changing World - 9th IACC - Durban, 1999

LINK: http://ww1.transparency.org/iacc/9th_iacc/papers4.html#4ws2

8.3.1.1 From workshop entitled: Sectoral Initiatives in Health:

Accountability in Health Services (Anderson, N.)

LINK: http://ww1.transparency.org/iacc/9th_iacc/papers/day4/ws7/dnld/d4ws7_nanderson.pdf

The main results of "social audits" carried out in 1998 by CIET in Bangladesh, Nicaragua, Pakistan, South Africa, and Uganda are presented. CIET social audits gather data from households, communities and local public service workers about how well the public services serve the public. They focus on system flaws and create locally identified solutions for regional and national reform.

The Cost of Corruption in Health Institutions (Gadzekpo, A. / Lamensdorf Ofori-Atta, A.)

LINK:
http://ww1.transparency.org/iacc/9th_iacc/papers/day4/ws7/dnld/d4ws7_gadzekpolamesdorf.pdf

The authors explore the effects of corruption on health provision in Ghana. Using their own in-depth interviews, they show how in public hospitals corruption is rife in the award of contracts, the procurement of supplies and food, and the way in which these supplies are then mismanaged and pilfered. The effects of this are costly both in financial and human terms. The main reasons for continuing high levels of corruption are complacency among the patients; low salaries for health professionals; and weak regulatory institutions. Centralised planning, poor hospital management practices and internal separation of powers are also often problematic.

Corruption in the Health Sector (Mwaffisi, M. J.)

LINK: http://ww1.transparency.org/iacc/9th_iacc/papers/day4/ws7/dnld/d4ws7_mjmwaffisi.pdf

The paper analyses the effects of corruption on the health sector of Tanzania. In the health sector, there is both petty and grand corruption, and the poor are worst affected by the resultant increase in costs and reduced quality of service. The main causes of corruption in the health sector include: chronic shortages; excessive red tape; poor salaries; poor management and supervision; lack of information for clients. The effects are wide-reaching and include public dissatisfaction and the loss of credibility for the health professions. The most important measures which need to be taken to combat further corruption include, among others, more information for clients, better internal and external regulation, a greater health sector budget, and more severe punishment for corruption offenses.

8.3.1.2 From workshop entitled: Public Sector Financial Transparency and Accountability: The Emerging Global Architecture, and Case Studies:

LINK: http://ww1.transparency.org/iacc/9th_iacc/papers/day4/ws2/dnld/d4ws2_summary.pdf

Fiscal transparency and participation in the Budget process. South Africa: A country report, executive summary (Folscher, A.)

LINK: http://ww1.transparency.org/iacc/9th_iacc/papers/day4/ws2/dnld/d4ws2_afolschersummary.pdf

The Budget Information Service of the Institute for Democracy in South Africa and the International Budget Project of the Centre for Budget and Policy Priorities based in Washington, D.C. have undertaken this report on transparency and participation in South Africa's budget process. The report may serve as an approach that would be of use to researchers in other countries who are interested in assessing how the IMF Code of Fiscal Transparency and other principles of transparency and participation could help inform and improve the budget process in their nations. The report borrows from, modifies, and adds to the IMF Code of Fiscal Transparency by emphasising the measures needed to facilitate effective participation by the legislature and civil society. The report describes in detail the need for: a) a legal framework for Fiscal Transparency; b) clarity of roles and responsibilities in practice; c) the public availability of information; d) independent Checks and Balances on the Budget; e) information on execution and Government Data. It also traces the exact budget decision making process. An executive summary is also provided.

8.3.2 Together Against Corruption: Designing Strategies, Assessing Impact, Reforming Corrupt Institutions - 10th IACC - Prague, 2001

Cultural Support for Unethical Practices: The Case of a Hospital in Kyrgyzstan (Tasirdinov,T.)

LINK:http://www.10iacc.org/content.phtml?documents=300&art=45&c=taalai

Corruption in an ignored sector: assessing the level of impact of bribery on patients' access to health care and suggesting possible solutions to the problem (Danilovik,I)

LINK: http://www.10iacc.org/content.phtml?documents=300&art=49&c=access%2Bto%2Bhealth%2Bcare

Under-the-table Payments for Health Services (Dr. Te Kuy Seang)

LINK: http://www.10iacc.org/content.phtml?documents=114&art=113&c=kuy

Conflict of Interest as an ethical problem in Health Research in developing countries (Wikler, D)

LINK: http://www.10iacc.org/content.phtml?documents=114&art=116&c=wikler

New Ways of Corruption and the Colombian Health System Reform (Londono Soto, B)

LINK: http://www.10iacc.org/content.phtml?documents=114&art=114&c=beatriz

Some Elements of Corruption in Transition Period in Moldova (Stempovscaia, E)

LINK: http://www.10iacc.org/content.phtml?documents=114&art=112&c=Stempovscaia

8.3.3 Different Cultures, Common Values - 11th IACC - Seoul, 2003

LINK: http://www.11iacc.org/

8.3.3.1 From the workshop entitled Curbing Corruption: Healthcare and Pharmaceuticals

Development Of The Pharmaceutical Industry: How, Why, and When Corruption Came In (Dukes, G)

LINK: http://www.11iacc.org/download/paper/WS_9.4_Dukes_Final_Paper.doc

Increasing Transparency in Pharmaceutical Systems: strengthening critical decisions points against corruption (Cercone, J)

LINK: http://www.11iacc.org/download/ws_papers_extra/WS%209.4_P1_Cercone.pdf

8.4 Pay reform, salaries, and informal payments

8.4.1 When staff is underpaid: dealing with the individual coping strategies of health personnel

Van Lerberghe, W., Conceicao, C., Van Damme, W., Ferrinho P., Bulletin of WHO, 2002

LINK: http://www.who.int/bulletin/archives/en/80(7)581.pdf

Health sector workers in both developed and developing countries respond to inadequate salaries and working conditions by developing various individual "coping strategies" - some, but not all, of which are of a predatory nature and all of which have eroded the implicit civil service values of well-functioning public organisations. The paper reviews what is known about these practices and their potential consequences (competition for time, brain drain and conflicts of interest). By and large, governments have rarely been proactive in dealing with such problems, mainly because of their reluctance to address the issue openly.

The effectiveness of many of these piecemeal reactions, particularly attempts to prohibit personnel from developing individual coping strategies, has been disappointing. The paper argues that a more proactive approach is required. Governments will need to recognise the dimension of the phenomenon and systematically assess the consequences of policy initiatives on the situation and behaviour of the individuals that make up their workforce.

8.4.2 Political and Economic Incentives During an Anti-corruption Crackdown

Rafael Di Tella and Ernesto Schargrodsky, 2002

LINK: http://www.utdt.edu/%7Eeschargr/Political%20and%20Economic%20Incentives.PDF

This paper analyses the incentives of procurement officers and government bureaucrats involved in an anti-corruption crackdown in public hospitals in the City of Buenos Aires. The intervention to crackdown on corruption included wage increases to procurement agents and intermediate level auditing to ensure compliance. Auditing included a required system to publicly report procurement prices paid. The study examines the economic incentives of procurement officers and how they were changed by the anti-corruption program. It also examines the political incentives of the government officials in implementing the system.

Controlling for hospital fixed effects and relative to the pre-crackdown period, the effect of wages on input prices was negative (meaning that higher wages reduced input prices paid) but insignificant during the first phase of the crackdown, when audit intensity was expected to be maximal. The effect, however, was negative and well defined during the last phase of the crackdown, when monitoring intensity could be expected to take intermediate values. The wage elasticity of input prices exceeded 0.20. Given the volume of purchases of these hospitals, the authors' estimates suggest that anti-corruption wage policies would be cost-effective.

In contrast to previous research, the findings of this study suggest that the degree of audit intensity is crucial for the effectiveness of anti-corruption wage policies. Exclusive emphasis on wage increases may be misplaced; as such policies would only work if there were audit policies in place. On the other hand, exclusive emphasis on auditing may be difficult to sustain over time.

8.4.3 Informal economic activities of public health workers in Uganda: implication for quality and accessibility of care

McPake, B., Asiimwe, D., Mwesigye, F., Ofumbi, M., Ortemblad, L., Streefland, P &Turinde, (1999) *Journal of Social science and Medicine*, 49

LINK: http://dx.doi.org/10.1016/S0277-9536(99)00144-6

This paper reports the results of a study in Uganda of the "informal" economic activities of health workers, defined as those which earn incomes but fall outside official duties and earnings. The study was carried out in 10 sub-hospital health facilities of varying size and intended role and used a variety of quantitative and qualitative methods. The paper focuses on those activities which are carried out inside public health facilities and which directly affect quality and accessibility of care. The main strategies in this category were the leakage of drug supply, the informal charging of patients and the mismanagement of revenues raised from the formal charging of patients. Few of the drugs supplied to health units were prescribed and issued in those sites. Most health workers with the opportunity to do so levy informal charges. Where formal charges are collected, high levels of leakage occur both at the point of collection and at higher levels of the system.

The implications of this situation for the quality and accessibility of services in public health facilities were assessed. Utilisation levels are less than those expected of the smallest rural units and this workload is managed by a handful of the expected staff complement that are available for a fraction of the working week. Even given these few patients, drugs available after leakage were sufficient to cover less than half of those attending in most facilities. Evidence on staff motivation was mixed and better motivation was associated with better performance only in a minority of units.

Informal charging was associated with better performance regarding hours worked by health workers and utilisation rates. Drug leakage was associated with worse performance with respect to both of these and, unsurprisingly, with drug availability. Short term strategies to effect marginal performance improvements may focus on the substitution of strategies based inside health units (such as informal charging) for those based outside (facilitated by drug leakage). In the long term, only substantially higher funding of the sector can be expected to facilitate major change, but alone will be insufficient.

Investment strategies supported by appropriate policy development has to be informed by understanding and monitoring of the "informal" dimension of health sector activity.

8.4.4 Pilfering for survival: how health workers use access to drugs as a coping strategy

Ferrinho,P., Omar, M. C., de Jesus Fernandes, M., Blaise, P., Bugalho, A. M., and Van Lerberghe, W., (2004) *Human Resources for Health*, 2(4)

LINK: http://www.human-resources-health.com/content/2/1/4

Coping strategies have, in some countries, become so prevalent that it has been widely assumed that the very notion of civil services ethos has completely - and possibly irreversibly - disappeared. This paper is based on a self-administered questionnaire addressed to a convenience sample of health workers in Mozambique and in Cape Verde and describes the importance and the nature of pilfering of drugs by health staff as perceived by health professionals from these countries. Their opinions provide pointers as to how to tackle these problems. The study confirms that misuse of access to pharmaceuticals has become a key element in the coping strategies health personnel develop to deal with difficult living conditions.

Different professional groups (mis)use their privileged access in different ways, but doctors diversify most. The study identifies the reasons given for misusing access to drugs, shows how the problem is perceived by the health workers, and discusses the implications for finding solutions to the problem.

The findings reflect, from the health workers themselves, a conflict between their self image of what it means to be an honest civil servant who wants to do a decent job, and the brute facts of life that make them betray that image. The manifest unease that this provokes is an important observation as such. The findings suggest that, even in the difficult circumstances observed in many countries, behaviours that depart from traditional civil servant deontology have not been interiorised as a norm. This ambiguity indicates that interventions to mitigate the erosion of proper conduct would be welcome. The time to act is now, before small-scale individual coping grows into large-scale, well-organised crime.

8.4.5 Official, unofficial and informal fees for health care, first check the wallet: what price official and under the counter payments in health systems?

Killingsworth, J .R., (Draft Discussion Note 13, Third health sector development technical advisory group meeting, WHO, 2002)

LINK: http://www.eldis.org/healthsystems/pdfs/corruption1.pdf

For the patient, all fee payments for health services look alike. Is there any point in treating fees "outside" the health system - unofficial and informal fees - as intrinsically different to those within the system? Do they help keep under-resourced health systems going or hinder the achievement of health system goals? In this WHO draft discussion paper the impact of official, unofficial and informal fees is explored through case studies from the former Soviet Union, China and Bangladesh. The author rejects the view that informal and unofficial fees should be curbed because they induce irrationality within the health system, on the grounds that this is too simplistic. The paper examines case studies of unofficial fees in Bangladesh, informal fees in Central Asia/Eastern Europe and the former Soviet Union, and "red packet", or traditional "gratitude" payments to health providers, in China. Key analytic points are drawn from the case studies.

8.4.6 When is "free" not so free? Informal payments for Basic Health Services in Bolivia

Sarbani, C., Gatti, R., Klugman, J., Gray-Molina, G., The World Bank, 2002, draft

LINK: http://www1.worldbank.org/wbiep/decentralization/laclib/Gatti.pdf

Although the issue of corruption has attracted substantial attention in the economics and policymaking arena, few studies have actually been able to quantify the phenomenon. This paper focuses on the

specific dimension of informal payments by health users in Bolivia. Using newly collected data from a sample of 106 municipalities and 2,800 households, the researchers investigate the determinants of informal payments for health services that are supposed to delivered free of charge under the Seguro Basico de Salud - a national program that aimed at, and succeeded in, increasing national coverage of basic health services.

The characteristics of the program and its close links with major decentralisation reforms in the mid 1990s make the data particularly suitable to explore whether mechanisms of voice and accountability are effective in keeping corruption in check at the local level. Moreover, the authors are able to quantify distributional patterns of informal payments.

The empirical results demonstrate not that the Seguro has failed, for it has been associated with important gains in maternal and child health, as reflected in both service and outcome indicators, nationwide. However removing obstacles to access is difficult, and the study found that "free" programs may not realise all their stated objectives, and that decentralised mechanisms designed to enable voice have not offset fairly widespread patterns of informal payments that adversely affect the poor.

8.4.7 Who is paying for health care in Eastern Europe and central Asia?

Lewis Maureen, The International Bank for Reconstruction and Development/The World Bank, 2000

LINK:
http://lnweb18.worldbank.org/eca/eca.nsf/Attachments/Who%2Bis%2BPaying%2Bfor%2BHealth%2BCare%2Bin%2BEurope%2Band%2BCentral%2BAsia/$File/Who%2BIs%2BPaying%2Btext.pdf

Informal payments in the health sector in Eastern Europe and Central Asia are emerging as a fundamental aspect of health care financing and a serious impediment to health care reform. This paper outlines the key policy issues of informal health payments, summarises the available data on the scope and nature of such payments within ECA, and spells out policy implications. It also suggests possible strategies to address the problem, such as comprehensive anti-corruption policies, downsizing of the public system, paring back the set of services subsidised by government, encouraging cost sharing for those who can afford it, improving accountability, and promoting private alternatives.

8.4.8 Armenian reproductive health system review: structure and system inefficiencies that hinder access to care for rural populations

Washington, DC: Emerging Markets Group, Ltd. for USAID/Armenia. Contract number GHS-I-802-03-00031-00, May 2005

LINK: http://www.u4.no/themes/health/armenianreproductivehealth.pdf

This report, prepared by Alisa Pereira, a consultant to EMG, looks specifically at vulnerabilities to corruption in the health sector in Armenia and their consequences for health outcomes. The purpose of the report is to recommend ways that USAID projects in the health sector can help to build accountability and transparency, and support organisational changes to reduce corruption.

Obstacles to transparent and accountable services include widespread informal payments for care (over 90% of respondents reporting making informal payments to receive care, according to one study), unnecessary referrals and improper diagnosis and treatment due to possibilities for medical personnel to gain revenue or receive kickbacks. The consequences of these forms of corruption are that patients have to borrow money or sell assets to gain access to services, and that many patients do not seek care because they cannot afford to make the informal payments. In addition, quality of care is lowered because of biased and improper medical advice.

The author presents her analysis in terms of "enablers" of corruption. These include non transparent flows of financing and reporting within the health sector, leading to confusion about how much money is supposed to be available at different levels. This does not allow proper accountability for use of funds. Incentives for misreporting also exist, resulting in under- or over-allocations of budgets to

certain sectors and programs. Flaws and irrational processes in the national budgeting system are exposed.

On the policy implementation side, vulnerabilities or "enablers" include inconsistent application of health care regulations, and health care reforms such as privatisation and decentralisation that have been implemented without proper preparation or control. Finally, the paper deals with societal acceptance of corruption and some of the socio-cultural determinants for this acceptance.

Recommendations for reform include improving the health financing system, strengthening management and supervision (including internal control structures), increasing awareness of inaccurate reporting and consumer demand for accountability, and development of a professional code of ethics for the health community. A report annex contains the questionnaire used for the study, which is a helpful resource for people interested in anti-corruption assessment tools.

8.4.9 Reports on informal payments in countries such as Russia, Kazakhstan, Poland, China, Hungary, and Boliva

CORIS web

LINK: http://www.corisweb.org/article/articlestatic/351/1/306/

8.5 Staff Recruitment, posting, ethical training, ethical codes

8.5.1 Ghost doctors: Absenteeism in Bangladeshi health facilities

Chaudhury, N., and Hammer, J., World Bank , Research paper 3065, World Bank, 2003

LINK: http://info.worldbank.org/etools/docs/library/206821/Chaudhury.pdf

Chaudhury and Hammer report on a study in which unannounced visits were made to health clinics in Bangladesh with the intention of discovering what fraction of medical professionals were present at their assigned post. This survey represents the first attempt to quantify the extent of the problem on a nationally representative scale.

Nationwide the average number of vacancies over all types of providers in rural health centres is 26%. Regionally, vacancy rates (unfilled posts) are generally higher in the poorer parts of the country. Absentee rates at over 40% are particularly high for doctors. When separated into level of facility, the absentee rate for doctors at the larger clinics is 40%, but at the smaller sub enters with a single doctor, the rate is 74%.

Even though the primary purpose of this survey is to document the extent of the problem among medical staff, the authors also explore the determinants of staff absenteeism. Whether the medical provider lives near the health facility, access to a road, and rural electrification are important determinants of the rate and pattern of staff absentee rates. This paper- a product of Public Services, Development Research Group - is part of a larger effort in the group to assess and improve the quality of services for poor people.

8.5.2 To Serve the Community or Oneself: The Public Servant's Dilemma

Barr, A., Lindelöw, M., and Serneels, P., World Bank, Working Paper No 3187, 2004

LINK: http://econ.worldbank.org/files/32554_wps3187.pdf

Embezzlement of resources is hampering public service delivery throughout the developing world. Research on this issue is hindered by problems of measurement. To overcome these problems the authors use an economic experiment to investigate the determinants of corrupt behaviour. The paper focuses on three aspects of behaviour: (i) embezzlement by public servants; (ii) monitoring effort by designated monitors; and, (iii) voting by community members when provided with an opportunity to select a monitor. Participants in the study are Ethiopian nursing students. The authors examine the

effect of wages, effort "observability", rules for monitor assignment, and professional norms, and find that service providers who earn more embezzle less, although the effect is small.

Embezzlement is also lower when observability (associated with the risk of being caught and sanctioned) is high, and when service providers face an elected rather than randomly selected monitor. Monitors put more effort into monitoring when they face re-election and when the public servant receives a higher wage.

Communities re-elect monitors who put more effort into exposing embezzlement. Framing - whereby players are referred to as "health workers" and "community members" rather than by abstract labels - affects neither mean embezzlement nor mean monitoring effort, but significantly increases the variance in both. This suggests that different types of experimental subject respond differently to the framing, possibly because they adhere to different norms.

8.6 Health budgets and financing

8.6.1 Survey Techniques to Measure and Explain Corruption

Reinikka, R., and Svensson, J., World Bank, 2003

LINK: http://econ.worldbank.org/view.php?type=5&id=27279

Reinikka and Svensson demonstrate that, with appropriate survey methods and interview techniques, it is possible to collect quantitative micro-level data on corruption. Public expenditure tracking surveys, service provider surveys, and enterprise surveys are highlighted with several applications. While often broader in scope, these surveys permit measurement of corruption at the level of individual agents, such as schools, health clinics, or firms. They also permit the study of mechanisms responsible for corruption, including leakage of funds and bribery, as data on corruption can be combined with other data collected in these surveys.

8.6.2 Survey Tools for Assessing Service Delivery

Dehn, J., Reinikka, R., and Svensson, J., World Bank, 2002

LINK: http://www1.worldbank.org/publicsector/pe/PETS1.pdf

Improving public services in education and health is partly a problem of measuring the transfer of funds and the efficacy of spending in a reliable and comparable way. This paper introduces micro-level tools to assess both the quality and quantity of services in all their complexity, and serves as a guide to implement these surveys in the field. Public Expenditure Tracking Surveys (PETS) assess (often diagnostically) the issue of leakage of public funds or resources prior to reaching the intended beneficiary.

The Quantitative Service Delivery Surveys (QSDS) focuses on the service facility and factors affecting quality of service. When used together in sequence or in parallel, they document the characteristics of service providers (governmental and nongovernmental, public and private) and identify problems along the chain of budgetary transfers and service delivery points (inputs, outputs, and measures of quality). When deployed carefully they provide data that can be used to analyse the determinants of failure and success at the frontline.

8.6.3 Primary Health Care in Mozambique: Service Delivery in a Complex Hierarchy

Lindelöw, M., Ward, P., and Zorzi, N., World Bank 2004 Africa Region Human Development Working Paper Series, Number 69. 2004

LINK: http://siteresources.worldbank.org/AFRICAEXT/Resources/ww11888final201.pdf.pdf

The Expenditure Tracking and Service Delivery Survey (ETSDS) presents results from a survey of health care providers, with a focus on institutional arrangements, the flow of resources, and service

delivery in Mozambique. The ETSDS - implemented nationwide between August and October 2002 - focused on the primary health care system, which is the main or only source of health care for the majority of the Mozambican population.

The survey collected data from five different levels, covering all eleven Provincial Directorates of Health, 35 District Directorates of Health, 90 primary health care facilities, 167 health workers, and 679 users. In this way, if offers a unique perspective on the interaction between different levels of the health system, in particular in relation to the financing, allocation, distribution, and use of resources. The report covers a broad set of issues, including institutional context, budget management, cost recovery, allocation and distribution of drugs, human resources, infrastructure and equipment, and service outputs.

8.6.4 The Budget process and good governance

Fubbs, J. - AWEPA International, Amsterdam 1999.

LINK: http://www.awepa.org/downloads/OPS05-_The_Budget_Process_and_Good_Governance.pdf

From 1994, a new decentralised budget system was introduced in South Africa. What are the key elements that have made resource allocation more democratic? How has civil society been given a greater role in formulating budgets? This paper, published by AWEPA (European Parliamentarians for Africa), analyses the process with relation to the province of Gauteng.

South African provinces no longer serve simply as spending agencies for central government. They have greater autonomy to tax and spend, and can develop and process their own policy priorities in certain key areas. This prioritisation is translated into resource allocations that support provincial policy objectives in a multi-year framework. National and local governments have the responsibility of developing budgets that balance social and fiscal objectives with the economic environment. Provincial finance committees and other portfolio committees monitor the budget process. Civil society can engage with the executive before budgets are tabled and participate in committee meetings. These reforms have resulted in a culture of sound policies, legislation and planning within a transparent and accountable environment.

Fundamental to the new system are the Constitution, which came into effect in 1997, the introduction of enabling legislation and the roles of the legislature and finance committees in providing oversight. The case of Gauteng province supports the finding that budgets can only be effective instruments of policy implementation and transformation when they incorporate public participation and that governments must engage with citizens in the early stages of budget formation so that allocations reflect and respond to their concerns.

8.7 Procurement

8.7.1 Quality medicines for the poor: Experience of the Delhi programme on rational use of drugs

Chaudhury, R., Parameswar, U., Gupta, Sharma, S., Tekur, U., and Bapna, J. S., 2005. Health Policy & Planning. 20(2)

[online purchase only]

This article describes how the Indian capital state of Delhi implemented reforms to reduce irrational drug use and expand the availability of drugs in the public sector. Prior to 1994, problems with drug supply and use included procurement and prescribing of unnecessary drugs, lack of availability of essential drugs, purchasing practices that led to high input prices paid, substandard and counterfeit drugs (estimated to be 15-20% of total supply), and unrestrained prescribing habits influenced by pressure on doctors and inadequate drug information.

Starting in 1994, the state developed and implemented a new Essential Drugs Programme (EDP). The programme started with the creation of a state drug policy which specified the overall mission,

priorities, and objectives of the EDP. Steps taken to implement the policy included the selection of an Essential Drugs List (EDL), establishment of a pooled procurement system, introduction of a quality assurance system, development of standard treatment guidelines and training in rational prescribing, and the provision of unbiased drug information, including new guidelines on drug advertising and promotion.

The new procurement system included competitive bidding through tenders, prequalification of suppliers, and measures to ensure transparency in the tender process. The more transparent, centralised procurement system resulted in higher quality drugs and lower procurement costs, despite a general increase in retail drug prices over the years of implementation. A savings of 30% in drug procurement costs was documented; the Delhi state system achieved procurement prices that were 118-248% lower, on average, than other Government agencies involved in drug procurement. On the quality side, the state reported a quality sample failure rate of 1%, compared to 20% of samples that failed inspection before the Essential Drugs Programme was implemented.

Factors that influenced the success of the EDP included an innovative management model involving non-governmental representatives in the government procurement process; focus on the selection of dedicated and powerful people to lead the change; technical training and changes in the mindset of government staff to increase their commitment; and repeated dialogue with stakeholders to increase commitment.

The authors emphasise the need for a comprehensive, multi-faceted approach to reforms in drug management. Implementation using a modular (phased) approach is preferred, as it allows some progress even if time is needed to begin some more controversial aspects of new programming.

8.7.2 Operational Principles for Good Pharmaceutical Procurement: Essential Drugs and Medicine Policy

World Health Organisation, 1999

LINK: http://www.who.int/medicinedocs/en/d/Jwhozip49e/#Jwhozip49e

This document provides 12 principles for good pharmaceutical procurement, divided into four groups: efficient and transparent management; drug selection and quantification; financing and competition; and supplier selection and quality assurance. Each principle is justified by explaining how it contributes to achieving a more cost-effective, high quality and timely supply of drugs at the lowest possible total procurement cost.

For example, under the heading of "efficient and transparent management", one principle is to divide procurement functions (selection, quantification, product specification, pre-selection of suppliers, and adjudication of tenders), among different committees and individuals, each with the best expertise and resources for the job. Following this principle helps to avoid influence by special interests which could cause procurement agents to bias drug selection, manipulate orders to increase quantities of certain drugs, prejudice supplier qualification decisions, manipulate final awards, or slant product specification to limit competition.

The document ends with practical suggestions for implementation.

8.7.3 Practical Guidelines on Pharmaceutical Procurement for Countries with Small Procurement Agencies

World Health Organization Regional Office for the Western Pacific Manila, Philippines, 2002

LINK: http://www.who.int/medicinedocs/en/d/Jh2999e/#Jh2999e

Targeted to small countries with no local pharmaceutical industry and no drug registration, this guide is a distillation of the procedures for two key functions in the procurement process: tendering and pre-qualification of suppliers. The guide doesn't cover drug selection or quantification. Types of tendering are discussed, as well as how to choose among the different methods. Tools for

pre-qualification of suppliers are explained with examples and tips. Fully half of the guide is dedicated to model questionnaires, checklists, and other tools that can be adapted to the specific laws and local context of each country.

8.7.4 Technical note: The procurement of Health Sector Goods

Washington DC, World Bank, 2002

LINK:
http://web.worldbank.org/WBSITE/EXTERNAL/PROJECTS/PROCUREMENT/0,,contentMDK:20062738~menuPK:84284~pagePK:84269~piPK:60001558~theSitePK:84266,00.html

The World Bank has posted standard bidding documentation on this web site, as well as the technical note on procurement of health sector goods. The notes and documentation are intended to support international competitive bidding (ICB) in the procurement of medicines, vaccines, and condoms. The technical note is geared toward procurement in World Bank project settings, but some information is of relevance to anyone interested in improving procurement methods. The note discusses issue and choices such as centralised versus decentralised procurement, assessing capacity for procurement at the national or implementing agency level, importation and marketing authorisation issues, and methods for procurement. Drug kits and packaging issues are also discussed.

8.7.5 International Drug Price Indicator Guide

Management Sciences for Health and WHO, annually updated

LINK:
http://erc.msh.org/mainpage.cfm?file=1.0.htm&id=1&temptitle=Introduction&module=DMP&language=English

The guide contains prices from pharmaceutical suppliers, international development organisations, and government agencies involved in the procurement of drugs. The list provides a comparative database for managers who want information on the international price of drugs. All medicines on the WHO's essential drug list, plus selected others, are included. The guide allows user to create and save a customised list, and to perform budget calculations.

8.7.6 Improving Transparency in Pharmaceutical Systems: Strengthening Critical Decision Points Against Corruption. Latin American and Caribbean Region

Cohen, J. C., Cercone, J. A., and Macaya, R. Human Development Network. World Bank, Washington, DC, 2002

LINK: http://www.u4.no/themes/health/cohen_wb_paper_pharma2002.pdf

The purpose of this study was to create a diagnostic framework and methodology to evaluate a pharmaceutical system's vulnerability to corruption, and to determine priorities for anti-corruption program intervention.

Researchers working in Costa Rica identified 46 indicators to measure compliance with standardised processes and decision-making criteria in the sub-systems of drug registration, selection, procurement, and distribution. The indicators evaluate current practice in relation to "best practice" in pharmaceutical policy and management. Overall, Costa Rica's government pharmaceutical sector received a rating of 7.7 out of 10, indicating "marginal" vulnerability to corruption. The procurement function was rated as "moderately vulnerable" (5.4 out of 10), due to problems such as lack of documentation of prices paid and criteria used for awards. The indicators helped health managers to have a more precise idea of specific interventions needed to reduce vulnerability.

8.7.7 Using technology to fight corruption in pharmaceutical purchasing: lessons learned from the Chilean experience

Cohen, J. C., and JCarikeo Montoya, J., WBI, 2001

LINK: http://info.worldbank.org/etools/docs/library/48617/oj_chile.pdf

A successful anti-corruption strategy is Chile's experience with electronic bidding for procurement of health items. This document explains the objectives and implementation steps followed to put in place this innovative system. CENABAST, the supply agency for the National Health Service, was responsible for procuring drugs for 180 public hospitals and 300 health centers throughout the country. The reform of the procurement process included four components: 1) electronic bidding; 2) use of internet to disseminate information; 3) change in role of CENABAST from a central medical stores model to a role as mediator between facilities and suppliers, as well as guarantor of drug purchases; and 4) communications campaign to inform and persuade stakeholders.

The change in role of CENABAST broke the monopoly on drug procurement, and the new technology allowed better monitoring of drug prices and suppliers. The electronic bidding reduced the possibility of collusion by subjecting suppliers to competitive bidding and making drug price information available to all suppliers and clients. In the year after the system was put in place (1997), CENABAST saved so much that it could reduce the margin charged to hospitals for its services from 14% to 5-10% (depending on volume). Hospitals saved an additional 5-7% on direct procurement costs.

8.7.8 A multisectoral approach to improve ethical business practices: a contribution to improving access to medicine in Latin America and the Caribbean

Jaramillo, L., Speech, Sept 2000

LINK:
http://wbln0018.worldbank.org/LAC/lacinfoclient.nsf/0/921d461c069a434d8525696f00514142?OpenDocument

Although not based on empirical sources, this speech is interesting in that it provides an emic perspective to the issue of corruption in medicines. The speaker is a corporate executive in a private health care service company, and describes the risks of corruption in drugs from his company's experience. Risks include theft; irregularities in drug sales (discounts and commissions); manipulation of bidding; avoidance of bidding (i.e. bias toward direct procurement to avoid competition); problems with quantification, stock control, and irrational use; "administrative chaos" in lack of planning, budgeting, and control; and political favors.

8.7.9 Two case studies of corruption in Medicine and medical supplies procurement in the Ministry of Public health Part I

(Thailand) Civil Society and Movement against corruption, rural doctors fight against corruption in Thailand, Trirat, Dr, N/ Civil Society and Governance Programme, IDS, 2000

LINK: http://www.ids.ac.uk/ids/civsoc/final/thailand/tha1a.doc

8.7.10 Two case studies of corruption in Medicine and medical supplies procurement in the Ministry of Public health Part II

(Thailand) A framework of relationships between civil society and good governance. Corruption in medicine and medical supplies procurement in Thailand. Tumkosit, U. / Civil Society and Governance Programme, IDS, 2000

LINK: http://www.ids.ac.uk/ids/civsoc/final/thailand/tha1b.doc

The Civil Society and Governance Programme was a 3-year research programme started in 1998. It examined the interplay between civil society and governments in 22 countries. This case study of Thailand was written by local researchers.

Part I tells the story of an anti-corruption movement. The story is told chronologically, detailing the newspaper reports, calls for investigation, opinion polls, and interviews conducted as the corruption was exposed. The movement ultimately resulted in the resignation of the Ministry of Health and Deputy Minister.

Part II completes the analysis, examining the types of corruption in detail. Important causes of the corruption were the elimination of controls such as rules on ceilings for prices of medicines procured, and a shift to centralise procurement at the provincial level, which eliminated checks and balances and allowed manipulation by central corrupt figures. Politicians also exerted pressure on bureaucrats to procure from certain sources and at higher prices.

Several civil society organisations were responsible for the successful exposure of the corruption, and for stopping it from continuing. The rural doctors' forum, rural pharmacists' forum, and other local NGOs were important in monitoring the problems and bringing them to the attention of the media and the public. Part II of the case study examines the role and actions of these stakeholders in detail. Factors for success in this civil society action against corruption are analysed in the cases. Some factors that made the Thai situation unique included the connection with ongoing political reforms, and prior experience in participating in social change.

9 Links to relevant websites

9.1 DfID Health Resource Centre

LINK: http://www.dfidhealthrc.org/hrc/index.html

The DFID Health Resource Centre is an international consortium funded by DFID to provide top quality advice and expertise in public health and health systems in low and middle income countries. The HRC provides access to technical assistance, knowledge and information in support of pro-poor health policies, financing and services for the Department for International Development (DFID) and its partners. The HRC works with national, regional and international initiatives in support of health systems capacity to deliver affordable health services to poor people in developing countries.

9.2 The Network on Equity in Health in Southern Africa

LINK: http://www.equinetafrica.org/

EQUINET's work covers a wide range of areas identified as priorities for health equity, within the political economy of health, health services and inputs to health, covered in the theme areas shown on the site. EQUINET is governed by a steering committee with representatives from fourteen institutions in southern Africa and is co-ordinated at the Training and Research Support Centre Zimbabwe.

9.3 World Bank Health, Nutrition & Population Page

LINK: http://www.worldbank.org (do search for title)

Resource aimed at policymakers, managers and researchers involved in health sector reform in developing countries, providing information resources, training materials, and interactive features to allow users to find targeted information and global expertise on the economics, policy strategy and implementation of health sector reform. HPN also provides distance learning courses for healthcare managers, analysts and decision makers who want to learn more about the economics and financing of health care delivery.

9.4 CORIS

LINK: http://www.corisweb.org/

CORISweb is Transparency International's (TI) Corruption Online Research and Information System, a portal, which provides all those with an interest in anti-corruption and governance issues with easy access to high quality, processed information. CORISweb provides an alternative way to disseminate the vast amount of information available though thematic and country pages. Thematic pages are edited and dynamically generated and offer the latest and best knowledge on a selection of themes related to corruption. These include access to information, international anti-corruption conventions, corruption in the health care sector, and corruption and education.

9.5 Id21 development research - Health

LINK: http://www.id21.org/

This site provides a searchable database of concise, easy-to-read summaries of research relevant to health policy in developing countries. A wide range of subjects is covered, including health sector reform, maternal and child health, sexual and reproductive health, disease and disability, and environmental health. id21Health also offers this information in a free email newsletter, "id21HealthNews", for those with limited internet access.

9.6 International Budget Project

LINK: http://www.internationalbudget.org/

The International Budget Project assists non-governmental organisations (NGOs) and researchers in their efforts both to analyse budget policies and to improve budget processes and institutions. The Project is especially interested in assisting with applied research that is of use in ongoing policy debates and with research on the effects of budget policies on the poor. The Project works primarily with researchers and NGOs in developing countries or new democracies.

9.7 Healthlink Worldwide

LINK: http://www.healthlink.org.uk/

[formerly Appropriate Health Resources and Technologies Action Group (AHRTAG)]

NGO aiming to strengthen primary health care, disability services and community based rehabilitation in the South by maximising the use and impact of information, providing training and resources and actively supporting the capacity building of partner organisations. Supports the development of information services in the South, and undertakes consultancy work on request. Operates a library and information service open to public on appointment.

9.8 Management Sciences for Health (MSH)

LINK: http://www.msh.org/

MSH is a non-profit, educational and scientific organisation working to close the gap between knowledge and action in public health. Since 1971 MSH has worked with decision makers to improve the management of and access to critical health services such as primary health care, child survival, maternity and child health, family planning, and reproductive health. Experiences are shared via technical assistance, training, applied research, publications and fellowships. MSH's International Drug Price Indicator Guide is available online. This resource allows procurement agents to compare the prices of their vendors to prices available on the international market, allowing greater transparency in the drug procurement process.

9.9 SHARED (Scientists for health and research development)

LINK: http://www.shared-global.org/main.asp

Database of projects, people and organisations. This web site aims at linking scientific activities (research and international networking) with implementation activities (health intervention projects, national health information systems and health care systems).

9.10 Partners for Health reform plus

LINK: http://www.phrplus.org/

The Partners for Health Reform plus (PHRplus) project is the U.S. Agency for International Development's flagship project in health policy and systems strengthening. The contractor responsible for the PHRplus project is Abt Associates, Inc., a social science policy and research firm. USAID looks to PHRplus to provide technical assistance in health care reform, health policy, management, health financing, and systems strengthening. This project maintains close working relationships with NGOs and USAID cooperating agencies, international and developing country partner organisations, including the World Bank, WHO, UNICEF, bilateral donors, PVOs, foundations, universities, and host country government agencies. One division of the project works specifically on National Health Accounts data, an important source of information for improving government accountability in use of funds according to stated objectives. Partner web links include:

9.11 World Health Organisation

LINK: http://www.who.int/

9.12 UNAIDS

LINK: http://www.unaids.org/

9.13 The Global Fund

LINK: http://www.theglobalfund.org/

9.14 Harvard School of Public Health

LINK: http://www.hsph.harvard.edu/

9.15 DELIVER Project

LINK: http://www.deliver.jsi.com/

The Deliver project is also funded by the U.S. Agency for International Development. The purpose of the project is to ensure secure supplies of contraceptives and other essential drugs. The project provides assistance with policy formulation, quantification of needs, and design and implementation of management systems for drug procurement, storage, and distribution. Special tools have been adapted to the logistics system needs of HIV-AIDS programs.

9.16 Accountability and Transparency for Health

LINK: http://www.bu.edu/actforhealth

Work by anti-corruption and health expert Taryn Vian and her colleagues at the Boston University School of Public Health can be found on this web site.

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