

Tackling Healthcare Corruption and Governance Woes in Developing Countries

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Fighting corruption in big ticket infrastructure is a constant concern for governments, donors and contractors. But in service delivery efforts like health care where investments are meant to improve people's lives, these same concerns fall off the agenda. This may be because governments, donors and philanthropists underestimate the challenges of governance in health care delivery, or perhaps where lives are at stake they simply overlook corruption and poor governance as a cost of doing business.

Yet health care is no more immune to governance problems than any other sector. The rush to endorse the MDGs and translate these goals into real programs has largely overlooked the limited ability of institutions to deliver. The need to identify and address corruption and weak governance is often lost in the commitment to raise funds and expand services. Yet numerous studies have documented such problems, for example, in the procurement of health supplies, in under-the-table payments for services, and in nurses and doctors who fail to show up at their clinics but nonetheless collect their salaries. Fortunately, mechanisms exist for addressing these types of problems. These include better management, improved logistics and information systems, and strengthened accountability. None of these measures is easy but they are necessary to ensure that the billions of dollars in donor funding now pouring into developing country health initiatives reaches the intended beneficiaries.

How do we know if healthcare investments are working?

Determining whether investments in health care are reaching their target population requires knowing which outcomes to monitor. Traditional measures, such as the infant mortality rate, are poor reflections of health sector performance because they are too general and because of the tenuous link between health inputs and health status at high levels of infant mortality. To compensate for poor data and the difficulty of measuring impact in health care delivery, indirect measures of performance can be used. Basic functions such as clear policies, hiring of staff, purchasing of drugs, building of clinics and procurement practices, can be easily accomplished but only represent the identification of inputs, which though necessary, may have little bearing on effectiveness of delivery.

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The more complex and important measures of health system performance are such things as staff availability, availability and quality of drugs and medical supplies, regularity of funding transfers,

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functioning equipment, and existence of patient records. These factors, which can be readily observed, can tell us whether a health system is meeting minimal efficiency and quality standards. Utilization data and patient satisfaction offer complementary metrics of health system effectiveness because under-utilized public facilities or the dissatisfaction of target groups often point to implementation problems. By monitoring these measures, it is possible to determine how seriously corruption and governance woes are affecting a health system.

What indicates shortcomings in health service delivery?

Systems of poorly functioning health systems include:

MISMANAGEMENT AND INADEQUATE TRAINING

Core management problems include human resource management and supervision, basic subsystem operations (e.g., procurement, drug distribution, logistics) and input availability. Mismanagement in such areas undermines service delivery. For example, hospital efficiency suffered due to lack of management training in Turkey and the Dominican Republic, but similar problems emerge at public clinics where clinical training substitutes for management skills.

Indicators Capturing Poor Governance in Health Service Delivery

Mismanagement

- Leakage of drugs and supplies
- Patients provide in-kind supplies and drugs
- Irregular budget transfers

Absenteeism of Staff

Corruption

- Mis-procurement and kickbacks
- Irregularity in purchase of drugs and supplies
- Petty theft

Informal payment from patients

Vague and poorly understood policies, uneven recordkeeping and minimal use of such information contribute to poor management. An assessment in Nigeria found a low level of knowledge among health ministry staff regarding standard

procedures and regulations, and current budget allocations. Moreover, current budgets and expenditures did not correspond. In Uganda staff records were inadequate as only 56 percent of facility staff existed in district records. In Honduras 2.4 percent of staff were “ghost” workers and 5 percent of staff had unilaterally moved to other locations without the knowledge of management. These kinds of problems stem from lack of management skills, absence of information systems and flawed oversight.

Drugs and supplies are among the most commonly “leaked” products. Drugs in particular fetch a high price in the private market. Virtually all qualitative studies that have probed this issue emerge with the view that quality and drug availability are virtually synonymous. Lack of drugs has been repeatedly shown to discourage utilization of public facilities. In China various studies indicate that on average about 30 percent of public drug supplies are expired or counterfeit, attributed to minimal public budgets, graft and no accountability. The average leakage rate for drugs in rural public facilities in Uganda was estimated at 73 percent, ranging from 40 to 94 percent.

In-kind supplies from patients entail bringing or purchasing basic supplies (e.g., bed sheets, bandages or drugs), and in some instances equipment. The concentration of private health services adjacent to public hospitals and clinics in many countries attests to the chronic shortages of basic inputs and malfunctioning equipment.

In the Kyrgyz Republic in 2001, among hospitalized patients 98 percent brought food, 73 percent linens, 80 percent had family members purchase drugs and 76 percent supplied medical supplies. Similar patterns were reported for Tajikistan. Patients paid for 50 percent of drugs in an urban hospital in the Dominican Republic.

In Nigeria equipment inventory showed that 25 percent of health facilities had about half of the minimum package of equipment, while 40 percent had less than a quarter of what was needed. In Ethiopia two separate surveys revealed that only 21 percent of public hospitals had autoclaves (sterilizers) and 46 percent had functioning operating theaters, both serious shortcomings given the spreading AIDS epidemic and the high volume of patients.

Tracing non-wage funding between central government and local providers using public expenditure tracking systems (PETS) identifies a key problem in effective public management. In Ghana, Peru, and Uganda leakage is 70 percent of total transfers; it is 40 percent in Tanzania. High leakage means inadequate funding for non-salary spending, which

requires patients to “contribute” via financial or in-kind contributions. Poor recordkeeping in the sector has limited the number of countries with data, in itself an indicator of serious flaws that deserve attention.

ABSENTEEISM

Health provider absenteeism is chronic in much of the developing world leading to closed public clinics, limited patient access to services, lower quality, and, eventually, corruption. But absenteeism occurs for various reasons, many of them legitimate or necessary. For example, rural health workers often need to travel to larger towns to receive their paycheck, fetch supplies or drugs, and impassable roads or bad weather delay them. All lead to absences but are necessitated by inadequate management or other shortcomings. In other cases physicians or nurses simply don't show up.

Recent measures of absenteeism in health clinics in developing countries report averages of around 50 percent, ranging from a low of 19 percent in Papua New Guinea to a high of 75% recorded in one study in Bangladesh (Figure 1).

In Ethiopia, understaffing was attributed to late arrivals, long breaks and a general disregard for the necessity of staffing clinics. Absences are frequently motivated by responsibilities at second jobs. Managerial reluctance to confront physicians often inspires lower level workers to behave accordingly, leading to high absenteeism and low productivity at all levels.

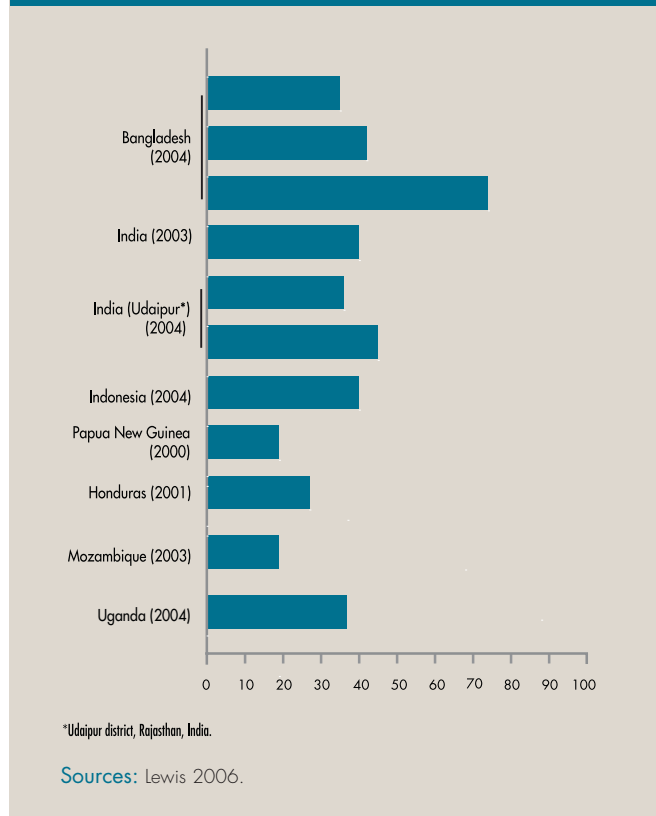
Low or unpaid wages also force workers to seek additional employment outside government. In Mozambique, focus groups of health workers said they missed work or cut short their hours to devote time to other economic activities. In Kogi State, Nigeria, 42 percent of the staff had not been paid their salaries for more than 6 months in the past year, converting staff into virtual volunteers and eroding the credibility of the health system. Another study in Nigeria showed that the greater the lag in paying salaries the more likely health workers were to engage in pharmaceutical sales and seek other employment in the private sector. Family survival therefore plays a role in absenteeism and low productivity.

Absent health workers face few consequences due to the lack of accountability for public servants. Without accountability, abuses are more likely to proliferate and eventually undermine the health care system.

CORRUPTION

The line between mismanagement and corruption is a fine one, and varies by circumstance and setting. Corruption can

Figure 1. Absence Rates Among Health Workers in Selected Countries

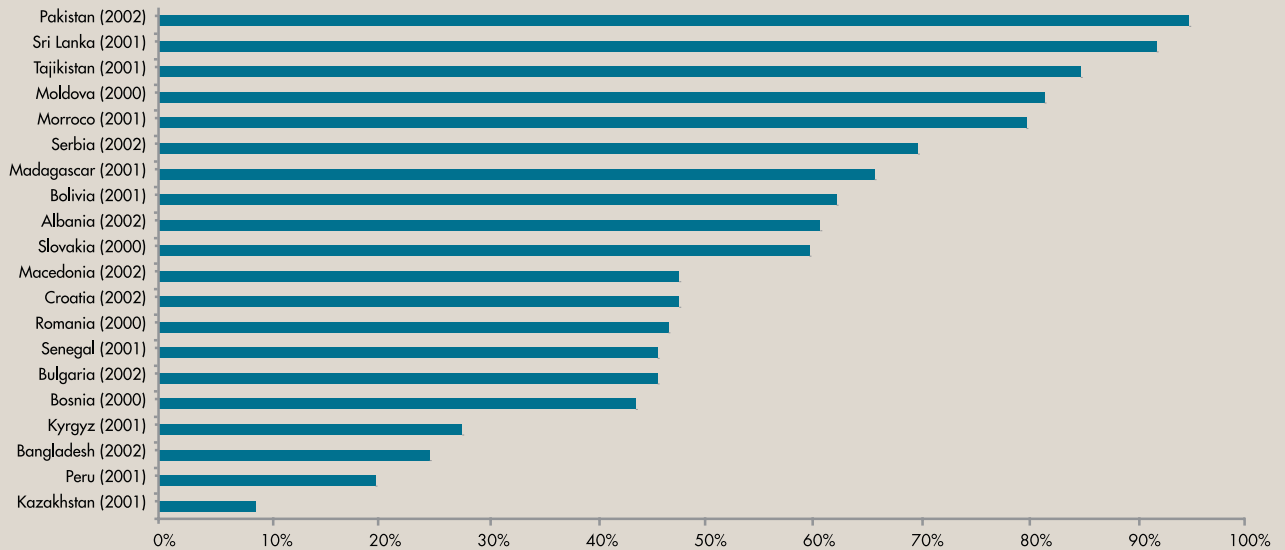


be defined as “use of public office for private gain”(Bardhan 1997). Country surveys of public officials, the business community and the general public, and health provider perception surveys gauge perceptions of corruption in public service provision giving a sense of the kinds and frequency of corruption in facilities as well as the likely perpetrators by profession. Both types of surveys capture corrupt practices, which by their nature are not typically visible.

In corruption surveys interviewing public officials, business executives and the general public in 23 countries, health ranked in the top four most corrupt sectors in 10 countries: Moldova, Slovakia, Tajikistan, Bangladesh, India, Sri Lanka, Kazakhstan, Kyrgyz Republic, Madagascar and Morocco (Figure 2). These countries also ranked prominently on the percent of the population perceiving high levels of overall corruption.

In Bosnia and Herzegovina, Bulgaria, Macedonia, Romania, Croatia, and Montenegro 45-55 percent of respondents felt that corruption among doctors was widespread. Albania and Serbia showed much higher levels in the 61-71 percent

Figure 2. Percent Perceiving Corruption in the Health Sector



Sources: Lewis 2006.

range. In Bolivia a local survey of patients considered the Health Ministry and public hospitals less corrupt than customs or police, but ranked health corruption 2.7 on a scale of 1-4, noting the nepotism, *clientelism* and higher charges for the unconnected as some key indicators of irregularity. Surveys from South Asia suggest similar perceptions of the sector.

Overpayment for supplies, ignoring competitive bidding practices and taking kickbacks are documented in Argentina, Colombia and Venezuela, and in Ghana 18 percent of the value of contracts is routinely required of public contracts. Anecdotal evidence and focus group results suggest that these are not isolated events, but they are perpetrated because of a lack of both oversight and/or enforcement of rules.

Selling public positions and requiring bribes for promotion builds a corruption spiral since the newly hired and promoted must find the resources to ensure their continued employment and advancement. In Latvia, Armenia and Georgia the "cost" of public positions is well known among public officials and the general public with the higher cost jobs in the most corrupt enclaves of government. In Bosnia and Herzegovina, 75 percent of officials thought bribes were required for obtaining positions and for promotion. In Ghana 25 percent of jobs were allegedly bought in government hospitals, and in Uganda 20 percent of municipal officials acknowledged that the practice occurred in the health sector.

Corruption compromises public investments, and reflects a lack of both accountability to and oversight by public officials and citizen. Moreover, it entails waste in a highly constrained resource environment.

INFORMAL PAYMENTS

Informal payments are payments to individual and institutional providers outside official payment channels. This encompasses cash 'envelope' payments to physicians, 'contributions' to hospitals and in kind compensation to providers. They are under-the-table payments to doctors, nurses and other public medical staff for jumping the queue, receiving better or more care, obtaining drugs, or just simply for any care at all (Figure 3).

Informal payments create a parallel market for services within public health care systems, and, like the informal sector are typically illegal and unreported. Informal payments have become a widespread phenomenon in much of the developing world. For example, in Bolivia the incidence of informal payments was significantly correlated with perceptions of corruption in specific public hospitals and 40 percent of interviewed patients acknowledged making illicit payments for care. In Costa Rica 85 percent of the medical staff indicated that under-the-table payments to physicians were common, valued at roughly 50 percent of a private sector consultation.

In South Asia patients typically must pay at arrival and individually for services, and in Georgia and Poland for each item, from registering to paying bribes for changing bed sheets. Left unchecked such practices lead to flaunting of rules and policies and blatant corruption.

Of concern is the relative cost of informal payments to patients, and numerous studies point out the heavy burden on the poor. While outpatient fees are more common, inpatient costs can exceed annual family income forcing the sale of assets or the accumulation of debt in order to afford care.

So what can be done? Strategies for improving health care delivery

Actions are needed to improve government effectiveness, reduce corruption and encourage accountability of public providers. Some of the proven strategies for correction include the following interventions.

IMPROVING MANAGEMENT

Adequate incentives for health professionals lie more in the structure of the health care system and its financing than in limited actions that fix existing arrangements. Fundamentally money needs to follow patients at least in terms of tying medical staff time to specific patients. Payment methods are the cornerstone of incentives for productivity and performance.

Money needs to follow patients to establish proper incentives and increase productivity.

In the OECD physicians whose earnings are based on salary rather than fee-for-service, bonus payments or capitation showed lower productivity, lower levels of care and higher wound rates from surgery.

Low wages represent one area of potential temptation for corruption. Where earnings are low individuals have second and third jobs, but they also perceive that low wages entitle

Figure 3. Proportion who make Informal Payments Among Users of Health Services, Selected Countries



Sources: Lewis 2006.

them to demand contributions from patients. Civil service reform may be required to address structural problems related to postings, promotion and pay, but experimentation with other payment arrangements remains a priority.

Drug procurement reform in Chile to blunt high costs, align the mismatch between need and supply, and address frequent stock outs entailed: (1) electronic bidding for pharmaceuticals; (2) allowing the drug purchasing agency to only serve as the procurement agent for hospitals; (3) informing pharmaceutical procurement agents they are under scrutiny; and (4) removing the drug purchasing agent monopoly. Together these actions raised performance and lowered costs

In addition to basic skills, **institutional incentives**, particularly the ability to hire and fire staff, are far more powerful than education or experience in raising the quality of care, so incentives are needed to foster improvements in health care.

A nationwide **database** for matching staff and wage payments to maintain up-to-date personnel records to eliminate abuses such as paying “ghost” workers is key.

ADDRESSING ABSENTEEISM

Wage increases are commonly recommended, but the evidence on resulting performance does not support such policies, at least not without additional efforts of the kind discussed here.

Experimentation in Tanzania suggests the importance of local authority to hire and fire staff as a means of raising reliability and quality of physician performance, suggesting that accountability effectively used can have an impact on both absenteeism and output.

Adequate management entails some form of **staff oversight**. In Bolivia, frequent written evaluations of performance, and means for rewarding and disciplining staff proved effective. Informing staff of possible sanctions with absenteeism reduced the practice in Venezuela, and in education, initial surprise visits to schools in eight countries led to lower teacher absenteeism in subsequent unannounced visits.

Evidence from Tanzania suggests accountability effectively used can have an impact on both absenteeism and output.

Together these suggest that informing staff that their performance will be monitored and they will be held accountable can reduce absenteeism.

In education, **inspectors** lowered absenteeism in some cases, and this may apply in health care through abuses reported in CIS countries suggest caution in adopting inspections. Inspectors were an effective tool of accountability and had some effect in Ecuador, India and Indonesia, but no effect at all in Peru and Uganda.

STEMMING CORRUPTION

A national, integrated, mutually reinforcing anti-corruption strategy with strong political backing and a willingness to take a position and follow through can provide the support that sectoral reforms need. Poland is a case in point where health was encompassed by a broader anti-corruption agenda and illegal practices declined.

An experiment in Ethiopia showed that the potential for getting caught offers a stronger disincentive for corrupt behavior than higher wages, suggesting the importance of oversight and enforcement.

A fundamental initiative is the **establishment and enforcement of clear procurement and contracting rules**. In Argentina when the health system transparency policy was introduced the prices of procured supplies dropped sharply but rose again once the policy was no longer enforced. In Colombia price variations in purchases across public hospitals were systematically lower where the price lists negotiated and endorsed by a local NGO were applied.

The frequency of health provider audits by the central government and enforcement increased immunization coverage, suggesting that local governments can benefit from auditing, and auditing encourages more responsible public services. In Madagascar, sanctions for misuse of funds led to systematic following of financial procedures.

Community oversight in Bolivia, Madagascar, the Philippines, Uganda improved local public performance. The centralized hiring, promotion and deployment of public health workers in all countries effectively neutralizes the role of local supervision. If the consequences of absenteeism, taking of bribes and stealing of drugs are beyond the authority of local boards or community oversight bodies, abuses cannot be contained. Locally organized oversight has also shown promise based on experience in Ceara, Brazil and in Bolivia.

ELIMINATING INFORMAL PAYMENTS

Controlling **informal payments** can be achieved through establishing alternative sources of funding and

better management. Raising official fees as a substitute for under-the-table payments improved patient payment and utilization in two pilot programs in Kyrgyz Republic, and in Cambodia where patients spending declined by 20 percent and 50 percent for drugs and supplies, respectively.

In Cambodia **reorganization of hospital staffing combined with a transparent official fee policy**, clearly designated exemptions, and retained fee revenue that supplemented physician salaries at levels comparable to those earned under informal arrangements led to more reliable pricing, stable revenue and higher demand. Predictability and equity adjustments improved access without compromising utilization or hospital revenue, the latter a critical component of compensation given salary levels.

Fee exemptions offers the potential for targeting resources at those least able to afford health care. Existing programs are uneven across income groups. Generally the absolute amount the poor pay is lower than what the non-poor pay, but amounts tend to be a significantly higher proportion of income for the poor as compared to the better off.

Venezuela found a decline in theft and unjustified absences with greater **accountability** within hospitals.

RAISING ACCOUNTABILITY

Government contracting out services can often raise the performance of publicly subsidized services, partly because holding contractors accountable is far easier than doing so with public workers. Experience in Haiti, Cambodia and Central America suggest contracting out can work even in the lowest income environments.

Consumer satisfaction surveys help build accountability because it offers an independent assessment. Exit surveys, mini-household surveys or focus groups to elicit responses help gauge the strengths and weaknesses of public programs.

More information to citizens about resource flows from central and local governments and clarity on the roles and responsibilities of local authorities strengthens accountability. In education, Uganda used the local press and updates on central government transfers attached to schoolhouse doors to inform the community about the status of resource availability at the local level, significantly raising the amount of transfers received locally. These same techniques apply to health as well.

Citizen report cards equip citizens with information on the strengths and shortcomings of public health services. Press reports based on such assessments provide a public

forum for informed local debate and action on public health care delivery. Progress can be achieved on multiple fronts, but good diagnosis, careful implementation and at least minimal health care accountability are critical if health service delivery is to be improved.

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Related CGD Work

Global health is one of the Center's core areas of policy-based research. Our work on global health concentrates on the challenges and opportunities it presents to global development and poverty reduction, including issues of human capital formation, institutional development, corruption, and accountability. For related CGD materials on this issue, please refer to the following publications, which are available online at www.cgdev.org.

- Owen Barder. *Making Markets for Vaccines*. CGD Brief. (Washington, DC: Center for Global Development, 2005.)
- Ruth Levine and the What Works Working Group with Molly Kinder. *Millions Saved: Proven Successes in Global Health*. (Washington, DC: Center for Global Development, 2004.)
- Todd Moss and Michael Clemens. *What's Wrong with the Millennium Development Goals?* CGD Brief. (Washington, DC: Center for Global Development, 2005).
- Theodore H. Moran, Edward M. Graham and Magnus Blomström, eds. *Does Foreign Direct Investment Promote Development?* (Washington, DC: Center for Global Development, 2005).

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