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Addressing corruption in the health sector

Securing equitable access to health care for everyone

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U4 Anti-Corruption Resource Centre
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Summary

- Tackling corruption in the health sector is essential for achieving better health outcomes;
- Addressing corruption may seem daunting, but experiences from around the world has shown that a collective donor response can be effective;
- What is deemed as 'corruption' and what constitutes an appropriate response will vary from country to country;
- Systematic analysis of vulnerabilities to corruption/abuse is necessary to identify problems, select priorities, and sequence interventions in a sector-wide approach;
- A political economy analysis of the sector can help you be selective, opportunistic and realistic when trying to influence the overall situation;
- Mitigating strategies should focus on corruption prevention by strengthening transparency, enforceable accountability and stakeholder participation in the health sector. These must be linked to measures to detect abuse and apply sanctions;
- Tackling corruption in health needs to be linked to broader governance reforms, including public finance, public administration and external oversight reforms. Both, 'supply' and 'demand-side' reform measures[1] need to be supported, taking into account government's commitment and implementation capacity, as well as the capacity and environment for civil society engagement;
- Strategies to address corruption can be systematically integrated into health sector plans using the WHO health systems model and/or health sector integrity strategies.
- Implementation of mitigating interventions can be monitored through sector reviews and external evaluations.
- In the absence of an integral sector-wide anti-corruption approach, health advisors should actively look for opportunities to address corruption and unethical behaviour in specific sub-sectors (e.g. drugs) or systems (hospital management, payroll management, etc.).

[1] "Supply-side" reform refers in this context to improving government capacity and accountability, while "demand-side" measures refer to proactive civil society engagement and fostering the enabling conditions for civic participation.

Purpose of this U4 Issue

The development community is striving to achieve results and value for money with its investments in health around the world. Yet, donors often work in countries where the risk of corruption is high and where public management and oversight systems are weak. In many countries, international assistance has strengthened accountability bodies such as anti-corruption commissions and the Office of the Auditor General. As the capacity of these bodies increases, so does the likelihood of corruption being uncovered at the sector level. Sector advisers need the knowledge and skills to prevent, detect and address corruption in their sectors.

The main purpose of this U4 Issue is to increase awareness around corruption in the health sector and provide practical guidance on how to identify and prevent it. Specifically it will:

- explain what corruption is and the different forms it can take in the health sector;
- identify vulnerabilities to corruption and mitigating strategies;
- present instruments to identify and track corruption in health;
- suggest ways to integrate anti-corruption approaches into health sector programmes.

1. Introduction: why should donor agencies care about corruption in the health sector?

Corruption in the health sector can be a matter of life and death, especially for poor people in developing countries. In China, an estimated 192,000 people died of fake drugs in 2001 alone. An IMF study across 71 countries showed that countries with high incidences of corruption have higher infant mortality rates, even after adjusting for income, female education, health spending and urbanisation[2].

Corruption in the health sector can have severe consequences for access, quality, equity and effectiveness of health care services:

- At the service delivery level, unofficial user fees discourage the poor from using services or lead them to sell assets driving them further into poverty. Evidence shows they are regressive, constituting a major burden on poorer households.[3]
- Bribes to avoid government regulation of drugs have contributed to the rising problem of counterfeit drugs which can lead to increased disease resistance and death. Globally 10% of all drugs are believed to be fake, while in some African countries the figure can amount to 50%. An estimated 10-25% of public procurement costs for drugs are lost to corruption[4]
- Corruption in financial management has a direct negative effect on access and quality of care. A study of 64 countries found that corruption lowered public spending on education, health and social protection. In Chad, the regions only received a third of the centrally allocated resources; in Cambodia 5-10% of the health budget was lost at the central level alone; in Tanzania, local or district councils diverted up to 41% of centrally disbursed funds; in Uganda, up to two thirds of official user-fees were pocketed by health staff.[5].
- Finally corruption in the health sector erodes the legitimacy of, and public trust in, government institutions. Corruption 'shocks' can lead to the freezing of donor funding to the sector and the interruption of life saving services.

Ultimately, corruption in the health sector has a corrosive impact on the population's level of health.[6] Evidence shows that reducing corruption can improve health outcomes by increasing the effectiveness of public expenditure. Tackling corruption in the health sector is essential for achieving better health outcomes.

1.1. Why is the health sector particularly susceptible to corruption?

Annual global spending on health is approximately US$3 trillion. Health spending ranges from 5% of GDP in low-income countries to more than 15% in OECD countries. Resources spent in the health sectors globally and at country level offer lucrative opportunities for abuse and illicit gain.

Health systems are particularly susceptible to corruption because uncertainty, asymmetry of information and the large number of actors create systematic opportunities for corruption and hinder transparency and accountability.

Uncertainty regarding the effectiveness of medical treatments, the inability to predict who will fall ill, when and with what kind of illness, distinguish health markets from others, leading to inefficiencies

[2] See e.g. Gupta, S. et al (2000), "Corruption and the provision of health care and education services", IMF, USA.

[3] See e.g. Vian, T., et al (2010), Lewis, M. and Pettersson, G. (2009); U4 Issue Paper 10 (2008) in bibliography.

[4] See e.g. U4 Issue Paper 10 (2008).

[5] Delavallade, C. (2006), "Corruption and distribution of public spending in developing countries"; Journal of economics and finance.

[6] A study by the International Monetary Fund with data from 71 countries showed that countries with high incidences of corruption have higher Infant Mortality Rates. Studies have shown that corruption has a significant negative effect on health indicators even after adjusting for income, female education, health spending and level of urbanization.

and scope for abuse. The poor functioning of health markets makes it difficult to set standards of accountability and to discipline health care providers for poor performance. Consumer choice is not a good regulator as patients can not "shop around" for the best care due to a public service delivery monopoly, distance, limited availability or high cost of private care.

The health sector is characterised by a high degree of asymmetry of information (information is not equally available to all health sector actors) leading to significant inefficiency and vulnerabilities to corruption. The discretion given to providers puts patients in a vulnerable position if providers should choose to abuse their position. Asymmetry of information also affects decisions related to prescriptions, as pharmaceutical company representatives know more about their products than the doctors who prescribe them. This asymmetry of information makes it difficult to fully monitor the actions of different actors, to hold them accountable and to detect and assign responsibility for abuses.[7]

The large number of dispersed actors (see 2.7.) exacerbates these difficulties. The relationships between medical suppliers, health care providers and policy makers are often opaque which make it difficult to detect conflicts of interest that can lead to policy distortions. Health service delivery is also often decentralised making it difficult to standardise and monitor service provision and procurement. When regulators are put in place to remedy the situation, new avenues for corruption emerge: powerful interest groups may try to "capture" the regulator and influence their decisions through bribes.

Identifying and punishing corrupt practices is difficult. The lines between inefficiencies and abuses are often blurred and abuses may be intentionally hidden behind inefficiencies. But experiences from around the world have shown that it is possible to begin a dialogue about these problems, and develop strategies to address them.[8]

2. What is corruption and how does it manifest itself in the health sector?

It is important for people working in the sector to have a shared understanding on what corruption is and to know how it is defined in the country's own constitution and laws.

"Corruption" is a loosely used term. It refers to everything from paying bribes to civil servants and large-scale theft from public funds to a wider range of economic and political practices that people consider abuses of power and that are increasingly criminalized. Corruption is today widely accepted as a global public ill and key obstacle to good governance and development.

Although there is no single, universally-accepted definition of corruption, the most commonly used refer to the abuse of public or entrusted power for private gain (e.g. World Bank, Transparency International).[9] Many practitioners prefer a broad understanding of corruption that embraces anyone with entrusted power, including private sector staff, corruption that occurs between private firms and within civil society organizations.[10]

[7] Patients lack information to judge decisions made on their behalf or assess the correctness of a bill; insurance auditors have a hard time assessing whether the billing is correct and services provided were necessary; and regulators are hard pressed to assure the quality of drugs and medical equipment.

[8] See bibliography and links to useful websites (Sections 7 & 8) for references to these experiences.

[9] A recent evaluation of anti-corruption assistance around the globe suggests the following modification as to include the systemic dimension of corruption: ***"The abuse of entrusted authority for illicit gain"*** **(**Norad 2008)

[10] Those in the private sector who willingly collaborate with corrupt government officials are equally guilty of corrupt practices when they offer and/or pay bribes in order to obtain an advantage for their firm. The same goes for employees of civil society organizations who embezzle funds or resort to bribes to win certain public contracts.

Box 1 – The United Nations Convention against Corruption (UNCAC) and corruption

The most important international treaty on corruption, UNCAC, does not define corruption as such. It rather defines specific acts of corruption that should be considered in every jurisdiction covered by UNCAC. These include bribery and embezzlement, abuse of function, trading in influence, illicit enrichment, bribery within the private sector, but also money laundering, concealment and obstruction of justice. It places corruption in a broader governance context, highlighting the antidotes, in particular the participation of society, rule of law, proper management of public affairs, integrity, transparency and accountability. Also, in defining who might be considered as possible participants in corruption, UNCAC uses a functional approach to the term 'public servant': it covers anyone who holds a legislative, administrative, or executive office, or provides a public service, including employees of private companies under government contract.

Many corrupt practices are not only a crime[11], but are both a cause and consequence of poor governance. Corruption thrives where transparency, accountability, and participation are weak, where public sector and financial management capacity are low, and where public decision making has been compromised by conflicts of interest and political interference. Conversely good governance can discourage corruption (see Glossary in Annex I).

2.1. How does corruption manifest itself in the health sector?

The different types of corruption (see Annex I) find many manifestations in the health sectors of countries around the world. However, social, political and cultural differences in what is considered acceptable or unacceptable behaviour require context-specific understanding. While certain forms of grand corruption may be more universally considered criminal/unethical, the often blurred lines between gifts, socially accepted favours and bribes, and other historical and social factors make it hard to define other forms of corruption across nations. Even within a given country, not everyone will agree on the nature of corruption.

Whilst most people would agree corruption is 'wrong,' it is not always illegal. For example, some countries tightly regulate physician conflict of interest in ownership of medical ancillary services, whereas other countries do not.

Advisers can assess the health sector's vulnerability to corruption by examining the roles and relationships among different players and by understanding the current "rules of the game". The main players can be classified into five categories: i) government regulators (health ministries, parliaments, specialized agencies); ii) payers (social security institutions, government office, private insurers); iii) providers (hospitals, doctors, pharmacists, NGOs and faith-based organizations); iv) consumers (patients) and v) suppliers (medical equipment, pharmaceuticals, construction).

The different types of corrupt practices can also be identified by reviewing the processes of the health care delivery system and examining the potential risks and abuses that could occur within them (see Table 1 below in Section 4).

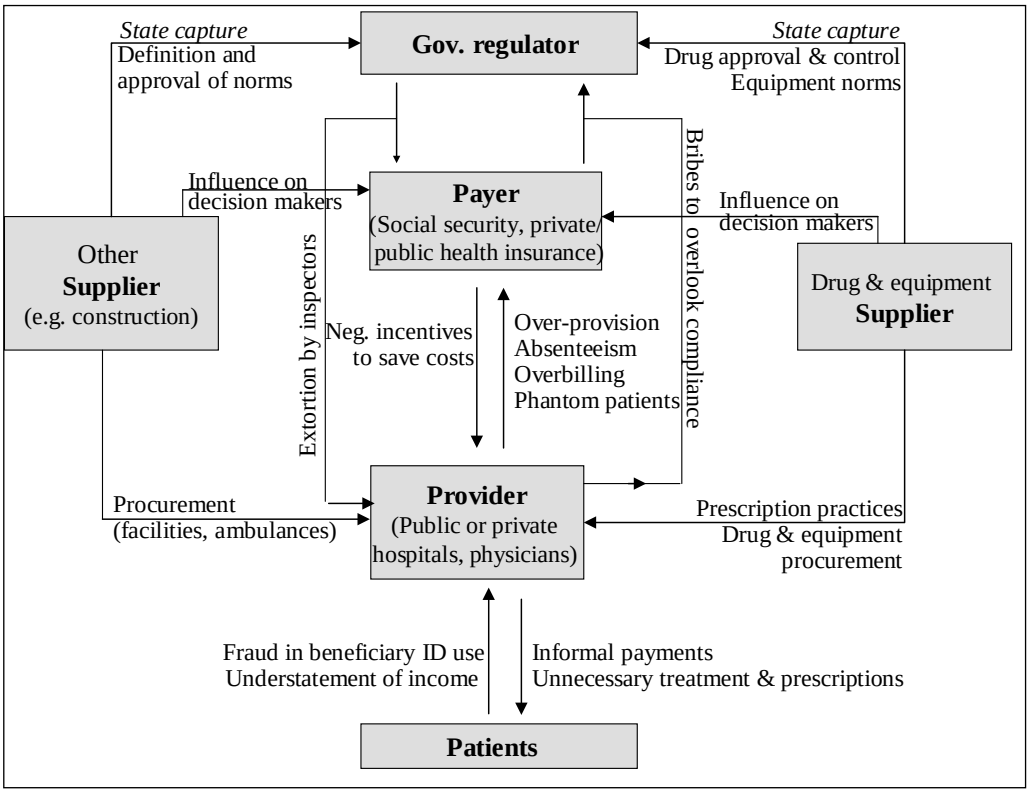
In addition a political economy analysis that assesses how powerful players are and what motivates them to behave as they do is useful to identify potential supporters and spoilers of reform (see Annex III).

Risks of corruption and abuse may differ depending on how funds are mobilised, managed and paid. Health systems can be classified as i) integrated systems where the public sector finances and directly provides health care, and ii) finance–provider systems that separate public financing from provision. Integrated systems are common in developing countries and vulnerable to large scale diversion of funds at ministerial level, bribes in procurement, illegally charging patients, diverting patients to private practice, and absenteeism. Finance-provider systems, often found in middle income countries,

[11] One of the starting points for addressing corruption in any country is to know whether or how it is defined in general and in detail in the country's own constitution and laws (*see Box 2 and 6.8.*).

are vulnerable to excessive or low-quality medical treatment and fraud in billing government/insurance agencies. State capture, budget leakages and corruption in the appointment systems can occur in both.[12]

Figure 1: Examples of corrupt practices among different health sector players



Source: Adapted from Savedoff, W.D. and Hussmann, K. (2006): Why are health systems prone to corruption? In: Transparency International (ed.) Global Corruption Report 2006.

This U4 Issue focuses on integrated systems. References providing information of addressing corruption in finance-provider systems can be found in the bibliography. Corruption risks in the private health sector are not covered by this U4 Issue.

3. Framework to understand and mitigate corruption in the health sector

Corruption is a public health issue that will not disappear by itself, nor can it be ignored. Health advisors should recognize that it is possible to confront corruption by changing the conditions that allow it to happen and support it.

Efforts to tackle corruption need to translate the main principles of good governance (information, transparency, integrity, accountability, participation) into action. It is particularly important to close off opportunities for corruption by creating mechanisms for transparency and ensuring accountability for results. However, reducing opportunities for corruption is not sufficient: it also necessary to increase the likelihood of detection and appropriate enforceable sanctions when corruption occurs, be they of administrative, criminal or social nature.

In order to design strategies to prevent or control corruption, it is important to understand the factors that explain the patterns of corrupt practices. Figure 2 presents a conceptual framework of corruption

[12] For more information see Savedoff, W.D. and Hussmann, K. (2006): *Why are health systems prone to corruption?* In: Transparency International (ed.) Global Corruption Report 2006.

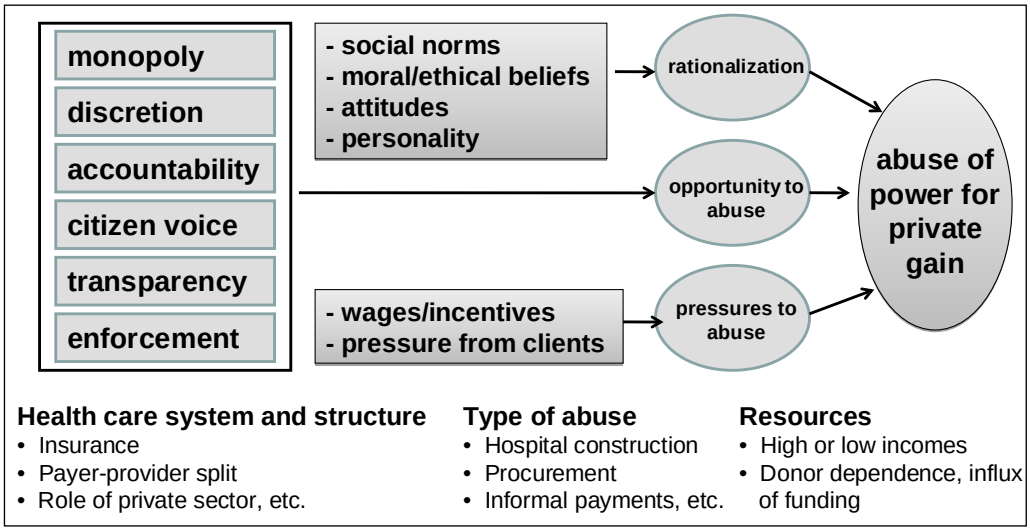
in the health sector. People generally cross the line between honest and corrupt behaviour when they have an opportunity to misuse their power and when they feel pressured to do so. They then devise rationalizations to justify their behaviour.

Opportunities for corruption are greater in situations where the government agent has monopoly powers (e.g. the only provider of health services); where officials have discretion without adequate control of this decision-making authority; where there is not enough accountability for decisions or results (including measurement of results and punishment for non-performance or corruption); where transparency (active disclosure of and access to information) is lacking and citizen voice (means for active participation) does not allow for external control; and where abuse or corruption is not detected or punished (enforcement).

Individual beliefs, attitudes and social value systems influence corruption and provide the basis for how those engaged in corrupt practices rationalize or justify their behaviour.[13]

Finally, government agents may feel pressured to engage in corruption. These pressures can be political, financial or social[14] and need to be considered in anti-corruption measures.

Figure 2: Framework to understand and mitigate corruption in the health sector



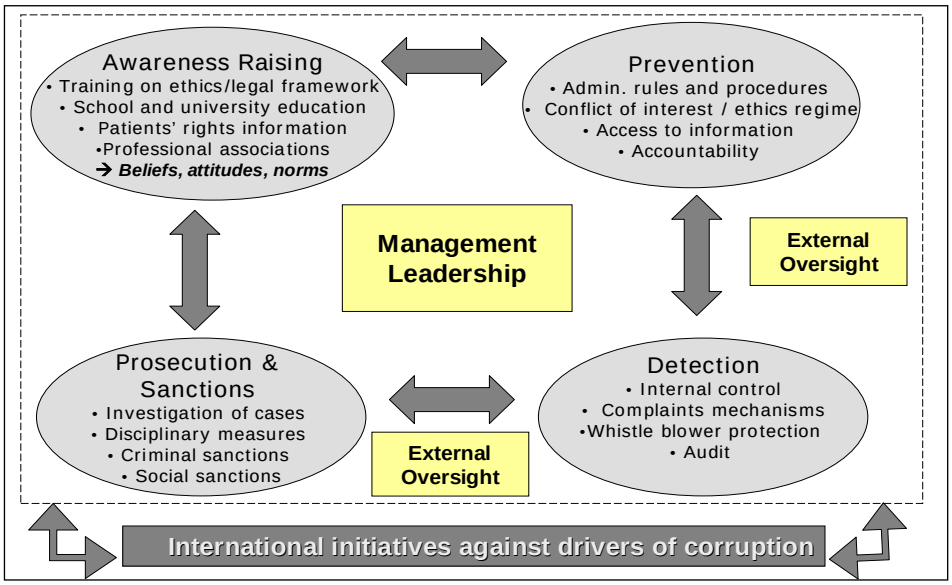
Source: Vian T (2008): Review of corruption in the health sector: theory, methods and interventions. In: Health Policy and Planning 2008.

Efforts to address the risks to corruption in the health sector usually contain a combination of legal, institutional and performance management measures. Specific emphasis should be given to awareness raising, prevention, detection and sanctions to bring about results. Of particular relevance, as reflected in Figure 3, are sound management systems and practices coupled with transparency, accountability and participation for external oversight.

[13] In post-communist Europe and Central Asia, e.g. the introduction of capitalism came along with the notion that "everything has its price". Or in African societies corruption may be justified by the logics of gift-giving, solidarity, predatory authority or redistributive accumulation.

[14] Public officials may be pressured to return political favours to superiors, the party or suppliers. They may feel pressured financially because of low public sector wages. Or public officials may be pressured socially, e.g. to favour relatives in awarding contracts or filling positions.

Figure 3: Interplay of awareness, prevention, detection and sanctions of corruption



Source: author

While the focus on prevention is key, credible control systems and enforceable sanctions, including audits, internal and external complaints handling mechanisms,[15] and whistle blower protection, are needed to catch what is not prevented. Clear consequences for those involved when corruption is detected are needed. Expectations about the prospects for detection and deterrence to work effectively in countries with weak rule of law need to be realistic.

Anti-corruption interventions should also look at levers that help impact on grand corruption, e.g. that will help deter senior health officials from embezzling larger sums of money (in the US$ millions). These levers include monitoring of assets, interests and life-styles of key senior health sector officials and scrutiny of the acquisition and movement of assets by such figures through asset declarations and anti-money-laundering efforts, both in country and internationally.

Corruption prevention and control also requires authentic political commitment[16], sufficient knowledge of the health sector, and resources to implement strategies and interventions. These conceptual considerations should be borne in mind when reading the next sections.

4. What are the main risks to corruption and selected mitigating strategies in the health sector?

Context matters: In order to address corruption in the health sector effectively, it is crucial to identify and understand the problem within the country context and to design appropriate counter measures. As governance challenges and the nature of corruption vary widely between countries it is important to understand how corruption manifests generally in a specific country and then look into the specific sector. Agency health advisors must work closely with their governance colleagues and other partners to review where they can impact against the types and risks of corruption summarised in Table 1. A detailed analysis of risks and counter-measures is contained in Annex II.

[15] Complaints handling mechanisms could include those within the facility, within the MOH, but also those with a national Anti-Corruption Commission and Anti-Corruption Legal Assistance Centres (ALACs) managed in an increasing number of countries by civil society organizations often affiliated to Transparency International, see http://www.transparency.org/global_priorities/other_thematic_issues/alacs (accessed 17 September 2010).

[16] Please note that political commitment is difficult to assess. There are risks to overestimate the commitment of senior public officials to reform and to underestimate political challenges in delivering on promises if they are serious.

Table 1: Types of corruption risks in health service delivery

Area	Issue – process	Type of corruption	Select mitigating strategies
Regulation	**Health policy**	• Political influence in definition of health policy, priorities, primary versus hospital care, benefit packages, etc.	• Increasing transparency and access to timely, accurate and relevant information on preparation and drafts of policies and laws • Strengthen participation of stakeholders in decision making • Follow international standards (WHO drug policies, manufacturing, selection and pricing standards) • Regulate / monitor interaction of interested parties
	Health care financing	• Political influence and bribes in market regulation, insurance packages, etc.	
	Quality of products, services, facilities, and professionals	• Bribes and political considerations in definition of drug policy, accreditation system for health professionals, etc.	
Budget and resource management	**Budget process**	• Political influence and bribes in resource allocation • Budget leakages, embezzlement and fraud in transfer of budgets: diversion of public into private accounts	• Public Expenditure and Financial Accountability (PEFA) indicators • Tracking resource flows • Increasing internal transparency • Strengthening external audits • Budget transparency and participation
	Billing for services	• Fraudulent billing for services (not) provided • Over provision of services	• Strengthening of accounting • Increased external audits • Ethics and self-regulations • Transparency in billing for services
	Payroll management	• Ghost workers • Extortion of a share of salaries	• Payroll cleanup and management • Transparent recruitment, assignment, and promotion systems • Using the private sector to speed up recruitment and deployment
	User fee revenue	• Theft of formal user fees • Abuse of exemption schemes for poor and vulnerable	• Improve budget & accounting systems • Increasing internal transparency • Strengthening external audits
	Use of resources	• Theft or unlawful use of equipment, vehicles, other inputs	• Codes of conduct & ethics training • Internal control systems strengthened
Procurement	**Construction and rehabilitation of health facilities**	• Bribes to influence procurement process including tender specifications • Bribes to influence monitoring and inspection of facilities • Collusion among contractors	• Transparent guidelines & standards • Maximum publication of information • Using e-procurement to improve efficiency and discourage corruption • Establish procurement databases • Use fraud detection software • Strengthen internal control systems • Undertake equipment audits and reviews of maintenance contracts • Foster external audits, including equipment audits
	Equipment and supplies	• Bribes to influence procurement process and skew specifications of goods and medical equipments • Bribes and extortion to influence monitoring and inspection • Collusion among contractors	

			• Civic participation (ie. in oversight) • Increasing transparency and accountability
Drug management	**Approval**	• Bribes to speed the process or gain approval for drug registration, drug quality inspection or certification of good manufacturing practices	• Systems approach focussing on transparency and accountability • WHO Good Governance for Medicines (GGM) Programme • Medicine for Transparency Alliance (MeTA) • Independent drug regulation agency • Transparent and uniform laws and standards • Strengthen drug management systems • Information technology & systems • Transparency & accountability in decision making processes • Publication of information and participation of stakeholders • Self-regulation of the pharmaceutical industry and professional associations
	Procurement	• Bribes, collusion and political considerations to influence the specifications of bids and the tender process as • Bribes, extortion, collusion in monitoring and auditing the procurement process and delivery of drugs	
	Distribution	• Bribes to influence drug inspection • Theft, diversion and reselling of drugs along the distribution chain	
Human resource management	**Appointments and promotions**	• Favouritism and nepotism in selecting ministry, department and facility level staff • Selling and buying of positions and promotions (vertical corruption)	• Transparent recruitment, assignment, and promotion systems • Publication of educational background and qualifications of key personnel • Building a professional team of "health managers" from the existing cadre or recruiting "professional managers" for the health sector • Using the private sector to speed up recruitment and deployment[17] • Use or promote asset declaration monitoring of relevant officials, including their inclusion in domestic and international politically exposed persons (PEPS)
	Accreditation of health professionals	• Bribes, extortion, collusion, nepotism in the licensing, accreditation and certification of health sector staff	• Strengthen self-regulation and oversight of professional health worker associations • Random checks on qualifications
	Time management	• Absenteeism and use of publicly paid time for private practice	• Effective incentives • Frequent inspections and peer supervision • Sanctions against workers who are absent without authorization • Hiring contract health workers

[17] Using private sector should be viewed as a short term measure until wider civil service reforms, especially transparent recruitment, promotion and transfer policies, are generating the desired results.

	Education and training	• Bribes to enter medical school and pass grades • Nepotism, favouritism, bribes in selection of training • Use of o per diems	• Increasing transparency and accountability • Publication of information on criteria for selection • Complaints mechanisms • Internal control and oversight
Service delivery	**Service delivery at facility level**	• Informal payments required / extorted from patients • Use of public facilities and supplies to treat patients privately • Unethical referral to private practice or laboratories • Stealing and reselling of drugs & supplies	• Formalizing user fees with exemptions or subsidies to accommodate the poor • Increasing provider / health worker remuneration • Increasing transparency and accountability • Information systems on drug allocation and storage • Regular communication for inventory control – monitoring • Use of health scorecards

Source: Author with inputs from: Vian T (2008): Review of corruption in the health sector: theory, methods and interventions. In: Health Policy and Planning 2008.

Addressing corruption risks in the financial management system of the health sector requires a combination of measures, and collaboration with institutions across government. Public financial management reforms are often led by MOF staff, but health personnel must also "own" these reforms to be sure they are fully implemented in the health sector. Health leaders should not only act as medical personnel, but also as managers and stewards of resources. Improvements in administrative and financial systems can deter employees from attempting fraud. These procedures are generally part of an organization's internal control system. In addition, specific attention should be paid to procurement procedures and control. Reducing discretion and increasing transparency and accountability are particularly relevant in the drug sector, as otherwise regulators can be captured and the decision points of the drug supply chain are open to corruption.

A systems approach is needed. Many performance problems, including absenteeism, stem from weak governance systems that fail to reward good performance and discipline workers who under-perform, hence specific attention needs to be given to incentive and accountability systems. When tackling corruption at the service delivery level, a combination of strategies will be needed, always with an eye to ensuring equitable access to quality care by the poor.

In many developing countries faith based organizations provide health services in partnership with government and form the backbone of the rural health system. The mix of public and "private" providers further increases the complexities of budget transparency as well as the definition of accountability relationships. Faith-based organizations are not free from risks and vulnerabilities to corruption, and may also benefit from interventions.

5. What are the main tools to identify, track and measure corruption?

An increasing number of initiatives are emerging to identify and measure corruption at sector level. These help define the problem and get buy-in for anti-corruption measures, agree goals and targets,

and monitor improvements (or deteriorations) over time. Nevertheless, most such initiatives are still rather recent making it difficult to assess their pros and cons.

Some assessment tools can be used to focus specifically on corruption – experiences, perceptions, and sectoral risks, while others enable a wider look at how the health sector is governed. Also, some of the tools focus on specific areas or sub-sectors within health, e.g. drugs or human resources.

Existing international surveys already examine either perceptions or experiences of corruption in general, with some including a look at health. Table 2 identifies the main tools currently available to identify corruption risks and track progress. For a full description of these tools see Annex III.

Table 2: Key tools to identify, track and measure corruption risks and corruption

Area	Issue	Tools to identify and track problems
General	Cross-cutting	• Political economy analysis in the health sector • Vulnerability to corruption assessments • Value chain analysis • Sectoral accountability assessment • Value for money audits • Analysis of governance in health care systems
Budget and resource management	Budget processes	• Public Expenditure and Financial Accountability indicators (PEFA) • Focus groups and interviews with public officials, recipient institutions, and civil society
	Payroll leakages	• Public Expenditure Tracking Surveys and Reviews (PETS, PERS) • Household surveys • Focus groups with public officials and health workers
	In-kind leakages	• Public Expenditure Tracking Surveys (PETS) • Quantitative Service Delivery Surveys • Facility surveys • Focus groups with public officials, recipient institutions, and health workers
	Pharmaceuticals	• WHO Good Governance in Medicines programme to assess transparency in drug supply and management • International Drug Price Indicator Guide • Internet based drug procurement data bases
Individual Providers	Job purchasing	• Official administrative records combined with facility surveys • Interviews with public officials and former officials • Governance and Anti-Corruption Country Diagnostic surveys
	Health worker absenteeism	• Quantitative Service Delivery Surveys • Surprise visits • Direct observation • Facility records • Focus groups or interviews with facility heads and patients

Informal Payments	**Informal payments**	• Household surveys (E.g. WB Living Standards Measurement Surveys and Demographic and Health Surveys (DHS)) • Facility exit surveys and score cards • Focus groups/interviews with providers/patients and health staff • Governance and Anti-Corruption Country Diagnostic surveys
Corruption Perceptions & Experience	**Perceptions of Corruption**	• World Bank Governance Indicators (Control of Corruption), TI Corruption Perception Index • Governance & Anti-Corruption Country Diagnostic surveys (WB) • National level perception surveys by CSO and others
	Experiences of corruption	• AfroBarometer, LatinBarometer, EuroBarometer, TI Global Corruption Barometer • National experience based surveys • Patient satisfaction surveys and report (score) cards • Focus group surveys /studies

Source: Adapted from Lewis, M. and Pettersson, G. (2009): "Governance in Health Care Delivery: Raising Performance" (October 1, 2009). World Bank Policy Research Working Paper No. 5074.

One tool that is missing from the list is a means of assessing the capacity of civil society to provide external oversight and to serve in a watchdog capacity on health services. More work is needed to adapt assessment tools to health sector needs. This may include involving CSOs who are not traditionally working in health and orienting them to take on functions of health system monitoring.

None of the assessment and measuring tools will be enough by itself to identify, track and measure risks to corruption and corrupt practices. Instead, a combination of different tools is most useful. This is not an argument for duplication of assessments but rather an invitation to decide on the appropriate combination of tools for each context and purpose.[18]

In addition, close collaboration with national oversight and accountability institutions is important to identify areas vulnerable to corruption and track progress. These include:

- Office of the Auditor General (Supreme Audit Institution): annual audit reports as well as specific investigations provide important insights into vulnerable areas and where leakages actually occur.
- Anti-Corruption Commission, Inspector General's Office or Ethics Office: close cooperation in investigating specific allegations and regular analysis of complaints about alleged corrupt or unethical behaviour are useful tools to identify risk areas.
- Parliament: regular interaction with Parliamentary complaints commissions and Parliamentary Accounts Committee may also provide information about specific risk areas.

6. How to integrate anti-corruption strategies into health policies/plans?

Integrating anti-corruption measures systematically into health policies and plans is relatively new but lessons are emerging, especially in using value chain analysis for drug procurement.[19]&[20] Box 2

[18] For example, perception indicators could be used to identify areas in the health sector where governance is poor. Afterwards, health advisors may apply more detailed analytical or assessment tools (PETS or value chain analysis) to guide the design of public health policy, programs and projects.

[19] See bibliography and relevant links for the main documented references of country experiences (Sections 7 & 8).

provides guidance on using an integrated approach to address corruption in health sector plans and policies. However as country contexts vary widely, there is no blue-print and health advisors must work closely with governance advisers, government and partners (World Bank, WHO, civil society) to identify the most appropriate approach.

Box 2: Key elements for integrating anti-corruption strategies into health plans.

Get an overview on the nature of corruption in general in the country and understand which approaches to address it have or have not worked so far, including other sectors.

Understand corruption in the national context taking into consideration local norms and beliefs, legislation and international standards.[21]

Identify the types of corrupt practices in the health sector, their scope and seriousness, ideally in collaboration with government, partners and civil society.

Conduct political economy analysis in the health sector to assess how powerful the individual players are and what specifically motivates them to behave as they do. Analyze why corruption occurs, applying principles of governance, economics and crime prevention to understand the drivers and enabling factors.

Identify and cost the consequences of corruption and select priorities for interventions → be realistic and "opportunistic" in choosing priorities taking the results of political economy analysis into consideration. Aim for visible if modest results to generate traction and support.

Design strategies as part of the health sector plans and facility governance and management systems – avoid stand alone approaches.

Ensure that the levers of change described in the framework above are appropriately taken into consideration for analysis and design.

Select an adequate combination of supply-side and demand-side interventions according to the country context and the relative performance/strengths of the different actors. Put specific attention on fostering civic participation in monitoring services and holding health providers to account.

Link anti-corruption approaches in health with national anti-corruption policies and foster institutional cooperation between relevant agencies.

Combine measures to raise awareness of relevant stakeholders with management systems/tools/practices aimed at prevention, internal and external oversight for detection and enforceable sanctions to punish and deter abuse.

Link facility level efforts with national and international efforts and vice-versa.

Establish baselines and create a sound monitoring and evaluation system, to measure results and identify unintended negative consequences. Quantify losses in health systems to corruption where possible.

Create a communication strategy to frame the issues, advocate for reform and sustain political & public support, including a clear and simple statement of the problems that need to be addressed, defined in terms of missed opportunities to achieve the development outcomes for which the relevant agency is responsible.[22]

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[20] See Annex II.C.3 on drug supply, procurement and distribution.

[21] One of the starting points for addressing corruption in any country is to know whether or how it is defined in general and in detail in the country's own constitution and laws. Many countries have an anti-corruption law that defines corruption, e.g., corrupt transactions in contracts, in procurement, in employment; bribing of domestic or foreign public officials; sexual favours or any other favours, embezzlement, abuse of position, trading in influence. Other laws that relate to corruption could include the public procurement, revenue, proceeds of crime, or money-laundering acts.

[22] Please bear in mind that the more challenging the reform process, the greater the need for a clear and effective communications strategy that also pursues to foster and maintain ownership of the key constituencies.

Identify risks and establish a dynamic risk management system, including the technical and political levels of the reforms and focused on maintaining buy-in of key reformers.[23]

The following sections outline two different models that can be used to systematically apply this analysis across the health sector.

6.1. Integrate corruption diagnostic(s) and mitigating strategies into health systems development using the WHO model

The health systems strengthening approach developed by the WHO provides one model to systematically address corruption and improve transparency and accountability. With its six building blocks it already places emphasis on the importance of leadership and governance (see Figure 4). The opportunity consists in "mainstreaming" a governance, transparency and accountability dimension into the five other building blocks, instead of dealing with it as "stand-alone".

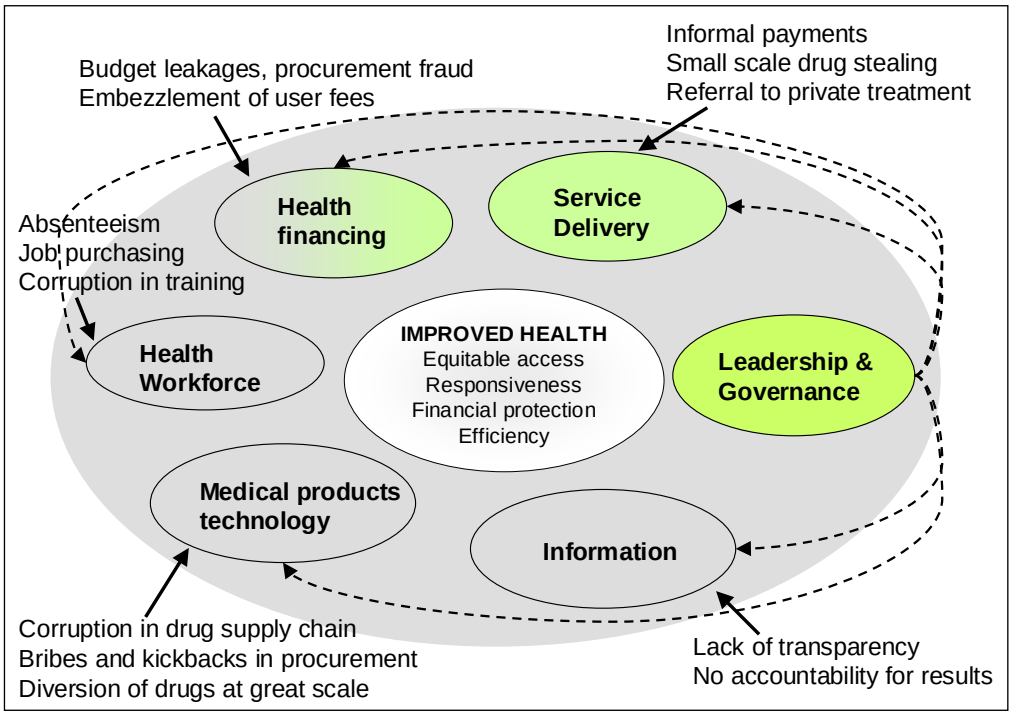
Health advisors should build the case for the need to address corruption in health systems through an evidence based diagnosis of the perceived and experienced levels of corruption and of the risks for abuse that affect the performance of the different building blocks (see Box 2). Demonstrating the impact of corruption on health systems performance and the potential benefits of reducing corruption can help get broader government buy in.[24]

The development of new national health plans is an ideal opportunity for integrating governance strengthening and anti-corruption strategies into the sector. New plans should reflect priorities for anti-corruption interventions, and develop appropriate benchmarks and indicators to monitor progress. These priorities should be selected based on evidence from vulnerability analysis and on feasibility based on a political economy analysis.

[23] Even for committed reformers political reform processes are challenging, in particular as anti-corruption measures tend to have an impact on power relations as well as the distribution of economic resources.

[24] In framing the issues, language may be critical in contexts where the word corruption itself may cause resistance. In order to prepare the ground for national diagnostics, it may be helpful to quantify the current ***impact*** of the problem and the ***potential benefits*** if the problem can be solved, using examples from the health sector in other countries where successes have been achieved following the type of reforms being proposed.

Figure 4: Integrating an anti-corruption and governance dimension in health systems



Source: Author

6.2. Develop accountability, transparency, integrity strategy for the health sector

Alternatively a health sector integrity strategy can be developed to complement and strengthen the governance of existing health sector plans. An integrity strategy would focus on assessing the current situation (levels of and risks to corruption) to identify constraints and bottlenecks, initiate dialogue among all relevant stakeholders to select priorities, agree on appropriate and context-specific interventions, and propose ways to implement sustainable change within institutions.. The strategy must draw on and feed into the national anti-corruption policies in order to ensure coherence with national priorities and to make full use of synergies.[25]

An example for such an effort can be found in Mongolia where a comprehensive project on Strengthening Ethics and Integrity for Good Governance in the Health Sector of Mongolia was developed and implemented with the support of UNDP.[26]

Advisors should consider a phased implementation approach focusing on issues that are doable within the comfort zone of government counterparts before attempting more ambitious and difficult tasks. Similarly, health advisors should consider conducting pilot initiatives that generate a demonstration effect, and can then be scaled up.

[25] DFID Zambia is currently supporting the development of such an approach which involves close cooperation and coordination among its governance and health sector teams and programmes.

[26] For more information see http://www.undp.org/oslocentre/docs09/UNDPMongolia_web.pdf. It included, e.g., the review of laws, regulations and procedures in the health sector to ensure efficient and transparent procurement, financial management processes and human resources practices; the development of a Code of Ethics of Medical Professionals; the organization of trainings on professional, civil service and public management ethics; the creation of ethics sub-committees in every health organization; a corruption and transparency perception baseline study of the health sector, the assessment of application of benchmarks on accountability and transparency in health sector.

6.3. Ensure that the national development/poverty reduction strategies include corruption diagnostics and mitigating strategies

To support sector efforts, performance indicators on corruption in the health sector should be integrated into national development or poverty reduction strategies and monitoring frameworks.[27] Given that high-level donor dialogue and progress monitoring is usually based on the objectives and indicators of these documents, they constitute an important opportunity to further political commitment at the highest levels of government as well as in the health sector to address the most "burning" corruption issues in the sector. As specific governance and anti-corruption commitments are usually reflected in a separate chapter, linkages between the two need to be established. This may come more "easily" if anti-corruption efforts in the health sector are linked with the national anti-corruption strategy. Sceptics may argue that a focus on these high-level policy instruments is unlikely to bring about change, but it is an opportunity not to be missed and strengthens ownership and alignment.

6.4. Use opportunities for targeted reforms or measures

While the ideal approach would be one of comprehensive reform, linking governance and corruption issues in the health sector to a national governance and corruption strategy, and mainstreaming those issues into a health sector development strategy, as explained above, health advisors should use opportunities for less ambitious approaches to address a specific corruption problem where opportunities arise. Also, Political Economy Analysis provides a useful basis to identify potential targeted "entry points" for donor engagement which may open the floor for more difficult and/or comprehensive reforms at a later stage.

6.5. Introduce a focus on corruption in health into government-donor dialogue

Government donor dialogue should include sector-wide agreements on priority issues related with corruption in the health sector. A few relevant benchmarks and measurable indicators should be agreed upon and tracked through regular high-level and technical working group level meetings. Terminology may matter and should be carefully analyzed.[28]

The aid delivery systems of donors may inadvertently foster opportunities for abuse and corrupt practices by adding to spending pressures or through insufficient transparency regarding its contributions to the sector. For instance the late release of funding close to the end of the financial year may provide the excuse for officials to bypass agreed procurement protocols and open up opportunities for abuse. Health partners need to examine the way they provide funding and the accountability it requires to ensure it does not open up opportunities for fraud or create deviation from agreed procedures. Donor-provided aid for the health sector, including money channelled through vertical programmes, should be planned for, provided and executed with utmost transparency, accountability and external oversight. Major donors, like DFID, are well placed to foster a supportive donor response to corruption in health due to its comparative advantages in donor coordination, health sector engagement and governance.

Examples on how to put this into practice include the use of UNCAC as a reference framework (see Box 1). Joint government and partner sector agreements (e.g. IHP country compacts, Health sector MoUs) can be used to secure information sharing, define accountability requirements and monitor anti-corruption measures. They can also set out in advance how donors will respond in case of

[27] Again, language may be critical. Where possible perceptions and experiences with corruption should be framed as such, while in more sensitive contexts the issues could be framed more carefully, e.g. as "development effectiveness". However, the latter contains the risk of loosing sight of the problem as it may be too abstract.

[28] In particular in high-level political dialogue, focusing on corruption as such may be too sensitive, or a positive goal like improving value for money or development effectiveness may be more desirable. However, it is important to ensure at a more technical level an evidence base on vulnerabilities to and actual levels of corruption.

corruption scandals or deterioration in governance. Experience is emerging that sustained pressure through a collective donor responses, combined with support for reform programmes, has the potential to improve accountability.[29] Discussions on external audits (both financial and performance) could be included as an agenda item in the annual joint health sector reviews. Annual comparisons of essential drug procurement prices with WHO published international drug price lists could be conducted and the analysis of major procurements, using fraud detection software, could identify potential patterns of corruption. Specific attention should be given to ensure civil society participation in government-partner dialogue both in providing evidence based monitoring results of health provider performance and to hold the latter to account.

6.6. Foster external monitoring and oversight

External oversight and monitoring is crucial for anti-corruption, transparency and accountability measures to be effective and sustainable. To date the non-government actors usually focus on either good governance / anti-corruption or specific sector work, including health. Thus, health civil society and professional organizations tend to focus on public health issues and professional ethics rather than governance. Although they monitor service delivery, sometimes including a corruption dimension (e.g. focused on informal payments or absenteeism), they usually do not monitor corruption from a broader governance perspective. On the other hand, CSOs focusing on transparency, accountability and corruption usually do not work in specific sectors.

There is a significant opportunity to facilitate cross-fertilisation and cooperation. Donors should foster the capacities of non-government actors to monitor and oversee anti-corruption efforts in the health sector. Support should be given to e.g. the demand-side of reform eg by providing financial and technical support to CSOs producing score cards on health service delivery and patient satisfaction surveys or facility boards to perform their oversight functions. In addition, Donors should strive to facilitate CSO participation in the development of health sector plans as well as in high-level and working group meetings to review progress of implementation.

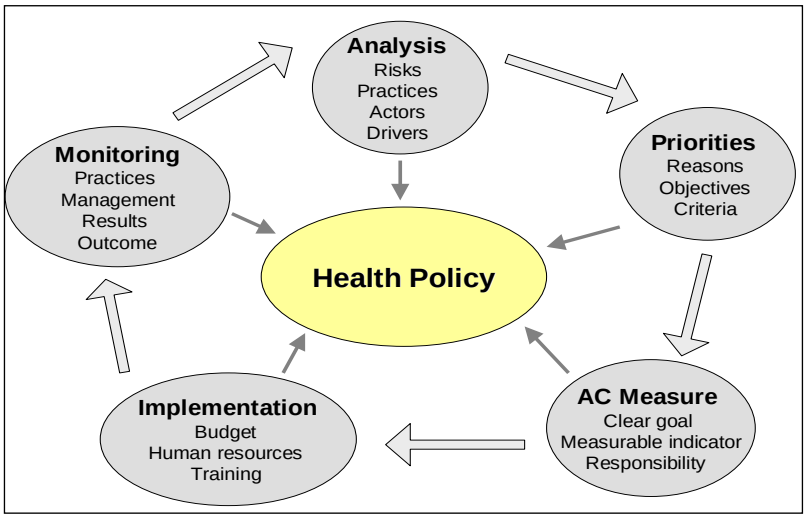
6.7. What is the right moment to initiate anti-corruption initiatives in health?

In the ideal scenario, a systematic anti-corruption initiative for the health sector would be started at the point when a new health policy or plan is developed and/or when a government committed to reform is at the beginning of the electoral cycle. However, action is possible throughout the life-time of a health sector plan.

Particular opportunities usually arise in the wake of a major scandal, or as part of a wider drive to improve value for money and development effectiveness. Opportunities may also arise for targeted initiatives to address specific problems or risk areas. The latter may be used to build the ground for a more systematic approach at a later point of time. What is most relevant, though, is that anti-corruption should ideally not be the result of an ad-hoc reaction. Efforts to address corruption tend to generate both high expectations of those affected and at times strong resistance by those who stand to lose. Both sides need to be managed carefully if the intervention is to be successful and sustainable. Box 2 and Figure 4 outline the main issues to consider when integrating anti-corruption efforts into the health sector:

[29] See OECD – DAC Anti-Corruption Task Team (2010), "Working towards more collective donor responses to corruption", www.oecd.org/dac/governance/corruption. Key factors to be considered include: i) prepare collectively in advance for responses; ii) follow the government lead where this exists, otherwise foster this lead, promote accountability, and co-ordinate donors; iii) agree in advance on a graduated response if performance stagnates or deteriorates; iv) act predictably in relation to other donors; encourage other donors to respond collectively to the extent possible, but allow flexibility for individual donors; v) maintain dialogue at different levels and focus on long-term development objectives; vi) foster accountability and transparency in country and internationally; vii) act internationally but link international action to anti-corruption work in partner countries.

Figure 5: Main steps to integrate anti-corruption efforts into a health policy



Source: Author

Advisers from any single agency cannot fight corruption alone and should promote a division of labour with other partners based on their comparative advantage, "historic" experience and willingness to engage. For example, the World Bank's expertise in Public Expenditure Tracking and financial management in health; WHO's tracking of regional pharmaceutical prices; and different country experiences from bilaterals. It is also useful for health partners to plan ahead and define who would do what if a corruption incident occurred.

6.8. Promote cooperation between health and governance teams / advisors within donor agencies

All agencies should promote and incentivize closer cooperation between its health and governance teams, in particular at the country level. Health advisors need to work closely with governance advisors to achieve interdisciplinary cooperation on the following:

- To analyse and understand the general context of corruption in the country;
- To support the development of political economy analysis for the health sector;
- To review the specific corruption vulnerabilities in the health sector and support the selection of priorities as well as the design of mitigating strategies;
- To build bridges with national anti-corruption policies, programmes, initiatives as well as with relevant broader governance reform issues;
- To establish linkages with efforts to address grand corruption, e.g. in regards to asset declaration and monitoring systems as well as to the scrutinizing of unusual or suspicious transfers of money of (senior) health officials. Also, "due diligence" checks of senior government officials with whom an agency signs financial agreements may be used.
- To identify "red flags". Health advisors should have the skills to spot and react appropriately to incidences of corruption in the sector.
- To contact the appropriate fraud unit if they suspect or know of any fraud, corrupt practice, theft or other misuse of agency funds, either via direct funding or where channelled through a third party. Information will be taken in confidence.

The health sector donor advisory cadre should interact with relevant governance / anti-corruption donor groups in order to mutually benefit from each other. Advisors can also draw on materials and expertise of the U4 anti-corruption resource centre. Additional information can also be accessed

through the Medicines Transparency Alliance, and the World Bank communities of practice tackling corruption in sectors.[30]

[30] See www.u4.no/themes/health and www.medicinestransparency.org. Also see for more links Section 9.

7. Relevant links

International Budget Partnership www.internationalbudget.org

MeTA (Medicines Transparency Alliance): www.medicinestransparency.org

Transparency International – Health Page: www.transparency.org/global_priorities/other_thematic_issues/health

U4 Anti-Corruption Ressource Centre: www.u4.no/themes/health

WBI Governance and Anti-Corruption: http://web.worldbank.org/WBSITE/EXTERNAL/WBI/WBIPROGRAMS/PSGLP/0,,contentMDK:20280417~menuPK:461615~pagePK:64156158~piPK:64152884~theSitePK:461606,00.html

WHO Good Governance in Medicines Programme: www.who.int/medicines/ggm/en/index.html

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9. Annexes

9.1. Annex I – Brief glossary of main types and forms of corruption

The main types of corruption (see Figure 1, Table 1) include the following:

Bribery: The offering, promising, giving, accepting or soliciting of an advantage as an inducement for action that is illegal, unethical or a breach of trust. Inducements can take the form of gifts, kickbacks, loans, fees, rewards or other valuables and advantages.

Collusion: A secret agreement between parties, in public and/or private sector, to conspire to commit actions aimed to deceive or commit fraud with the objective of illicit financial gain.

Extortion: Act of utilizing, directly or indirectly, one's access to a position of power to demand unmerited cooperation or compensation as a result of coercive threats**.**

Embezzlement: Act of dishonestly and illegally appropriating, using or trafficking the funds and goods office holders have been entrusted with for personal enrichment or other activities.

Fraud: Act of an office holder of intentionally deceiving someone in order to gain an unfair or illegal advantage (financial, political or otherwise).

Favouritism/nepotism: favourable treatment of friends and associates in the distribution of resources and positions, regardless of their objective qualifications and merit.[31]

Often used terms such as "grand/political" versus "administrative/petty" corruption, and "state capture" are used to describe different forms and levels of corruption. They usually do not occur in isolation, nor are there clear dividing lines. A distinction is helpful, however, because the drivers and motivations of the actors involved are often different and require different policy responses (see Figure 1).

So-called "*administrative*" or petty corruption involves lower-level bureaucrats who control access to public services such as health care delivery, demanding bribes or speed money before performing their public duties. Although considered by some policy makers as less serious, these "petty" sums constitute considerable shares of the income of the poor. It is also damaging to public morale and the legitimacy of the state.

Grand corruption, often also referred to as *political* corruption involves major embezzlement or exchange of resources such as bribes for advantages among elites at the highest levels of government and private industry. It is usually associated with procurement and investment decisions, large infrastructure or construction projects as well as position buying and selling. It is considered as serious due to its high economic impact and because leaders set a bad example eroding trust in government.

State capture: refers to the phenomenon when laws, policies or state institutions meant to benefit the public good have been "captured" (through bribes or opaque party funding, e.g.) by political and/or economic elites in order to foster political or personal economic interests. State capture can involve huge amounts of money or political influence and threats. It is considered serious as it affects the rules of the game, creating systemic inequalities.

9.2. Annex II - Main risks to corruption and selected mitigating strategies

In order to address corruption in the health sector effectively, it is crucial to identify and understand the problem within each context and to design appropriate counter measures. Selected strategies based on international experience are described below.

[31] Favouritism is the illegal preference given to any person while nepotism is the illegal preference given to a relative. Nepotism typically does not involve bribery, favouritism sometimes does, whereas purchasing of posts always does.

II. A. Service user level – informal payments where services should be free

Problems

Informal payments are charges for health services or supplies meant to be provided free of charge, or that are paid informally to public health care providers to obtain specific favors or even basic services. Types of informal payments include but are not restricted to fees for treatment, drugs, expedited or extra services, and as an insurance to receive better care in the future from physicians, nurses, and other health workers. It is often difficult to disentangle the specific types of informal payment and establish whether or not it is corruption. There is often a continuum of gravity ranging from gift, to nuisance, to obstacle, to extortion or bribes.

Informal payments are sometimes argued to be a coping strategy used by health workers to deal with low pay. However, the frequency of informal payments in the health sector offers an important indicator of underlying governance failures because it means fraudulent behaviour is being tolerated, controls are weak and ineffective, patients are not sure about their rights, and accountability is not enforced. When the probability of being detected and penalized is very low, as is the case in many developing and transition countries, informal payments tend to be more widespread.

Mitigating strategies

The design of mitigating strategies needs to take into account intentions, e.g. are informal payments seen as a voluntary contribution by patients to cover the cost of service or as an abuse of power by the provider? Responses need to be tailored to this analysis. Measures to address the problem include:

Formalizing user fees: replacing informal payments with a formal fee schedule may be a solution. Payments should be transparent and monitored and the money should stay in the health sector with decentralized retention of revenue to supplement salaries and increase quality of care which may also lead to greater patient satisfaction and overall use of services. Such policies require exemptions or subsidies to accommodate the poor. These are best accomplished through some form of sliding scale, and most countries have adopted some form of means test for patients. (Strategies to prevent the stealing of formal user fees are discussed below).

Increase provider / health worker remuneration: since informal payments for some health workers may constitute a significant share of their income, the removal of informal payments needs to be compensated by higher salaries. Linking bonuses to performance can also motivate staff to provide better care.

Increase transparency and accountability: clear policies, patient information and channels for complaints can help to reduce informal payments. This includes making patients aware of the official fee schedule, giving them information so they can evaluate how adequately staff are paid, telling patients what resources are available through the government and how they can ask questions or report concerns. Facility governance structures such as hospital boards can also increase accountability and deter abuse. Formal user fee revenues tend to benefit from fiduciary and citizen oversight and contribute to health service provision.

A combination of strategies may be an appropriate approach to address informal payments with an eye to ensuring equitable access to quality care by the poor.

II.B. Health provider level – procurement, fraud and absenteeism

II.B.1 Procurement & fraud

Problems

Hospital-based expenditures and procurement of drugs and supplies account for a large share of public health expenditures. Drug procurement can account for as much as 40-60% of hospital expenditure in low-income countries, whereas in high income countries it amounts to 5-10%. Not surprisingly, drug procurement in hospitals is susceptible to a wide range of scams, kickbacks and delivery of substandard or expired products, which in poorer countries can lead to death. Also, vulnerabilities to

corruption in equipment procurement enhance as the complexity of equipment increases. The health sector has less competencies in this area and asymmetry of information is high especially with regard to new technologies.

A major type of corruption in hospitals involves the collusion between public officials and suppliers. Accountants and purchasing clerks may collude with suppliers to make a deliberate overpayment for an order. The amount of the overpayment is then refunded by the supplier company to the account of the public official as a kickback. The contracting of venues for trainings or other services that are later cancelled but still paid for is another avenue for corruption. The amount paid is transferred back to the account of public official(s) while the supplier company may withhold a share as its "commission". Corruption within facilities leads to overpayment of suppliers, while the lack of sanctions and the low probability of getting caught makes it possible. In short, the lack of enforced rules, procedures, and accountability allows irregularities in purchasing practices.

Another area susceptible to systematic fraud and theft are formal user fees. While fee revenue generally comprises less than 10% of total hospital expenditures it can be an important source of local funding for essential supplies and salary supplements. Types of fraud and theft include pocketing the fees without recording the transaction, using a "refund" account through which the user fee is refunded to a fictitious patient while the money is transferred to the public official's bank account; and alteration of receipts after the service is rendered and paid.

Mitigating strategies

Improvements in administrative and financial systems can deter employees from attempting these types of fraud. These procedures are generally part of an organization's internal control system. In addition, specific attention should be paid to procurement procedures and control.

Strengthening internal control systems: increasing organizational and human resource capacity in internal and external audit services often is crucial. This could require investments in additional staff to provide these services, the purchase of equipment such as electronic cash registers or the introduction of new management procedures such as spreadsheet analysis of utilization and user fee income variation over time. Further, the segregation of duties, in particular in the areas of financial management and procurement can help to control fraud.

Procurement and information technology (IT): the use of IT tools, including procurement databases, to regularly monitor prices of common goods help to increase transparency to tackle procurement and other types of fraud. By holding purchasing managers accountable if prices substantially differ from those of other hospitals or benchmark prices, procurement fraud can be discouraged. But benefits must be sustained by complementing moral dissuasion with tangible sanctions. Also the use of fraud detection software is useful and helps to study patterns of corruption and collusion.

Increased transparency and accountability: in addition to audits and information technology, detection of fraud requires mechanisms for beneficiaries and employees to raise concerns without fear of retaliation. Complaint boxes, community awareness raising, hotlines and other mechanisms can be applied.

Strengthening of competencies for equipment procurement: equipment audits as well as the inclusion and monitoring of annual maintenance contracts are useful tools.

Health advisors should consult experts in financial control and procurement to review gaps and design specific interventions. Investments in fraud control need to be considered in decision-making, planning and budgeting, bearing in mind that often relatively small investments into technology can generate great benefits.

II.B.2 Absenteeism

Problem

Absenteeism is a chronic although often unmeasured problem in health systems in developing and transition countries. Health worker absenteeism can be defined as unauthorized absences by health workers during contracted hours. Absenteeism occurs for various reasons, some of which are

legitimate, i.e. rural health workers may need to travel to larger towns to receive their pay-check, or to fetch supplies and drugs. However, many health workers are absent without authorization, and in effect receive wages without providing even minimal services. Civil servants with high job security and who feel underpaid or overworked may have little incentive to abide by the rules when supervision is limited.

Mitigating strategies

Many performance problems, including absenteeism, stem from weak governance systems that fail to reward good performance and discipline workers who under-perform. Approaches to address absenteeism include:

Effective incentives: Financial incentives matter but are not the sole solution. A first step should include an assessment on whether health sector wages are actually low relative to comparable private sector wages, which may not always be the case. Also, financial incentives in an environment of impunity will fall short of expectations. They have to be accompanied by a combination of accountability mechanisms and/or non-financial incentives such as career development opportunities, a good work environment, and availability of resources and equipment. Housing and transport may also be important motivating factors.

Frequent inspections and peer supervision: unannounced onsite visits and community monitoring of health worker presence at the facility level may help to reduce absenteeism. However, context specific design of these measures in a given cultural context and regular close monitoring of effectiveness and potential undesired results is crucial.

Sanctions against workers who are absent without authorization: increasing the perceived probability of detection and punishment/penalties can lower absenteeism sanctions can include reductions in salary, dismissal, transfer to other locations and public shaming by publicizing attendance lists at facility level.

Hiring contract health workers: Health workers who have "permanent" contracts (civil servants) and enjoy significant job security may have higher absentee rates than "contracted" health workers who can be terminated, highlighting the importance of accountability for reducing absenteeism and raising performance. Local control (e.g. by health or hospital boards or communities) and renewable contracts may reduce absenteeism and improve health services.

Providing information to the communities: simply informing the community of their rights to health care services, and the level of service that the government has contracted to provide (e.g., a set number and schedule of office hours per week) can have a significant impact on actual utilization of services, with a corresponding improvement of health care outcomes. This may need to be combined with an effective complaints handling mechanism to ensure that providers who fail to deliver the expected results are held accountable.

II.C. Health payer level – financial and human resource management, drug supply

II.C.1. Financial management (embezzlement, fraud, procurement, etc.).

Problems

Without funding public health care services grind to a halt. Allocated resources for health flow through various layers of national and local government institutions on their way to the health facilities. 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, organizational deficiencies and lax fiscal controls over the flow of public funds (Table 2).

In addition, before even getting to funding flows, there are risks for abuse in deciding how funds are allocated and spent. Health personnel may be told there is „no money in the budget" for a specific need when in fact the money is there but a corrupt officer wants to divert it to a pet project or favorite staff member's department, instead of intended use. A causal factor is that medical staff often don't

think that finance is „their job"—but this leaves the decisions vulnerable to abuse by administrative staff who may not understand the goals of health sector.

Budget leakages, meaning the discrepancy between the authorized budget for health and the amount of funds received by intended recipients, may occur at multiple points in the health system. For example, funds at central level may be diverted before they get to the province, funds meant for use at the provincial level may be embezzled by staff at this level, or a cascade of outflows can create leakages across multiple levels. Budget leakages can take different forms, including the diversion of public funds into private accounts, mismanagement and corruption in procurement, and payroll irregularities associated with ghost workers (those listed on payroll but who no longer or never did work for the Ministry of Health or a lower level of government).

Countries with weak institutions and endemic levels of corruption face serious challenges in the procurement of medical supplies, drugs (see problems in drug supply chain below), equipment and facility construction. The absence of a clearly regulated procurement process, incentives for performance, accountability, adequate monitoring and oversight, and controls, can lead to last-minute changes to contract provisions; the alteration of contract specifications skewed towards a certain bidder; and the influencing of negotiations through kickbacks.

Table 3: Overview of vulnerabilities to public financial management relevant to health

Area of public financial management	Vulnerabilities
Budget planning and execution	• Decisions on how resources are allocated and spent • Transfers among line items of budgets • Absence or weakness in internal audit, external audit • Absence of management mandates for and review of regular financial reports • Lack of budget monitoring
Employee compensation	• Absence of clear rules on hiring • Absence of management controls, internal controls • Absence of treasury payroll matching • Absence of records, weak record keeping
Goods and services	• Absence of non-payroll expenditure controls • Absence of inventory control, asset registry • Weak procurement system • Absence of management oversight and review of payment and procurement practices
Transfers	• Cash or in-kind transfers • Weak or no record keeping • Absence of clear procedures for processing applicants • Failure to follow procedures • Absence of clear laws, regulations, rules for eligibility, criteria
Capital expenditures	• Absence of non-payroll expenditure controls • Absence of management oversight and review of payment and procurement practices • Weak procurement system

Source: Adapted from Lewis, M. and Pettersson, G. (2009): "Governance in Health Care Delivery: Raising Performance" (October 1, 2009). World Bank Policy Research Working Paper No. 5074.

An added complication in health is that it sometimes has sizable off-budget accounts. Donor funds are the most important external resource in many developing countries, particularly in Africa. Despite the trend for pooled funding, a considerable share of donor funds continues to be channelled off-budget through international and non-governmental organisations.[32] 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. Often these funds are placed outside the review of regular budget allocation, discipline and oversight processes.

Mitigating strategies

Addressing corruption risks in the financial management system of the health sector requires a combination of measures and collaboration with institutions across government, including first and foremost the Ministry of Finance.[33] Public financial management reforms are often led by MOF staff, but health personnel must also "own" these reforms to be sure they are fully implemented in the health sector . This may require changes in how health leaders see their own jobs: not only as medical personnel focused on health interventions, but also as managers and stewards of resources. Some examples of specific mitigating strategies are highlighted:

Public Expenditure and Financial Accountability (PEFA) indicators: these indicators are useful to identify where in the budget process governance problems exist. For example, a low score on availability of information on resources received by service delivery units suggests some combination of inadequate transparency, poor recordkeeping, low budget management capacity, and insufficient accountability. PEFA indicators can be helpful in pinpointing and prioritizing areas where action is needed to strengthen budget processes and help bolster good governance in PFM.

Table 4: PEFA indicators relevant to health

Predictability and control in budget execution	**Budget credibility**	**Budget comprehensiveness and transparency**
• Predictability in the availability of funds for commitment of expenditures • Recording and management of cash balances, debt and guarantees • Effectiveness of payroll controls • Competition, value for money and controls in procurement • Effectiveness of internal controls for non-salary expenditure • Effectiveness of internal audit	• Aggregate expenditure outturn compared to original approved budget • Composition of expenditure outturn compared to original approved budget	• Transparency of inter-governmental fiscal relations • Public access to key fiscal information
Policy-based budgeting	**Accounting, recording &reporting**	**External scrutiny and audit**
• Orderliness and participation in the annual budget process	• Availability of information on resources received by service delivery units	• Scope, nature and follow-up of external audit

Source: Lewis, M. and Pettersson, G. (2009): "Governance in Health Care Delivery: Raising Performance" (October 1, 2009). World Bank Policy Research Working Paper No. 5074.

[32] 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.

[33] Regrettably, one cannot assume that the MOF is, itself, free of corrupt practices. It is not uncommon, for example, for MOF staff to require unauthorized payments in exchange for the release of budgeted funds. Health advisors should explore and discuss these issues with their colleagues and peers of the governance teams.

Tracking resource flows: Measuring resource leakages and efficacy of public spending is important to detect problems. Public Expenditure Tracking Surveys (PETS), Public Expenditure Reviews (PERs), Quantitative Service Delivery Surveys, and Price Comparisons can identify places where funds are not reaching beneficiaries or are being used for non- intended purposes. They complement PEFA evidence about government-wide performance, offering an important diagnostic on budget management and leakages. It is critical to pair this kind of diagnostic with other interventions which build demand for reforms in budget management, putting pressure on public systems to improve.

Improved budgeting and accounting systems: health systems require a legal and institutional framework that provides clear accounting and procurement standards based on transparency, comprehensiveness and timeliness. They should have effective reporting, supervision and auditing systems to improve fiscal oversight and ensure effective enforcement of rules and sanctions for financial misconduct. But note, that there may be resistance from those benefiting from the risks to corruption in the system.[34]

Increasing internal transparency: ensures that information and data are recorded accurately and on a regular basis, and that they are available to decision makers on demand, and that decision makers feel confident in how to read and analyze reports. Inputs needed to increase transparency include better information management systems (accuracy, timeliness, and distribution of financial information), training of staff in their application and use, sensitization of stakeholders in how to use information for accountability, and, crucially, the introduction of incentives for regular data collection, maintenance, and use.

Strengthening external audits: Audits can detect financial irregularities and provide information on means to rectify problems. To help minimize the time and cost of audits, health and finance ministries can simplify records and streamline procedures. Local capacity for audit in many countries is very poor. Capacity strengthening for private sector firms, even firms affiliated with international accounting agencies, is needed. Additionally, health advisors need to develop clear scopes of work for performance audits which can detect fraud by actually verifying that suppliers exist, purchased equipment is working, etc. Too many times, audits are designed to test for rule following only, and auditors do not have the special skills required to detect problems such as ghost suppliers, faked invoices, or collusion.

Using e-procurement to improve efficiency and discourage corruption: Electronic government procurement (e-GP) can increase transparency and accountability in health procurement thereby improving resource management and reducing opportunities for fraud, ultimately, leading to lower prices.[35] Also, procurement databases are useful for price comparisons and the introduction of fraud detection software helps to identify collusion or red flags where normal audits fail to provide adequate insight into the patterns.

Budget transparency and participation: Civil society must also be enabled to take part in the budget process, both in formulating budgets and monitoring their use. 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.[36] The

[34] 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. See U4, 2008.

[35] One example of e-GP in health procurement is Chile, which created an electronic bidding system to oversee pharmaceutical procurement and used the internet for information dissemination at all stages of the procurement process. The system helped reduce collusion by ensuring a competitive bidding process, which reduced the incentives for corruption, and by making drug prices transparent to all bidders and purchasers resulting in cost savings (Lewis & Petterssen, 2009).

[36] Successful initiatives to expand participatory budgeting have been documented in Ireland; Porto Alegre, Brazil; and South Africa. Also, the effects of corruption on public health spending have been found to be mediated by social accountability in

government capacity as auditor and supervisor in weak institutional environments is very limited. Involving community organizations, professional associations, and other non-governmental bodies through dissemination of information will help monitor and challenge abuses and combat the culture of impunity.

II.C.2. Personnel management (ghost workers, purchase of positions and promotions)

Problems

The public sector health workforce represents the largest single group of civil servants in most countries, and as a result, the health sector claims a significant proportion of national budgets. When hired and paid by central level Ministry of Health but assigned to health facilities locally, health workers' lines of reporting and accountability become opaque as does managerial authority. In addition, management information on even simple things such as attendance are often lacking. In such a situation of minimal information, conflicting incentives and weak accountability, there are risks of abuse and corruption.

Payroll irregularities, in particular the existence of ghost workers constitute one serious problem. The main underlying problem is often a weak personnel information system, which failed to accurately record and regularly update health staff deployment. However, ghost workers on payroll are unlikely to be an operation by health workers alone (they may not be involved at all) rather, administrative staff in charge of maintaining payroll records may have greater opportunity to manipulate records to siphon off wage payments.

The hiring and promotion processes of health workers and health sector administrative staff constitute another significant area of risks. Bribes can play a key part in the selection process.[37] In some countries, physician and other posts can be "bought" from health facility committees, board members or ministerial staff. As a consequence, the recruitment and selection processes of health workers and also administrative staff are influenced by the ability and willingness to pay for positions rather than objective criteria. At the service delivery level, this may lead to newly hired health workers requiring fees from patients to recover their "investment" in the position. Within the health sector administration this may lead to administrators engaging in fraud and embezzlement to regain their initial payment.

Mitigating strategies

Payroll cleanup and management: Regular updating of employee lists and payroll commitments is a basic management tool and is a high priority for health systems, which have large numbers of employees. Physical verification at points of payment can be carried out. A less costly method is to have auditors carry out spot checks at health facilities to verify that workers on payroll actually exist.

Transparent recruitment, assignment, and promotion systems: Recruitment, assignment, and promotion procedures based on clear rules and criteria known to all relevant parties tend to reduce the scope for fraudulent practices. Hiring and promotion by selection committees is preferable to actions of a single administrator since it limits discretion, and improves credibility if they are transparent. Moldova implemented such a system in 2007, requiring all existing directors of facilities to re-apply for their jobs. However, it must be noted that promoting transparency and merit in recruitment, assignment, and promotions is often politically and administratively difficult. Also, in some countries the hiring and promotion of health staff may be part of a patronage system of corruption which is more difficult to break through than to address individual abuses.

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across-country study including 64 countries (U4, 2008). For more information on civil society participation in the budget process, see The International Budget Partnership website: http://www.internationalbudget.org

[37] The share of public officials who reported job purchasing in health as common or very common ranged from 9 percent in Benin and 14 percent in Indonesia to 25 percent in Ghana, and up to 50 percent in Zambia (Lewis, 2009). And in Bosnia and Herzegovina, 75 percent of officials and citizens reported that bribes were required to obtain positions and be promoted in the health sector. Interviews with health workers in Cambodia hint at the magnitude of illegal payments for public positions, with higher positions fetching higher prices. A director post at the Ministry of Health's national and provincial offices reportedly cost close to US$100,000, whereas lower level positions cost around US$3,000 (TI, 2006).

Using the private sector to speed up recruitment and deployment: Where public recruitment systems function poorly the private sector for recruitment can sometimes provide a faster and more effective alternative. Under the guidance and supervision of the relevant public sector institutions (Ministries of Health, Finance and others) a public company may be hired to recruit, deploy, pay, and manage through an agreed fast-track hiring system the contracts of newly recruited health workers later to be transferred to government payroll.[38]

II.C.3. Drug supply: procurement and distribution

Problems

In order to ensure drug safety and an efficient allocation of resources the very lucrative pharmaceutical sector is under government regulation at nearly every stage of the life cycle of medical products. Although this regulation should improve efficiency it also opens up for corruption at any stage of the regulatory process, i.e. during a) manufacturing; b) registration of medicines and pharmacies, c) drug selection, d) procurement, e) distribution and f) prescription and dispensing. The supply chain is extremely complex – sometimes including more than 30 parties – before the product reaches the users.

Table 5: Key risks and counter-strategies to corruption in the drug supply (value) chain

Decision points	Processes	Counter strategies
Manufacturing	• Adherence to Good Manufacturing Practices (GMP) • Quality management • Labelling • Production and in-process controls • Validation	• Regular and random inspections of GMP • Provide, train and rotate well-paid inspectors • Publicly post list of compliant manufacturers • Publicly name and shame non-compliant manufacturers.
Registration	• Full or abbreviated registration • Safety and efficacy • Labelling • Marketing • Re-evaluation	• Transparent and uniform laws and standards for drug registration • Ensure drug quality control capacity • Publish drug registration information • Market surveillance and random batch testing
Selection	• Determination of budget • Assessment of morbidity profile • Determination of drugs needs • Cost-benefit analysis of drugs • Consistency with WHO and other evidence based criteria • Pricing and reimbursement decisions	• Publish clear criteria for selection and pricing based on WHO international standards • Publicly available drug selection committee membership • Regular reporting of drug selection meetings • Publicly post results obtained and decisions made
Procurement	• Determination of supply / distribution model • Reconciliation of needs and resources	• Transparent and published procedures as well as explicit criteria for contract awards • Justify and monitor supplier selection

[38] In Kenya, it took 1-2 years in 2008 to fill open public sector positions in the health sector despite the existence of a large pool of unemployed health workers. To address this problem a group including the MOH, the MOE, and the MOF, was created to put together a fast-track hiring and deployment model. Deloitte & Touche Kenya was hired to recruit, deploy, pay, and manage the contracts of 830 recruited health workers later to be transferred to government payroll. Under this arrangement the recruitment process was reduced to less than three months, and, reportedly, retention and satisfaction of workers improved due to timely payment of wages and job orientation programs (Adano 2008). Whether a scaling up of this type of arrangement would be feasible in all settings is not clear but holds promise (Lewis & Pettersson, 2009).

	• Developing criteria for tender • Issue tender • Evaluate tender • Award supplier • Monitor order • Quality assurance	• Adhesion to dates and keeping of records • Make results on adjudication available to all bidders and public • Regular reporting on key procurement performance indicators
Distribution	• Import approvals • Reception and check of drugs with order • Appropriate transportation & storage • Distribution practices & inventory control • Demand monitoring	• Information systems on drug allocation, transport and storage • Regular communication for inventory control • Monitor stock in distribution electronically and check delivery orders against inventories •
Prescribing & dispensing	• Impatient and outpatient care • Dispensing of pharmaceuticals • Adverse drug reaction monitoring	• Adherence to codes of conduct through professional associations • Penalties and naming and shaming for breaches of legal and ethical standards • Regulate industry interaction with prescribers

Source: adapted from Cohen, J.C. et al (2007): "Corruption and pharmaceuticals: strengthening good governance to improve access". In: The Many Faces of Corruption; World Bank, 2007.

Mitigating strategies

Reducing discretion and increasing transparency and accountability are particularly relevant in the drug sector, as otherwise regulators can easily be captured and the decision points and processes of the drug supply chain are open to individual abuse of norms and corruption in general. A systems approach is needed. Particularly relevant elements of corruption risk mitigating strategies include the following:

WHO Good Governance for Medicines (GGM) [39] *programme*: The program helps to foster transparency and create clear administrative procedures for the procurement of drugs. In addition the programme works to promote the ethical conduct of health workers. In 2007, nineteen countries had taken on the Good Governance for Medicines. Most have not gone beyond Phase I so far, which is the assessment of transparency to identify specific gaps. However, evidence on positive results is emerging, such as in Thailand.[40]

Medicine for Transparency Alliance (MeTA)[41]: this multi-stakeholder process started in 2008 and is supported by DFID, WHO and World Bank. It aims at increasing access to medicines by creating transparency in all steps of the procurement of medicines. It brings together actors from the government, the pharmaceutical industry and the civil society and discloses 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 (see GGM above). Currently seven

[39] See http://www.who.int/medicines/ggm/en/index.html (accessed 13th August 2010)

[40] See for example the experience of a joint Thailand WHO programme tackling corruption in the pharmaceutical sector and reducing the prices of medicines, http://www.who.int/features/2010/medicines_thailand/en/index.html (accessed 13th August 2010).

[41] See http://www.medicinestransparency.org and http://www.dfidhealthrc.org/MeTA/index.html (accessed 13th August 2010).

countries have signed up to MeTA: Ghana, Uganda, Zambia, the Philippines, Peru, Kyrgyzstan and Jordan.

Independent drug regulation agency: the establishment or strengthening of an independent drug regulation agency, as recommended by the WHO, needs to be accompanied by a strong legal basis that ensures transparency as well as uniform and effective application of the defined standards. Many drug regulatory agencies are under staffed and lack technology. Others could use help in leadership development, strategic planning, and management systems. Where financial resources are limited and a full drug laboratory, e.g., is not available, reliance on drugs that have gone through the WHO prequalification process could be considered.

Strengthening of drug management systems. Investments in greater security and control in warehousing and distribution of drugs can prevent theft. Commercial best practice shows that there are logistics management techniques that can safeguard stock. In South Africa, Pharmaceutical Healthcare Distributors has reduced stock loss to less than 0.1% (from around 22%)[42], providing evidence that investment in preventing diversion can save valuable commodities. This type of approach is often funded as a health systems strengthening activity, but it has obvious benefits for controlling corruption as well.

Information technology: use of information technology can increase transparency and accountability. The establishment of online drug price catalogues; the publication of tenders, adjudication decisions and monitoring results on the internet; the use of e-procurement tools for drugs and medical supplies offer concrete examples[43]. The discloser(s) of information need to be committed and trained, the accuracy of the information needs to be ensured, and the recipient(s) of the information need to be empowered to use the information for monitoring and advocacy purposes.

Transparency and accountability in the decision making processes: opening up the different decision-making processes for participation of stakeholders, active disclosure of information to interested parties, and holding the actors involved accountable for their decisions and results, including through public naming and shaming, are key elements to prevent and control corruption in the drug supply chain.

Self-regulation of the pharmaceutical industry and professional associations: the pharmaceutical industry is concerned about mitigating against reputation risks, in particular by preventing infiltration of counterfeit drugs. And while the health professions enjoy a high degree of discretionary power they are also usually characterized by high professional ethical standards. Hence, the adherence to and effective enforcement of codes of conduct of the pharmaceutical industry (e.g. International Federation of Pharmaceutical Manufacturers Associations) as well as of medical professional associations (e.g. through the World Medical Association's International Code of Medical Ethics) should be promoted.

[42] U4 Brief No 4 (2006), "Anti-corruption in the health sector: Preventing drug diversion through supply chain management", www.u4.no.

[43] See WHO Global Price Monitoring Mechanism www.who.int/hiv/amds/gprm/en (accessed 13th August 2010).

9.3. Annex III - Main tools to identify, track, measure corruption

Political economy analysis: an assessment of how powerful the individual players are and what motivates them to behave as they do, is useful to map two key aspects of each player: (a) the level of power and influence they can exert; and (b) the extent to which they would favor or resist the reforms needed to achieve better development outcomes. That map provides critical information for the design of effective reform strategies, including efforts to empower those who would favor reforms (the often silent majority of patients and conscientious health care providers) and to exert pressure on those with power to be more accommodating of the reform effort. In addition to identifying potential entry points for changing the governance equilibrium, it also provides a reality check on the feasibility of achieving meaningful reforms in the first place.

Vulnerability to corruption assessments: the purpose of such assessments is to identify the main risks to different forms of corrupt practices, either in the health sector as a whole or in specific areas. The methodologies applied usually analyze laws, rules and procedures, and conduct interviews or focus group discussions to learn stakeholders' opinions. One weakness in this approach is that many assessments do not pay sufficient attention to the analysis of stakeholder interests and possible "winners" and "losers" of reform measures. This additional analysis would provide needed perspective for policy development.

Value chain analysis: this method consists in identifying corruption risks in each step of a program cycle or service delivery chain. It consists in establishing a road map of useful warning signals throughout the implementation process. By focussing on analyzing the obstacles to deliver results (e.g. drugs to patients or funding to the health facilities) it provides for a helpful management and policy tool. It also helps to identify key vulnerabilities and prioritize potential solutions. One of these tools is the assessment method used by MeTA which with the support of the WHO, WB and DFID assigns scores to each area of the drug supply chain under assessment (see GGM initiative mentioned above).

Family Tree Analysis: A highly informative but highly sensitive analysis that can accompany the value chain analysis is the "Family Tree" that portrays the major and intermediate players in the sector, politicians, public servants, local and foreign business people, foreign diplomats and members of their families. It can include the instances where politicians and public servants, or members of their families, are owners or members of the boards of directors of firms in the sector. More generally it can be put together to portray all actual or potential conflicts of interest in the sector. An example is on pp 48 & 49 of *Cambodia's Family Trees* (2007) by Global Witness.

Sectoral accountability assessment: this is a systems approach looking at the accountability relations between the many different actors involved in the regulation, policy making, the delivery of services and oversight of the health sector. By determining who is to be held accountable for what service delivery functions by whom and how, it is possible to determine whether there are any capacity gaps in the accountability mechanisms for the health sector. An assessment includes a review of horizontal (between governing institutions to check abuses by other public agencies and branches of government or the requirement for public agencies to report hierarchically) and vertical accountability (citizens, media, civil society and other non-state actors hold their representatives to account and enforce standards of good performance on officials). UNDP has applied this method in Mongolia and intends to apply it elsewhere in Asia[44]. This may be a interesting tool to complement the afore mentioned vulnerability to corruption assessments.

Analysis of governance in health care systems: the analytical framework developed by the World Bank provides a tool to analyze good governance in the health sector in order to raise performance and to address corruption.[45] Performance indicators that offer the potential for tracking relative health performance are proposed, and provide the framework for the analysis of good governance

[44] For more details contact UNDP Regional Centre in Bangkok. www.regionalcentre**bangkok**.**undp**.or.th

[45] For more detail see Lewis, M. and Pettersson, G. (2009): "Governance in Health Care Delivery: Raising Performance" (October 1, 2009). World Bank Policy Research Working Paper No. 5074.

in health service delivery in the areas of budget and resource management, individual provider performance, health facility performance, informal payments, and corruption perceptions.

Public expenditure indicators and tracking surveys: As indicated before, the Public Expenditure and Financial Accountability (PEFA) indicators are useful to identify budget process governance problems, while Public Expenditure Tracking Surveys (PETS), Public Expenditure Reviews (PERs), Quantitative Service Delivery Surveys, and Price Comparisons help to identify leakages, inefficiencies, and areas for reform.

Corruption perception indices: the most well known world wide corruption perception surveys are the Governance Indicators of the World Bank (including Voice & Accountability, Governance Effectiveness, Regulatory Control, Rule of Law and Corruption Control) and the Transparency International Corruption Perception Index. [46] In addition, in many countries national level corruption perception surveys have been produced, including those supported by the World Bank and more often those produced by national civil society organisations. Many of these surveys will have some useful information on corruption in the health sector as they often put specific focus on service delivery in social sectors. It should be noted that corruption perception surveys should ideally be complemented by other tools, such as experience based surveys and focus group discussion. Health advisors should contact governance advisors to see if general data on corruption are available in particular countries.

Experience based surveys (often with some data on perceptions as well): as opposed to perception based surveys, these tools ask respondents about their actual experience (or that of a household member or close relative) with corruption in a certain period of time, often during the year prior to data collection. In a variety of countries significant differences between the levels of perceived and experienced corruption can be observed, with the levels of the former usually being higher than those of the latter. The best known international or regional instruments include the AfroBarometer, the LatinBarometer, the EuroBarometer, Transparency International's annual Global Corruption Barometer.[47] Another approach to capture experiences with and perceptions of health sector institutions is patient satisfaction surveys at exit. Moldova, e.g., has implemented an annual survey of patient satisfaction which includes several questions related to corruption (informal payments).

Focus group based qualitative studies: as argued above, for the design and monitoring of anti-corruption measures it is crucial to analyze local attitudes towards and understanding of corruption. Focus group or interview-based qualitative studies are a useful tool for this purpose.[48] As societies and their underlying norms and principles change, patterns and perceptions of corruption also change. Hence, such surveys/studies should be repeated from time to time.

[46] For the World Bank Governance Indicators see http://info.worldbank.org/governance/wgi/index.asp, for Transparency Internation Corruption Perception Index see http://www.transparency.org/policy_research/surveys_indices/cpi/2009.

[47] For the AfroBarometer see www.afrobarometer.org/surveys.html, for the LatinBarometer see www.latinobarometro.org, for the Euobarometer see www.ec.europa.eu/public_opinion/archives/ebs/ebs_245_sum_en.pdf, and for Transparency International's Global Corruption Barometer see http://www.transparency.org/policy_research/surveys_indices/gcb.

[48] For example see Gardizi, M. (2007), "Afghans' Experiences of Corruption: A Study Across Seven Provinces", for Integrity Watch Afghanistan, Kabul.

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Abstract

The development community is striving to achieve results and value for money with its investments in health around the world. Yet, donors often work in countries where the risk of corruption is high and where public management and oversight systems are weak. In many countries, international assistance has strengthened accountability bodies such as anti-corruption commissions and the Office of the Auditor General. As the capacity of these bodies increases, so does the likelihood of corruption being uncovered at the sector level. Sector advisers need the knowledge and skills to prevent, detect and address corruption in their sectors.

The main purpose of this U4 Issue is to increase awareness around corruption in the health sector and provide practical guidance on how to identify and prevent it. Specifically it will:

- explain what corruption is and the different forms it can take in the health sector;
- identify vulnerabilities to corruption and mitigating strategies;
- present instruments to identify and track corruption in health;
- suggest ways to integrate anti-corruption approaches into health sector programmes.

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