Transparency and Accountability in Local Governments (TRAALOG)

UNDP Regional Centre Panama

VULNERABILITIES TO CORRUPTION IN THE HEALTH SECTOR:

PERSPECTIVES FROM LATIN AMERICAN SUB-SYSTEMS FOR THE POOR (WITH A SPECIAL FOCUS ON THE SUB-NATIONAL LEVEL)

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Presentation

The **Transparency and Accountability in Local Governments** (TRAALOG) regional initiative started in April 2010. The TRAALOG has been supported by the Democratic Governance Thematic Trust Fund (DGTTF), the Global Thematic Programme on Anti-Corruption for Development Effectiveness (PACDE), and the United Nations Development Progamme (UNDP) Spanish Trust Fund. The TRAALOG is an initiative of the UNDP Democratic Governance Practice Area of the Regional Bureau for Latin America and the Caribbean (RBLAC), and is implemented from the UNDP Regional Centre for Latin America and the Caribbean in Panama.

The TRAALOG targets small initiatives at the local level that can be scaled up through policy support and capacity development and partnerships. One of the key activities of TRAALOG is to promote the development and systematization of knowledge products and tools, focusing on specific initiatives aimed at increasing transparency and accountability, as well as to mainstream anti-corruption issues into other areas, such as access to information, ethics, climate change, health, Millennium Development Objectives and social audit. The idea is for these knowledge products to serve as means, to generate interest and discussion among UNDP Country Offices in and outside the region, regional service centers and other units of UNDP and the wider United Nations System, as well as development and democratic governance practitioners.

Similarly, it is hoped that these knowledge products could serve as reference in pursuing initiatives and in seeking opportunities for replication. These can also be used to develop and support projects and programs, as well as regional activities. These knowledge products are the result of partnerships with a number of UNDP Country Offices, donors, consultants and associate experts, academic institutions and civil society organizations. All helped to identify experiences that provide valuable practical information relative to improving democratic governance and increasing transparency and accountability.

These knowledge products are not meant to be prescriptive. Rather, their aim is to:

- Provide examples of transparency and accountability activities;
- Generate discussion and policy dialogue;
- Illustrate practices;
- Present tools, methodologies, approaches and frameworks;
- Highlight case studies;
- Direct readers to additional resources.

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Acronyms

ATI	Accountability, Transparency and Integrity
CCSS	Costa Rican Social Security System (*Caja Costarricense de Seguridad Social*)
CO	Country Office
CSO	Civil Society Organization
CRES	Health Regulatory Commission (Acronym in Spanish of *Comisión Reguladora de Salud*)
DFID	Department of International Development, UK
EPS and EPS-S	Health Insurance Companies (Acronym in Spanish of *Entidades Promotoras de Salud*)
FOSYGA	National Health Fund Colombia (Acronym in Spanish of *Fondo de Solidaridad y Garantía*)
GDP	Gross Domestic Product
GGM	Good Governance in Medicines Programme
IACC	Inter-American Convention against Corruption
IATI	International Aid Transparency Initiative
IDB	Inter-American Development Bank
IPS and IPS-S	Health Service Providers (Acronym in Spanish of *Instituciones Prestadores de Salud*)
IVC	Inspection, Vigilance and Control System
LAC	Latin America and the Caribbean
MDG	Millennium Development Goals
MINSA	Ministry of Health, Peru (Acronym in Spanish of *Ministerio de Salud*)
MeTA	Medical Transparency Alliance
MPS	Ministry of Social Protection, Colombia (Acronym in spanish of *Ministerio de Protección Social)*
MSH	Management Science for Health
NGO	Non-governmental Organization

PACT	Programme for Accountability and Transparency
PAHO	Pan-American Health Organization
POS	Benefit package of the Contributive System (Acronym in Spanish of *Plan Obligatorio de Salud*)
POS-S	Benefit package of the Subsidized System (Acronym in Spanish of *Plan Obligatorio de Salud – Régimen Subsidiado*)
RC	Contributive System (Acronym in Spanish of *Régimen Contributivo*)
RS	Subsidized System (Acronym in Spanish of *Régimen Subsidiado*)
SGSS	General System of Social Security (Acronym in Spanish of *Sistema General de Seguro Social*)
SIAF	Electronic Financial Management System
SIGA	Integrated System of Administrative Management
SISBEN	Socio-economic Assessment Instrument
SISFOH	Household Targeting System
TRAALOG	Transparency and Accountability in Local Governments Regional Initiative
UNDP	United Nations Development Programme

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EXECUTIVE SUMMARY

Executive Summary

Transparency and accountability are widely recognized as crucial dimensions of democratic governance. In the health sector democratic governance is acknowledged as one of the key building blocks for health systems strengthening as laid out by the World Health Organization (WHO). Yet, in Latin America and the Caribbean there is little knowledge and awareness about an important cause and consequence of bad governance in health systems: corruption.

Against this backdrop, the objectives of this study, commissioned by UNDP; are: i) to *raise awareness and increase the knowledge of key stakeholders about corruption risks* in national health systems of Latin America; ii) to *explore the main vulnerabilities to corruption in the national health sub-systems that provide health services to the poor* with a view to the specific risks that *affect service delivery at the sub-national levels*; and iii) to *identify potential areas for engagement and action of UNDP*.

The study is based on a desk-based literature review and two explorative case studies based on key informant interviews in Colombia and Peru. The countries were chosen as they allow exploring vulnerabilities to corruption against two different systems dimensions: decentralization and the public-private mix. Pursuing to provide a health systems perspective, the paper explains why corruption in the health sector needs to be addressed (Chapter 1), frames corruption and corruption risks in the health sector (Chapter 2), reviews evidence on corruption in health systems in the region (Chapter 3), provides a summary of the two country cases (Chapter 4), discusses emerging issues from the findings (Chapter 5), and concludes with programmatic ideas for UNDP and/or other UN agencies (Chapter 6). The following does not synthesize the chapters systematically but provides an overview of the discussion and findings.

National health systems in Latin America and the Caribbean are extremely heterogeneous regarding their system structure and country context. It is likely that risks to corruption show considerable differences in the areas and processes most affected as well as of the types, manifestations and drivers of corrupt practices. The forms of abuse tend to differ depending on how funds are mobilized, managed and paid (including the public-private mix), and at which level of the state administration (centralized, decentralized or in-between). At the same time, there are areas of the health systems that tend to face fairly similar vulnerabilities, such as procurement of drugs, goods and services, among others. This hypothesis has not been empirically proven. But, it is useful as starting point for reviewing what kinds of corruption are most prominent in a particular system.

Despite of the lack of hard data, it is safe to say that the increased levels of health care funding in most countries – the expenditure per capita has doubled from 1995 to 2009 in Latin America and the Caribbean – and efforts to decentralize health systems have increased opportunities for rent-seeking and abuse. This development has resulted, among others, in greater needs for adequate stewardship, transparent regulation as well as stronger information and control systems as is discussed in the text.

The findings of the case studies from Colombia and Peru provide, among the many interesting lessons, further insights on the hypothesis that forms of corruption vary across different health systems:

The Colombian case of the Subsidized System targeted at the poor illustrates that in a system with payment-provider split and ***competitive health insurance mechanisms, vulnerabilities related in particular to fraud and corruption in claims processing and beneficiary affiliation***, areas of vulnerability that do not exist in integrated public provision systems. It also shows that ***decentralization*** of the Subsidized System, in particular in the administration of funds, seems to ***have implied a "decentralization of corruption risks".*** However, it is ***impossible*** with the available data ***to compare the impact on the health sector goals*** such as equitable access and quality of care. What should be noted, though, is that decentralization allowed to achieve high health insurance coverage. The case also shows that while the sub-system for the poor is vulnerable to corruption and fraud, the ***larger amounts of money in the sub-system serving the richer population may make this a more attractive target for criminal activity***.

The Peruvian sub-system managed by the Ministry of Health and serving the poor relies on ***direct public provision of health services and public staff***. This creates a range of ***vulnerabilities in the area of human resources***. In particular, absenteeism is a serious problem, redirecting patients to private practice, and "buying" jobs. This kind of corruption is notably larger in the Peruvian system than in Colombia where managers seem to have stronger incentives for functional facilities and greater discretion in managing staff. The ***management of drugs and supplies*** as well as ***asset management*** in health service establishments ***has also surfaced as particularly vulnerable to abuses***, in contrast to the Colombian case. On the other hand, there are two issues similar to the findings of the Colombian case: The ***procurement of drugs and medical equipment continues to be an area of concern*** despite important reform efforts. And corruption risks as well as the associated volumes of funds are perceived to be higher in the other sub-systems which manage larger amounts of resources.

Based on the review of existing documented evidence and the two country case studies the following issues have emerged:

- There is a surprising lack of well-founded diagnostics of corruption and corruption risks in national health systems. This hinders approaches to pursue the principle "prevention is better than the cure".
- Health systems reforms can "reform" corruption risks. Changes in the predominant risks of corruption as a result of system reforms should not lead to quick but probably erroneous conclusions that one system is more prone to corruption than another. These changes may 'simply' indicate that the loci of the risks change.
- Decentralization risks "decentralizing" corruption. Decentralized systems are not a "silver bullet" for increased transparency and effective accountability. However, there is no evidence, either, that centralized systems are necessarily less corrupt.

- The risk that laws, executive norms, regulatory processes or oversight agencies of the health sector may be valuable targets for "capture" is undeniable yet little researched.
- Information systems and access to information are one of THE key components of efficient, responsive and accountable health systems. There is room for improvements, in particular in view of promoting access to information, for example through a sector wide transparency and information policy.
- An integral strategy of internal and external control that ensures complementarity of and coherence between the different actors is essential, but often lacking. This requires strong stewardship of the overall national health system(s).
- Not surprisingly, the area of drugs, medical equipment and supplies has emerged as one of the prime risks for corruption in particular with regard to challenges in regulation and procurement.
- Social accountability in the health sector seems to be somewhat under explored and faces challenges due to the technical complexities, information asymmetries, lack of publicly available information, and the apparent social tolerance of certain forms of abuse.
- The need for integration: Anti-corruption efforts need to be systematically integrated into health sector policies and vice versa. Too often corruption risks are neglected in health sector policy work, while national and sub-national strategies to address corruption tend to neglect specific sectors, like health.

In sum, corruption is a public health issue that will not disappear by itself, nor can it be ignored. Experience from the region and the rest of the world shows, that it is possible to address corruption by changing the conditions that allow it to happen and support it. For UNDP, potentially in collaboration with the WHO/PAHO, the IDB, the World Bank and others, this could mean to get engaged in the following:

In general terms:

- Support diagnostic work on corruption risks in health (sub-)systems particularly those targeted at the poor and vulnerable;
- Collect recent existing data and tools to assess experiences and perceptions of corruption in the health sector and identify gaps;
- Collaborate with the PAHO and the WHO to integrate a "corruption risk lens" into the health systems strengthening approach and build on the Good Governance in Medicines progress.
- Promote South-South exchange building on health sector integrity initiatives
- Develop a methodology for "integrity screenings" of health sector regulatory or oversight bodies

Using opportunities in broader democratic governance strengthening programs:

- Support to Parliaments could include strengthening the legislative support for health
- Support to sub-national governments could include strengthening their capacity to analyze, monitor and evaluate health policies sub-nationally. Also, the capacity of sub-national stakeholders to actively engage in national policy dialogue on health issues could be fostered.
- Include special components to increase transparency and accountability in health (and education) service delivery into programs that focus on decentralization and/or the strengthening of local governance and democratic governance.

Support civil society, the private sector and professional associations (nationally and locally) to specifically promote transparency and accountability in the health sector.

INTRODUCTION

Introduction

Transparency and accountability are widely recognized as crucial dimensions of democratic governance. In the health sector, which is crucial for the achievement of the Millennium Development Goals (MDG), democratic governance is acknowledged as one of the key building blocks for health systems strengthening as laid out by the World Health Organization (WHO). Yet, in Latin America and the Caribbean there is little knowledge about an important cause and consequence of bad governance in health systems, which plagues many countries in the region and which often makes efforts to improve sector governance a futile undertaking: corruption. Little is known how vulnerabilities to corruption affect the different functions and levels of national health systems, and perhaps even less with regard to health service delivery at the sub-national levels.

Corruption makes health policy, health initiatives, the provision of care and international aid less effective, undermining efforts to increase better coverage and quality in the health systems and to improve the health status of the population. There is no doubt, that corruption affects all health systems, both in developed and developing countries, through the embezzlement from health budgets, fraudulent drug procurement, health insurance fraud, or bribes extorted at the service delivery level. The negative consequences are huge and the burden falls disproportionately on the poor (see chapter 1).

The main purpose of this study is to raise awareness among key stakeholders on the vulnerabilities and complexities of corruption as well as on the possible mitigating strategies in the health sectors in Latin America and the Caribbean. The ***specific objectives*** are: i) to *generate awareness and increase the knowledge of corruption risks* in national health systems of Latin America; ii) to *explore the main vulnerabilities to corruption in the national health sub-systems that provide health services to the poor* with a view to the specific risks that *affect service delivery at the sub-national levels*; and iii) to *identify potential areas for engagement and action of UNDP.*

This paper is part of an effort by the UNDP Democratic Governance Practice Area and its Regional Transparency and Accountability in Local Governments Initiative (TRAALOG). The intended audience of the study is UNDP staff in country offices in Latin America and the Caribbean, other United Nations, policymakers and other actors who have an interest in strengthening transparency and accountability in the health sector and who are striving to promote the achievement of MDG results in Latin America and the Caribbean.[1] The study is based on two data collection components: i) a ***desk-based literature review***:[2] and ii) ***two explorative case studies based on key informant interviews in Colombia and Peru***.[3] The countries were chosen as they allow exploring vulnerabilities to corruption against two different health systems dimensions: decentralization and the public-private mix. The first dimension - health

[1] This study will also serve as reference for programmatic work by UNDP and partners to develop methodologies to mainstream corruption mitigating strategies in the health sector at the sub-national level.
[2] See bibliography.
[3] See summaries of the country profiles in chapter 4.

sector decentralization – differs across these two countries. Colombia's health system has a high degree of decentralized authority, functions and financing as a result of the major health reform started in the mid 80s. However, some functions have recently experienced a tendency of recentralization. By contrast, Peru remains substantially more centralized because efforts to decentralize or regionalize have been more inconsistent and it is undergoing a renewed regionalization process. The second dimension - the public-private mix – also differs across these two countries. Colombia's health system for the poor has public and private actors involved in health insurance as well as health service provision. By contrast, in the Peruvian health system for the poor the insurance and service delivery functions still lie largely within the public sector at central and sub-national levels, even though some initiatives are underway introducing more competition between public and private actors.

To date there is no methodology to identify vulnerabilities to corruption across national health systems. A variety of instruments for partial risk analysis have been used in different contexts and methodologies to assess governance and/or accountability in the health sector are being developed (see Annex II). For the purpose of this study to pursue a health system's perspective, the ***report is framed within the health systems approach developed by the WH***O (see section 2.2.). The two case studies discuss vulnerabilities to corruption in relation to each of the building blocks while the dimensions of decentralization and public-private mix are explored, where relevant, within these building blocks.

The study should be read bearing in mind the following ***limitations***. First, documented evidence on vulnerabilities to corruption in Latin America is relatively scarce and mostly limited to specific aspects of the health systems, such as the drug supply chain or human resource management. Secondly, the experiences that are documented relate to a variety of different health sub-systems, not only those targeted at the poor, and include social security systems financed by contributions of formal workers or specialized systems for public sector workers. Third, the two country studies are a first effort to explore the main corruption risks in the respective health sub-systems for the poor. They are largely qualitative reflecting to a considerable extent the informed opinions of the consulted experts.

The paper explains why corruption in the health sector needs to be addressed (Chapter 1), frames corruption and corruption risks in the health sector (Chapter 2), reviews the risks to corruption more generally in health systems in the region (Chapter 3), provides a summary of the two country cases (Chapter 4), discusses emerging issues from the findings (Chapter 5), and concludes with programmatic ideas that UNDP and/or other United Nations agencies could consider to pursue through new initiatives and/or their existing program activities (Chapter 6).

CORRUPTION – AN INCREASINGLY IMPORTANT CHALLENGE FOR HEALTH SYSTEMS PERFORMANCE IN LATIN AMERICA

Chapter 1

Corruption – an increasingly important challenge for health systems performance in Latin America

1.1 Corruption, health and human development goals (MDGs)

The resources spent in the health sectors around the world are huge, every year roughly 5.3 trillion US$ according to estimates of the WHO, offering lucrative opportunities for abuse and illicit gains. Health spending ranged in 2009 from 5.3% of GDP in low-income countries, over approximately 6.5% in middle-income countries in Latin America, with the wealthiest ones spending up to 10%, and more than 12.1% in high-income OECD countries (World Bank 2009). Conservative estimates indicate that in Latin America around 28 billion US$ are probably stolen or diverted per year from health services (Savedoff, 2007).

It should be noted that there is evidence that reducing corruption can improve health outcomes by increasing the effectiveness of public expenditures (Azfar, 2005). In a similar line, a study carried out by Transparency International in 2010 and covering 48 countries showed that increasing transparency, accountability and integrity has a robust correlation to better outcomes in health, education and water, irrespective of a country's wealth or how much it spends in a sector.[4]

On the other hand, corruption in the health sector can literally be a matter of life and death, in particular for poor people in developing countries. A study carried out by the International Monetary Fund, for example using data from 71 different countries showed that countries with high incidences of corruption have higher Infant Mortality Rates (Gupta, 2000). In Burkina Faso corruption by health professionals was found to be one of the primary causes of death of thousands of women during pregnancy.[5]

More generally, corruption in the health sector has severe consequences on access, quality, equity and effectiveness of health care services. At the service delivery level, unofficial user fees (informal payments) either discourage the poor from utilizing services or force them to sell valuable assets driving them further into poverty. Informal payments are regressive and can constitute a major burden on scarce household resources. For example, they make up 15% of half-monthly per capita income in Peru (World Bank, 2009). Absenteeism, in some countries affecting between a quarter and half of the medical staff, further reduces access and quality of care and increases mis- and self-referrals (U4, 2008). In Costa Rica, more than two-thirds of doctors and nurses surveyed for a study considered absenteeism as problem in their hospital (Cercone et al., 2000), while in Peru, 32% of doctors and nurses surveyed for a similar study classified absenteeism among doctors as "very common" or "common" (Alcázar & Andrade

[4] See Transparency International, The Anti-Corruption Catalyst: Realising the MDGs by 2015, Berlin 2010.
[5] See study by Amnesty International http://www.amnesty.org/en/news-and-updates/report/pregnant-women-burkina-faso-dying-because-discrimination-20100127

2001). Bribes to avoid government regulation of drugs and medicines have contributed to the rising problem of counterfeit drugs in the world which can lead to increased disease resistance and the emergence of epidemics.[6] Corruption in the financial management of health sector institutions also has a direct negative effect on access and quality of health services as resources are drained from health budgets through embezzlement and procurement fraud. Recent scandals on corruption in the health sectors in Colombia and El Salvador, for example, illustrate this problem and are reportedly causing millions of US$ in losses to the state.[7] An analysis of 64 countries from 1996 to 2001, found that corruption lowers public spending on health, education and social protection (Delavallade, 2006). Finally and not a minor issue, corruption in the health sector erodes the legitimacy of and public trust in government institutions, as health service delivery is a core area for state-society relations.

In sum, corruption has a corrosive impact on health outcomes and it is the poor and marginalized who are most affected. Unethical and fraudulent behavior in the health sector compromises the fundamental human rights[8] and seriously compromises the achievement of the MDGs related to health – the reduction of child and maternal mortality and the combating of HIV/Aids, malaria and other diseases –, as was highlighted by the United Nations Secretary General Ban Ki Moon in 2009.[9]

The message is clear: addressing corruption in health systems is an essential development goal due to the potential to achieve better health outcomes and to yield broader benefits to society. Taking action against corruption should be integrated into the development of public policy toward health (U4, 2011; UNDP, 2010; and Savedoff, 2007).

1.2 Health systems reforms, increasing levels of funding and risks to corruption

National health systems in Latin America and the Caribbean are extremely heterogeneous regarding their system structure and country context. It is likely that risks to corruption show considerable differences in the areas and processes most affected as well as of the types, manifestations and drivers of corrupt practices. The forms of abuse tend to differ depending on how funds are mobilized, managed and paid (including the public-private mix), and at which level of the state administration (centralized, decentralized or in-between). At the same time, there are areas of the health systems that tend to face fairly similar vulnerabilities, such as procurement of drugs, goods and services, among others (Savedoff & Hussmann, 2006) (see chapters 3 and 4). This section points briefly to the key elements of national health systems that need to be borne in mind when reading the study.

[6] In the US, up to 15% of all drugs sold are fake, while in some countries the figure can amount to 50%. Further, of the public procurement costs for drugs, an estimated 10-25% is lost to corruption (WHO, 2008).
[7] See http://www.elespectador.com/impreso/salud/articulo-268521-asi-fue-el-desfalco-salud y http://www.elsalvadornoticias.net/2011/04/06/estafa-en-que-habria-participado-ex-ministro-de-salud-sobrepasa-los-3-millones/
[8] Access to health is a human right guaranteed by the Inter American Convention of Human Rights and the San Salvador Protocol. Monitoring of the respect of this right is closely tied to transparency and access to information.
[9] See UN Secretary General speech on the International Anti-Corruption Day, 9 December 2009 http://www.un.org/News/Press/docs/2009/sgsm12660.doc.htm

Health systems in the region can be classified into four broad categories depending on their degree of fragmentation in terms of pooling the population for health (insurance) coverage (integrated versus segmented systems)[10] and the level of private sector participation in health insurance and health service delivery systems.[11] Segmented systems are the predominant type of national health systems in Latin America (Giedion, et al, 2010).

Table 1. Classification of Latin American health systems

		Integrated systems	Segmented systems
Participation of the private sector - in health insurance (i) - or health service delivery (s)	Yes	Brasil (s), Uruguay (i, s)	Chile (i, s), Colombia (i, s), Peru (i), Argentina (i), Nicaragua (i, s), Paraguay (i, s)
	No	Costa Rica, Cuba, Dominican Republic, Guyana, Haiti, Jamaica	Mexico, Ecuador, Belize, Bolivia, El Salvador, Guatemala, Honduras, Panama, Venezuela

Source: Giedion, U., Villar, M., Ávila, A. (2010), "Los sistemas de salud en Latinoamérica y el papel del seguro privado", Fundación MAPFRE, España.

One of the great challenges of the health sector in Latin America remains its financial basis and structure. Out-of-pocket payments by citizens, the most regressive form of health care financing that can easily cause households to slide into poverty, are still an important source of health funding in the region. In this regard the country studies reflect two very different cases: Colombia has one of the most progressive financing structures while Peru still depends heavily on out-of-pocket payments. Generally funding for the health sector comes from three sources: i) direct or indirect taxes levied at the national and/or local levels, ii) contributions to health or social security schemes by the employee, the employer and/or sometimes the State; and iii) private spending, including out-of-pocket payments. According to World Bank data from 2009, these sources together constituted on average in the region roughly7.3 % of GDP, more than the 5.6% spent on health in other middle income countries. However, there are great variations in the region. While Peru dedicates some 4.4 % of its GDP to health, this ratio is 9.5% in Argentina. It is noteworthy that over the past decades, the levels of national spending on health care

[10] ***Integrated systems*** refer to those "traditional" national health systems that used to exist in the region offering health services at all levels of attention (from small health posts to national level reference hospitals) to the vast majority of the population through a unified public system. Integrated systems still exist in Costa Rica, since recently in Uruguay and most of the English speaking Caribbean countries. ***Segmented systems*** refer to national health systems that consist of a variety of sub-systems, including mostly publicly financed sub-systems for the poor and different types of health or social security insurance sub-systems for certain population groups mostly financed through their contributions, such as formal workers, public officials, the armed forces or police.

[11] ***Private sector participation*** in Latin American health systems has been evolving and includes private actors, both for profit and non-profit, in public health insurance and health delivery systems. In some countries, private sector participation is focused on or limited to either of the functions while in others it is found in both. Also, private sector participation may occur in integrated or segmented systems.

have increased considerably. The expenditure per capita has doubled from 1995 to 2009 (from 243 US$ to 545 US$) in Latin America and the Caribbean (World Bank data from 2009).

The opening of health systems in the region to private actor participation, both for profit and non-profit, with the objective to extend health insurance coverage and to improve health service delivery has contributed to changing the political economy of the sector. Despite of the lack of hard data, it is safe to say that the increased levels of health care funding in most countries and efforts to decentralize health systems have further increased opportunities for rent-seeking and abuse. This development has resulted, among others, in greater needs for adequate stewardship, transparent regulation as well as stronger information and control systems as will be discussed below.

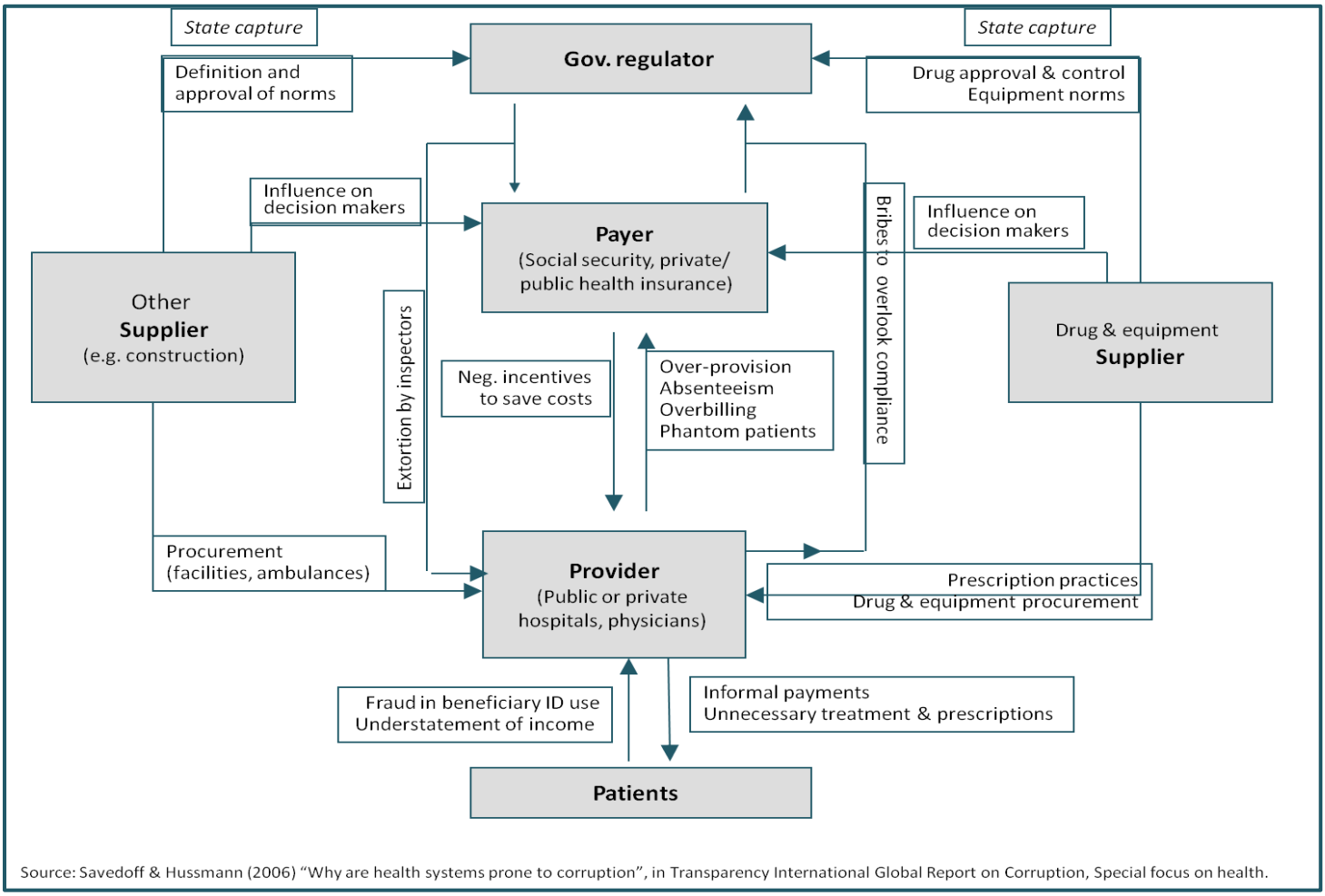
1.3 Special characteristics of the health sector compound risks to corruption

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

Perhaps the greatest challenge from a corruption risk perspective is the high degree of information asymmetry (information is not shared equally among the actors). For example, pharmaceutical companies know more about their products than service providers who have to procure them or doctors who prescribe them. Health care providers can overprice their services as both patients and health insurance companies have limited knowledge and/or oversight of actual services delivered. The biggest problem caused by asymmetry of information is that the health "market" cannot be self-regulating. Information asymmetry makes it difficult for patients and oversight bodies to fully monitor the decisions of the different actors, to hold them accountable for results and to detect and assign responsibility of abuses: for example patients lack information to assess the correctness of a bill; insurance auditors have a hard time to assess if the billing is correct and services provided were necessary; and regulators face challenges to assure the quality of drugs and medical equipment. The findings from the two case studies bring these information asymmetries in its many facets vividly to light.

In addition, the large number of dispersed actors increases the risks to corruption. The actors can be grouped in a simplified way into five broad categories (see Figure 1), which can be public or private except for the government regulators: i) *government regulators* – health ministries, parliaments, specialized commissions; ii) *payers* – social security institutions, ministries or other public agencies, private insurers; iii) *providers* – hospitals, doctors, pharmacists; iv) *patients* – consumers; v) and *suppliers* – medical equipment and pharmaceutical companies, construction companies, ambulance providers, etc..

Figure 1: Key actors in national health systems and generic corruption risks



Source: Savedoff & Hussmann (2006) "Why are health systems prone to corruption", in Transparency International Global Report on Corruption, Special focus on health.

Relationships between these actors are often opaque and the amount of relations between them increases the opportunities for corruption; for example, funds can be diverted or misallocated at a ministry, state hospital or local clinic by individuals working as managers, procurement officers, health professionals, dispensers, clerks or patients. Or, as will be discussed in the Colombian case, corruption risks increase with large numbers of contractual relations between insurers, providers and/or patients. Not to forget, the kinds of illegitimate interests are also multiplied. The actors may be tempted to abuse their positions for direct financial gain, to increase their prestige, political influence and power, or to expand their market share (Savedoff, 2006).

Also, the scope of corruption in the health sector may be larger than in other sectors because many private actors are considered to serve the common good. This is particularly the case of the medical profession which is expected to do what is best for the patient independent of the impact on their

personal income. Similar expectations are directed at insurance companies, pharmaceutical and medical equipment companies – none of whom are explicitly bound by any professional ethic (Savedoff, 2006).

As indicated above, the market failures of the health sector, including information asymmetry, adverse selection in health insurance schemes, etc., explain the need for public sector involvement in regulating the sector. However, when regulators are put in place to remedy the situation new risks for corruption emerge, as illustrated, for example, in the Colombian case: powerful interest groups may capture the regulator to avoid responsibility or to further their respective interests at public expense (U4, 2011).

FRAMING CORRUPTION AND CORRUPTION RISKS IN THE HEALTH SECTOR

Chapter 2

Framing corruption and corruption risks in the health sector

More often than not, "corruption" is a loosely used term. It is commonly associated with a wide range of practices ranging from lack of ethical behaviors, over 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.

There is ***no single, universally-accepted definition of corruption***, but the ***most commonly used***, including by UNDP, refer to ***the misuse of entrusted power for private gain***.[12] This allows for a broad understanding that embraces not only public officials with entrusted power, but includes private sector staff, and corruption that occurs between private firms and within civil society organizations.[13]

It should be noted that the most important international treaties on corruption that are relevant for Latin America and the Caribbean, the Inter-American Convention Against Corruption (IACC) and the United Nations Convention against Corruption (UNCAC), do not provide a definition of corruption but define specific acts of corruption as criminal offence.[14] These include bribery and embezzlement, abuse of function, trading in influence, illicit enrichment, but also money laundering, concealment and obstruction of justice (for a brief glossary of the types and forms of corruption see Annex I). Also, UNCAC uses a functional approach to the term 'public servant' which is relevant to many health systems in Latin America: it covers anyone who holds a legislative, administrative, or executive office, or provides a public service. As mentioned above, given that in national health systems private actors are often entrusted with public roles, the ***analysis of risks to corruption inevitably needs to take into account the relevant private actors*** and not just those officially on the public payroll.

The ***lines between clear abuse of entrusted functions, unethical behaviors and mistakes are often blurred***, a challenge particularly evident in health care provision. By way of illustration: If doctors in a public health facility consistently refer patients to private practice, where health insurance coverage does not apply like in the case of the Peruvian SIS (see chapter 3), it is difficult to determine if this is done in the interest of the patient to get the required care or in the interest of increased personal income. The same question arises when health providers regularly bill insurance companies or the government the most expensive treatments although cheaper or less comprehensive treatments are likely to generate the same result. And in case the treatment was not medically indicated, it is often difficult to establish whether the decision was an intentional abuse, unethical practice or a mistake. In

[12] See also World Bank and Transparency International.

[13] 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.

[14] One of the starting points for addressing corruption in any country is to know whether and how it is defined in general and in detail in the country's own constitution and laws.

addition, there are often ***no clear dividing lines between gifts, socially accepted favors and smaller-scale bribes***.

Finally, 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. Or, the influence (lobby) of powerful interest groups on laws and regulations may be regulated, or not. In many cases it is ***challenging to decisively discriminate between corruption, inefficiencies, and simply inadequate funding*** when observing certain questionable outcomes in the delivery of health services.

What are the implications of these complexities for this report? Most importantly, ***the study identifies risks and vulnerabilities to corruption*** – these terms are used interchangeably – ***as a means to draw attention to areas and processes where different practices of abuse can occur***. A review of the existing literature as well as the analysis of the two case studies provides insights in this regard. "Capture" is used to refer to the potential manipulation of laws, norms and regulatory agencies by special interests. "Corruption", "corrupt or fraudulent practices" is used to refer to the spectrum of unlawful or illegitimate behaviors mentioned above (criminal acts, administrative misdemeanors and unethical practices). More detailed research would be needed in the region to grasp the variety of expressions of corrupt acts and to distinguish between them, which would be an important project for the future.

The ***WHO health systems building blocks***[15] ***are used as a framework to explore corruption risks*** across the different functions of the Colombian and Peruvian health sub-systems for the poor (see chapter 4). According to the WHO six key components or building blocks constitute a well-functioning health system (see Figure 2 below with reference to some of the generic corruption risks identified in Figure 1):

i) Leadership and governance –stewardship, regulation, oversight and social accountability;

ii) Health systems financing – revenue raising, pooling (including health insurance) and allocation (including budget management);

iii) Health service delivery – organization of service provision, procurement, financial management, administration of stocks and inventories at service delivery points;

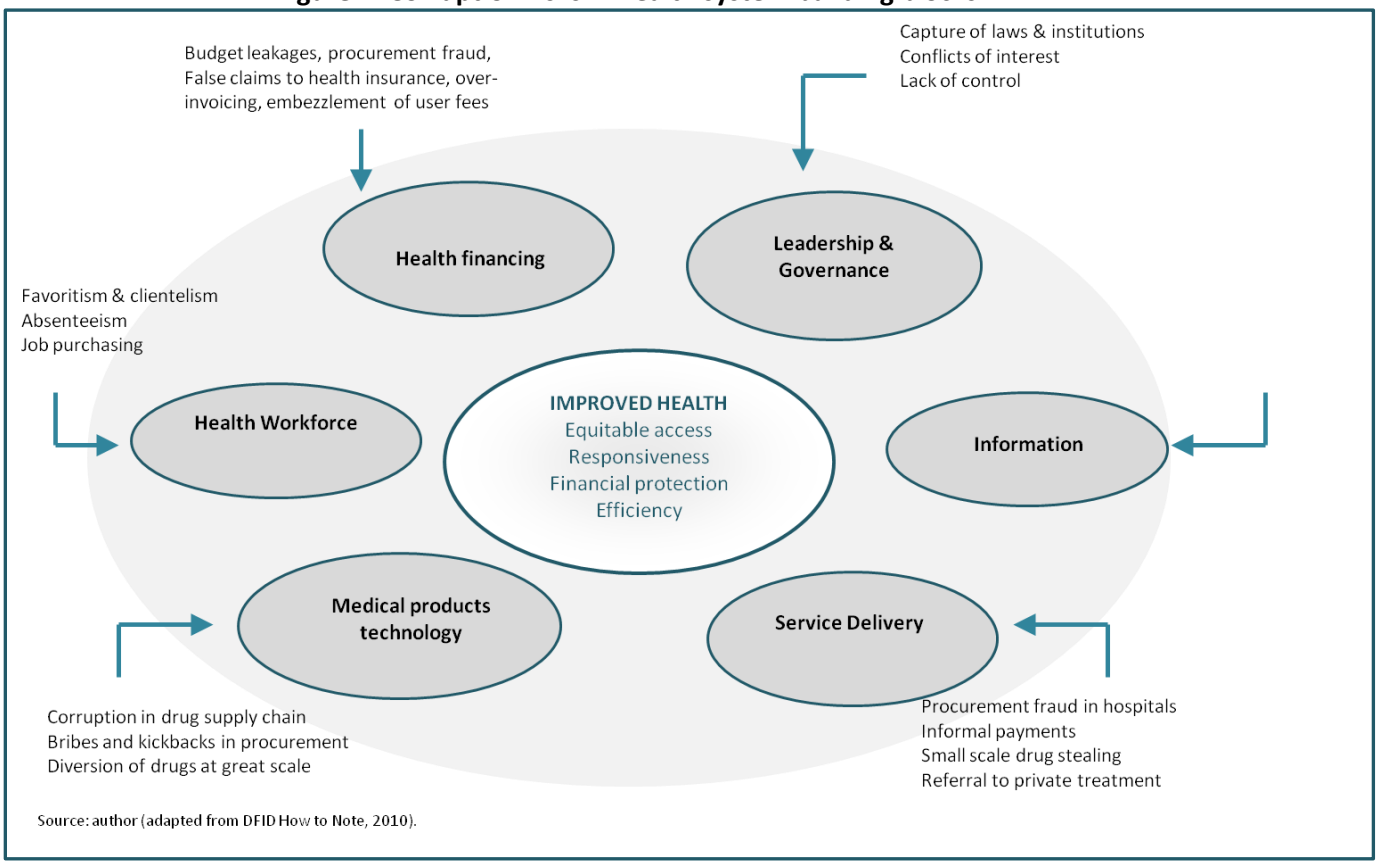
iv) Health workforce – recruitment and promotion of staff, compliance with working time;

v) Access to essential medicine – supply chain of drugs and medical equipment and supplies;

vi) Health information systems.

[15] See http://www.who.int/healthsystems/EN_HSSkeycomponents.pdf

Figure 2: Corruption risks in health system building blocks



Although the WHO framework does not identify specific actors, the two case studies in chapter 4 attempt to identify the actors that might be involved or affected by the different corrupt practices.

EVIDENCE OF CORRUPTION RISKS IN LATIN AMERICAN HEALTH SYSTEMS

Chapter 3

Evidence of corruption risks in Latin American health systems

Although documented evidence of corruption in Latin American health systems is scarce and mostly dates back to the late 1990s and to the first half of the past decade, a technical note on health produced by the IDB in 2007 provides a good overview of the findings of existing studies. And the World Bank report "The many faces of corruption" also from 2007 contains an in-depth analysis of corruption risks in the pharmaceutical supply chain.[16] The main issues relevant for this paper are summarized or reproduced in the following.

The IDB technical note distinguishes between systems of public provision of health services and those that separate public financing from provision. The Peruvian sub-system for the poor is an example for public provision while the Colombian one exemplifies a payment-provider split. Note that this distinction adds yet an additional dimension to the above mentioned integrated and segmented systems and underlines the need for system specific diagnostics. The above mentioned hypothesis – that forms of corruption vary across different health systems – has not been empirically proven. But, it is a useful starting point for reviewing what kinds of corruption are most prominent in a particular system.

Systems with direct public provision usually consist of a Ministry of Health, which hires the necessary administrative and medical staff, builds facilities, and organizes the purchase and distribution of drugs, equipment, and supplies. Such health systems have a wide range of structural differences, whether through decentralization or experimenting with autonomous health facilities, but they have common approaches for budget allocation and service delivery.[17] In health systems with direct public provision of health services the most common forms of abuse involve kickbacks and bribes in procurement, theft of drugs and supplies, illegal fees charged to or extorted of the patients, diverting patients to private practice, reducing or compromising the quality of care, and absenteeism.

For example, case studies in seven Latin American countries found that ***informal payments*** were charged in public hospitals (Di Tella & Savedoff, 2001).[18] In Bolivia, 40% of surveyed patients indicated that they had paid fees for services they should have received free of charge (Gray-Molina et al., 2001). In Costa Rica, more than 85% of doctors and nurses stated that at times physicians unjustifiably charged for their services. About half the patients surveyed indicated they had paid fees close to the average price of private sector consultations (Cercone et al., 2000). In other countries, Bolivia, Costa Rica, Nicaragua, and Venezuela, theft by employees and theft of supplies were found to be a serious problem. An average of 10% to 13% of all supplies and medications was estimated to be stolen. ***Absenteeism*** was

[16] See Savedoff (2007) and World Bank (2007) in the Bibliography.
[17] In Latin America, successes of direct public provision of health services are rare. In the most effective ones, health services reach the bulk of the population (for example Chile or Cuba). In most cases, however, the public systems have been unable to reach large segments of the population or to provide adequate services (for example Venezuela) (Savedoff, 2007).
[18] The cases referred to here are stand-alone chapters of the book edited by Di Tella and Savedoff (2001).

a significant problem in 22 Venezuelan hospitals where doctors were absent around 30% of their time (Jaén & Paravisini, 2001). In Costa Rica close to 70% of doctors and nurses identified absenteeism as a considerable problem in their hospital (Cercone *et al.*, 2000). Less studied, but important, is ***bribes and kickbacks in the procurement of medical supplies***. The before mentioned "studies in Latin American about public hospitals demonstrated that the prices paid for simple homogeneous products varied significantly in ways that could only be attributed either to gross mismanagement or fraud" (Di Tella and Savedoff, 2001).

Systems that separate public financing from provision are common in Latin American countries with social insurance systems like Colombia, or in large federated countries like Argentina. But they are rare in low-income countries. When public financing is separated from provision, the character of abuses is likely to change. The most common forms of abuse involve excessive or low quality medical treatment and fraud in billing government or insurance agencies. "The type of abuse is influenced by the payment mechanism chosen by the financers to pay providers for their services.[19] The public financing agent(s) itself may be a focus for corruption diverting or embezzling funds. Finally, public reimbursement of private providers raises a range of regulatory issues, which can create new opportunities for corruption, for example in reporting of cost structures, licensing procedures and inspections" (Savedoff, 2007).[20] The procurement of drugs, capital goods and medical as well as other supplies may remain a risk area, too.

In Latin America, the problem of ***inducing treatments*** that are not medically indicated has also been documented to some extent. While ***billing fraud*** has been addressed extensively in the business and public management literature it is not well documented in Latin America. "Transparency International highlighted the problem of billing fraud in the United States; insurance fraud in Colombia; and billing fraud in Canada.[21] In each of these cases, governments were billed for services that were not provided or they were overcharged" (Savedoff, 2007). This particular problem is currently one of the issues at the heart of a great corruption scandal in the Colombian health system (see chapter 4).

Specific attention has been paid by a variety of international organizations, such as the WHO, the World Bank and others, to ***analyze and address corruption risks in the pharmaceutical sector***, where governments have two core responsibilities: i) to regulate all actors involved in the sector, and ii) where drugs and pharmaceutical products are provided by the government, public purchasers are responsible for the selection, purchase and logistical management of drugs. A value chain analysis of six key decision points in the drugs sector that may be vulnerable to corruption[22] has been tested in 2002 in Costa Rica with support of the World Bank. It was later refined and included as a core instrument for the WHO's Good Governance in Medicines Program GGM (Cohen et al, 2007). Overall, the Costa Rican drug system

[19] For example, medical professionals who are reimbursed on a fee-for service basis have no incentive to be absent from work, but dishonest ones may be tempted to overcharge, bill for services that were not provided, or order tests and procedures that are not medically indicated. Provider payments on a capitation basis may introduce the right incentives for providers to focus more on preventive than on curative care, but it may also motivate the dishonest ones to neglect the provision of necessary care or to reduce quality below acceptable standards.

[20] Governments often establish regulations, for example to assure that private providers meet minimum quality standards.

[21] See Global Corruption Report 2006, www.transparency.org.

[22] The six decision points are: manufacturing, registration, selection, procurement, distribution, prescription of drugs.

obtained a ranking of 7.7 out of 10 indicating marginal vulnerability according to the methodology. The rating was diminished due to a low rating of 5.7 in the area of procurement. Problems with transparency and poor checks and balances in this area have a significant impact on the quality and efficiency of services delivered by the Costa Rican Social Security System (CCSS).[23]

There is little, publicly available documentation from Latin American countries on corruption risks in the areas of health sector regulation, control and oversight, social accountability and health care financing. In addition ***little if any attention*** has been paid to ***analyze corruption risks in the health sector with a "decentralization lens,"*** These are areas need more, context and system specific analysis.

[23] Illustrations are found in various reports to the CCSS that a common practice at some hospitals was to purchase excessive quantities of medicines not included in the official list of medicines. These were purchased under a budget line reserved for medicines needed for uncommon illnesses or exceptional cases, which are not subject to the usual CCSS controls. Another concern was the readiness with which some CCSS doctors accepted trips paid for by pharmaceutical companies. See U4, Improving Transparency in Pharmaceutical Systems: Strengthening Critical Decision Points Against Corruption, 2002, http://www.u4.no/pdf/?file=/themes/health/cohen_wb_paper_pharma2002.pdf

SUMMARY OF COUNTRY CASE STUDIES

Chapter 4

Summary of country case studies

This section presents the summary of the two country case studies from Colombia and Peru elaborated specifically as one of the backbones for the paper. As indicated above, the field work concentrated on identifying corruption risks in the national health sub-systems targeted at the poor and marginalized. These exploratory case studies discuss the main corruption risks that emerged on the basis of key expert interviews and the review of the limited existing literature. The analysis is structured according to the before mentioned health systems building block framework of the WHO and starts with a brief description of the respective health sub-systems. The case studies do not intend to be exhaustive and more detailed analysis is certainly needed in the future. What should be noted for both cases is that corruption risks in the health sector, as those of other sectors, must be understood against the broader country context. Both Colombia and Peru are countries with high levels of perceived corruption,[24] variations of clientelistic politics and considerable degrees of organized crime. Thus it is not to be expected that the respective health sectors escape these dynamics.

4.1 Colombia – Corruption risks in the subsidized health system (*régimen subsidiado*)

The Colombian health system aims since its major reform in 1993 at universal health insurance coverage through a regulated framework of competition among public and private actors. It consists of three sub-systems: i) the General System of Social Security (SGSS), in other words the public health insurance system, which covers close to 90% of the population and is divided into two sub-systems, the Contributive System (RC) for people with capacity to pay for health insurance (approximately 40%) and the Subsidized System (RS) for the poor and marginalized (approximately 50%);[25] ii) the Public System for the poor yet without health insurance coverage; and iii) Private Health Insurance which offers complementary plans to the services covered by the public health insurance.

In the Contributive and Subsidized System, health insurance companies (EPS and EPS-S), which can be public or private, are responsible to affiliate beneficiaries and to manage the delivery of benefit packages (POS and POS-S) to their beneficiaries.[26] The EPS in both systems contract the delivery of health services from health service providers (IPS and IPS-S), which can be again public or private and compete with each other. The Subsidized System has roughly twice as many health insurers (EPS-S) than the Contributive System and roughly 80% of health services are provided by public service providers.

[24] See World Bank Good Governance Indicators http://info.worldbank.org/governance/wgi/sc_country.asp and Transparency International www.transparency.org.

[25] Both the Contributive and Subsidized Systems consist of a basic benefit package (POS). The POS-S of the Subsidized System is still less comprehensive but harmonization with the POS-C has been mandated by the Constitutional Court and is gradually being pursued.

[26] The benefit package of the Subsidized System (POS-S) used to be less comprehensive than the one of the Contributive System (POS). But in 2008 the Constitutional Court issued a judgment to make the two health insurance packages equal.

While the Contributive System is financed through a payroll tax of 12.5% (1.5% of which used to co-finance the RS),[27] the Subsidized System is mainly financed through national and, to a much lesser degree, regional taxes. Affiliation to the Subsidized System is contingent on being classified as vulnerable through a national socio-economic assessment instrument (SISBEN).

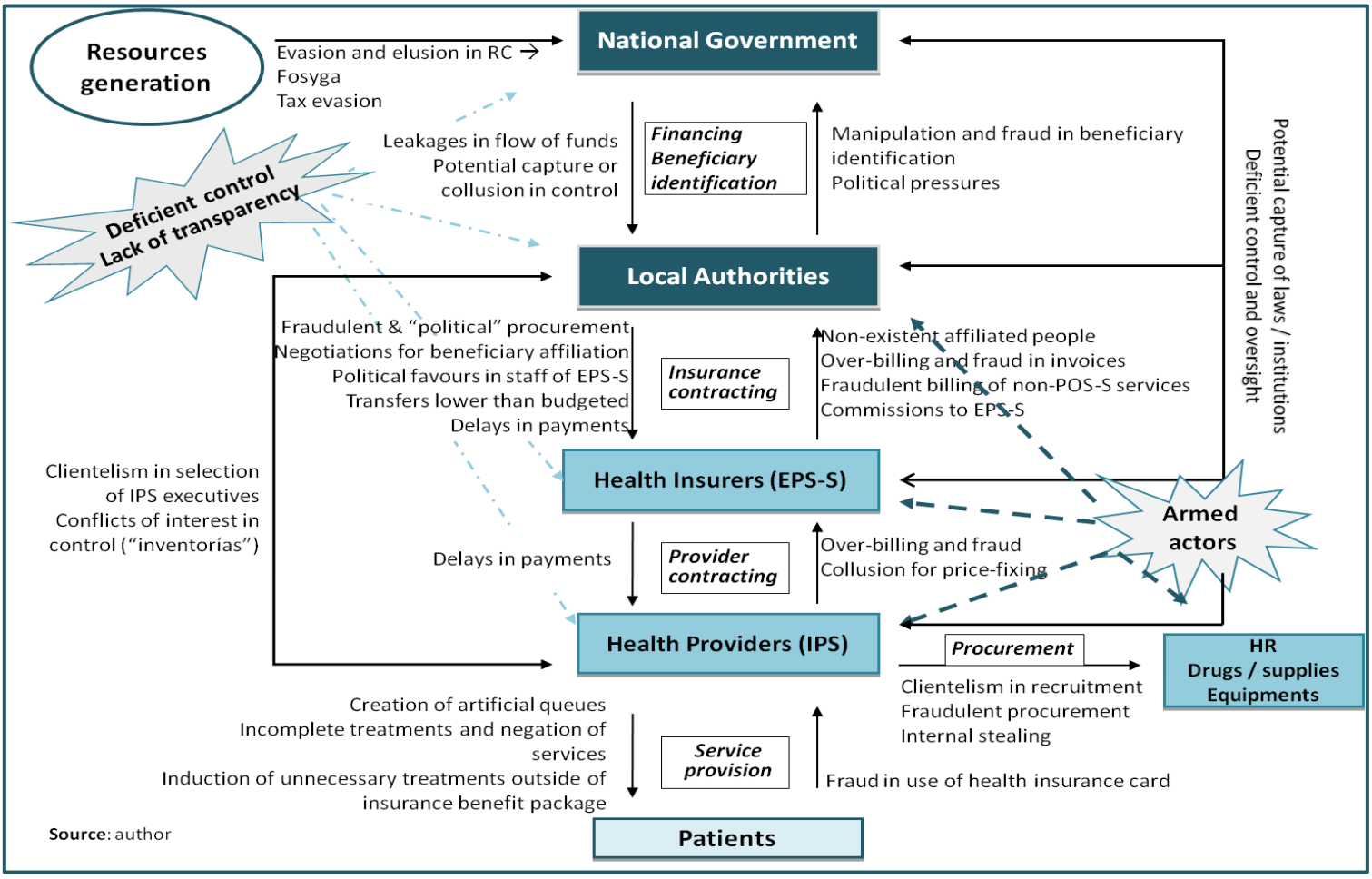
In line with the decentralization of Colombia's political system as anchored in the Constitution of 1990, the Subsidized Health System is also decentralized. The municipalities are responsible for the health insurance of their citizens and the regional governments (*departamentos)* are in charge of the health provider networks (IPS) within its territory. In a very simplified way the Subsidized System could be described as follows: the stewardship and regulatory function lie with the Ministry of Social Protection and Health and the Health Regulatory Commission (CRES) at the national level. The majority of funds for the system is raised at the national level and transferred to sub-national authorities through different mechanisms. Between 10% and 20% of the funds for the RS may be raised at the sub-national level. As said before, most functions related to the management of health insurance coverage (beneficiary identification, selection of health insurers in a particular jurisdiction, payment of health insurers, etc.) are managed at the sub-national level in particular by the municipalities. Service delivery is mainly ensured through public providers at the local level, with public hospitals enjoying significant degrees of autonomy as they are set up as public autonomous companies (see Giedion et al., 2001). The function of control and oversight is divided between a number of national and local level institutions.

Some important reforms have been carried out over the past few years in the Subsidized System in order to correct a series of inefficiencies and other systemic problems. Many of them are reflected in a new health law approved in 2011 (Law 1438/2011), in particular unified beneficiary data base at central level and the recentralization of the transfer of funds from the central level directly to health insurers and providers, thus eliminating their flow through local level authorities (see discussion below).

In sum, Colombia's Subsidized Health System is decentralized, with a payment-provider split, and has public and private actors involved in health insurance as well as health service provision. As such it is very complex and relies on the coordination of the Central and Local Governments. A contextual factor is the high level of violence in Colombia, the presence of paramilitaries, guerrillas, and criminal gangs who use many different ways to obtain money for their activities. This apparently includes the health sector because there are reports that armed groups find corrupt ways to extract funds from the health system, in particular in some areas of the county at the sub-national level. Figure 3 presents the main corruption risks identified in the Subsidized System while the discussion that follows below explains them in more detail.

[27] Since January 2011, part of this 1.5% have been used for other priorities of the national health system.

Figure 3: Corruption risks in the Colombian Subsidized Health System directed at the poor



In the ***building block of governance and leadership***, certain areas of ***the regulatory function risk to be captured by special interests.*** Some laws, the selection of lead executives of sector oversight agencies and the processes to define what is to be financed with public money (priority setting) are perceived to be influenced by particular economic or political interests. Some experts considered the risks of capture in law making as the bottle neck for improving the efficiency of and preventing corruption in the system, in particular in a context where economic and political interests are (too?) closely intertwined. There have been some cases, for example where parliamentarians were at the same time owners of a health insurance or health provider company, or even both. There have also been allegations that a "cartel" of health insurers has provided funds for election campaigns for various parties. However, it was recognized by the experts consulted that proving forms of alleged capture is difficult, and distinguishing between illicit capture, legitimate "lobby," conflicts of interest and "legalized corruption" is problematic, too. In addition, the complexity of the system with ***numerous public and private actors, their many contractual relations and the lack of a comprehensive legal framework*** generate inefficiencies and risks to corruption. Despite the potential value of the above mentioned new health law, most experts agreed that there is ***not so much need for more laws but much more for the full operationalization and***

implementation of the existing ones. For example, a prior law of 2007 was still lacking a number of important regulations and existing rules and regulations are deemed as not rigorously applied.

The ***control and oversight system***[28] was identified as one of the key factors that facilitates, increases or may even stimulate corrupt practices in a complex health system like the Colombian one. For example, one of the sector oversight bodies, *Superintendencia de Salud*, had only about 140 staff to oversee 25.000 contracts between regional authorities and health insurance companies in the Subsidized System alone,[29] not to speak of its oversight role in the Contributive System. And the *Superintendencia* does not have the faculty to oversee how roughly 1100 municipalities spend their health budgets. The control system is considered ***weak, lacks institutional capacities and is characterized by both voids and superposition of control mandates***. These challenges have been exacerbated by an ***apparently insufficient political will***, at least until recently, to strengthen the system and remedy its failures. Questions raised in this context included: why was a legal intervention by the courts required to "force" the national health fund (FOSYGA) to make its data base available to another health sector institution? Why were municipalities not sanctioned with existing legal instruments when inefficiencies and alleged manipulations were discovered in their handling of health insurance contracts and beneficiary identification? Further, allegedly politicized decisions regarding sanctions and short prison sentences, if they are pronounced, have ***reduced the legitimacy of the control system and its deterrent effect***. To some extent the identified problems may be the result of an "un-orderly" growth of the health system with too little attention being paid to the control systems. However, putting the house in order ex-post requires strong political will and management capacity to overcome resistance.

In terms of ***social accountability***, the panorama is ***diverse with interesting examples for social accountability in some areas and considerable challenges in others***. For example, Colombia is considered to be among the champions in protecting constitutional rights, including the right to health and in this regard access to the benefit packages. Also, public hospitals have interesting social participation mechanisms (Giedion et al., 2001). On the other hand, most of the consulted experts considered that there is neither sufficient capacity nor adequate conditions for social actors to exert effective control over a sector as complex and technically difficult as the health sector. Moreover social accountability at the local levels can be intimidated by pressures and threats of armed illegal groups. Strong ***information asymmetry***, the ***lack of publicly available information***, insufficient ***channels for complaints*** and the ***apparent tolerance*** of sector inefficiencies compound the difficulties for social accountability.

In the ***building block of health care financing***, the area of health insurance (pooling of resources) seems to have been particularly prone to abuse. Thus, ***beneficiary affiliation*** to the health insurance companies[30] constituted an important area for ***inefficiencies in resource allocation and political***

[28] In Colombia, the term "Inspection, Vigilance and Control System (IVC)" is used.

[29] As said before, the mandates and faculties for control and oversight are divided between several institutions at the national and sub-national levels. For example regional governments have a role to oversee the contractual relations between

[30] The term beneficiary affiliation encompasses for reasons of simplification the processes of identification, selection and actual affiliation through the issuance of an insurance card.

manipulations related to electoral promises and fraudulent practices, involving the local authorities, health insurance companies and citizens alike. Political authorities are alleged to have manipulated the poverty assessment tool to include non-eligible persons as political favors of different nature. Citizens sub-declared their income or exchanged insurance cards to benefit from subsidized care. Verification systems have been weak. Finally, local authorities were reported as negotiating the affiliation of beneficiaries with particular EPS-S in return for commissions and/or other political favors. ***In 2009 the government established measures to correct the mentioned problems focusing in particular on strengthening information systems***.[31]

The subsidized health system consists of a ***complex web of insurance contracts between local authorities and EPS-S*** which was until recently the base for the flow of resources. The contract management has been an area for ***many and great risks to corruption and political pressures***. There are allegations that some EPS-S were created fictitiously and with fake affiliates, at times with the participation of armed actors, thus losing money in dark channels. According to a study of the Colombian Ministry of Health, the contract system has been particularly prone to corruption due to hundreds of actors and thousands of contractual relations (MPS, 2009), specifically in a context of strong political and clientelistic pressures. At the same time, ***control and sanction mechanisms generally do not seem to have been applied***, allegedly due to ***conflicts of interests by local authorities*** who should have overseen the system but some of whom had no interest in uncovering their own irregularities. In light of these problems, the ***new health law of 2011 foresees to "recentralize" some aspects of the health insurance function***. The necessity for the thousands of contracts has been eliminated. The flow of funds will be managed directly between the central level and the EPS-S and IPS-S, like in the Contributive System, while local authorities continue to monitor and oversee health insurers.

In the area of ***budget management***, the disparate but often fairly low operational capacities of local authorities and the lack of transparency ***create risks for significant leakages.*** This is specifically the case for funds that are transferred to and managed by the local authorities. This is not a synonym for corruption, but is preoccupying, in particular in view of the repeated statement that "the health budget is the trophy for clientelistic practices at the local levels"[32] as these funds do not seem to be fully and transparently accounted for.

In the ***building block of health service delivery***, the consulted experts indicated that the ***management of public hospitals (IPS-S) has improved considerably*** over the past years. This is partly attributed to their regulation, which transformed IPS-S into autonomous public companies with boards and control systems similar to those of private companies. Nevertheless, there are still risks to corruption.[33] As in most countries, the ***procurement of goods and services*** is particularly vulnerable. "Commissions" are

[31] With the introduction of a unified data base (BDUA) in 2009, for example, the number of people who are duly affiliated to one of the health insurance companies and fulfill all the conditions to be a beneficiary dropped considerably (to between 60% and 85% of the originally registered people). On the other hand, the reforms established a separation of functions between identification, selection and affiliation.

[32] This expression was used by several of the consulted experts.

[33] See Giedion, et al. (2001), "The impact of health reform on irregularities in Bogotá hospitals," as one of the few or only publications on these issues. What seems to be more known and documented are public hospital inefficiencies.

said to be generalized ranging from 10%-30% or more. Direct contracting seems to be used to select favored providers against bribes and fictitious procurement and cost-inflation of goods are well-known. There are allegations of public IPS inflating the costs they charge to the EPS-S but proof is difficult as they are not obliged to report their detailed cost structure, the so-called RIPS. But, the government recognized the lack of standardized and efficient procurement and included into the new National Development Plan 2011-2014 an article stipulating that payments of local authorities to IPS-S can only be made on the basis of supporting documents proving the effectively delivered quantities and costs of services. ***A structural risk for inefficiencies and abuse is the fact that EPS-S have to contract at least 60% of their health services through public IPS-S***. This is certainly no incentive for the latter to become more efficient, less so given that the payment mechanism is a fixed sum per beneficiary (capitation). Finally, a ***worrying aspect is the presence of armed groups in some areas***. They are reported as extorting money, positions and contracts as well as penetrating the system through the creation of façade companies.[34]

The ***building block of workforce or human resources*** has ***not surfaced as particularly problematic with regard to corruption risks***, in contrast to the case study from Peru for example. This may be explained by either i) the other identified problems are more serious, or ii) it is an area really not very prone to irregularities.[35] However, two issues have been signaled repeatedly. On the one hand, the ***political interference in or manipulation of the selection of public IPS executives is not uncommon***. In fact, to reduce precisely this risk, the selection of the IPS-S executive(s) had been detached from the political cycle. But it was apparently changed back a few years later. On the other hand, the ***recruitment of general staff*** of the IPS-S, which may be more numerous than the staff of the respective municipality, as well as of the EPS-S is an ***area where political favors and election promises are said to be paid***.

The ***building block of drugs and medical supplies*** is, as in most countries, an ***area for significant risks to corruption*** along the chain of selection, approval, procurement, distribution and management of drugs and supplies. According to the experts and as evidenced in the recent scandal of corruption in the Colombian health system the risks to corruption, cost-inflation, collusion and other types of abuse ***seem to be greater in the Contributive than the Subsidized System because it the former handles larger sums of money.*** However, ***this should not lead to the inference that there are few problems in this area of the Subsidized System***. Rather, most experts assume that the risks are significant, too. But due to the lack and bad quality of information not much knowledge has surfaced yet. The absence of reference prices in a largely liberalized drug market has been identified as one of the risks for at least unethical if not illicit or collusive cost-inflation.[36] In all, indications for existing irregularities need to be analyzed with

[34] See, for example, http://www.nuevoarcoiris.org.co/sac/?q=node/1122 and www.elcolombiano.com (30 June 2011).
[35] Absenteeism has not been identified as a particularly relevant problem in Colombia, in contrast to a variety of other countries in the region. See Di Tella and Savedoff (2001).
[36] Drug prices for both relatively standardized and more exceptional drugs are often several times higher than those of other countries in the region or even the US. The recent establishment of reference prices for some drugs has reduced their price by up to 30%.

care in order to distinguish between inefficiencies in the normal functioning of markets, lack of capacity and intentional abuse.[37]

The ***building block of information systems*** is acknowledged ***as one of the backbones for the management and control of the Colombian health system*** as well as for the prevention and detection of corruption. Against this recognition, the ***absence of a clear information and transparency policy for the sector was identified as one of the key problems of which a number of others derive.*** Existing norms do not seem to allow greater transparency of the system, both with regard to information needs for the performance of regulatory and oversight agencies as well as for the public in general. Information systems are still weak and incoherent making intra-system communication difficult. On the other hand, there has been ***insufficient political will to make existing norms and systems work*** as has been shown throughout the case study. For example, the data base of the national health fund could have been made public, IPS-S could have been obliged (actually they had been for a while) to establish systems and capacity for detailed reporting of services and costs. Also, a law from 2007 already foresaw to improve information transparency, but the necessary measures were not taken. This challenge has been exacerbated by the apparent ***resistance of those actors that are subject to control and oversight***, as well as their ***insufficient human and financial resources*** to generate information systematically and to make it available at least internally in the system, and better publicly.[38] However, a certain vicious circle was identified as part of the problem, as those actors that are willing to be more open find themselves easily accused of incomplete, incorrect or inopportune information so that they opt not to publish it at all. It should be noted that the ***health law of 2011 puts a renewed emphasis on improving the management and flow of information.***

Although the Colombian case study focused on the Subsidized System for the poor, it is worth mentioning the ***most recently detected salient corruption risks in the Contributive System***.[39] An enormous corruption scandal exploded in early May 2011. Several charges were levied in Parliamentary Hearings and numerous articles in the press pointing at a *corruption carrousel* involving public and private actors alike. The first set of charges, the so-called "*Recobros,*" are ***payments for health services and drugs not covered by the mandatory benefit package*** but reimbursed to the EPS by the national health fund FOSYGA.[40] The abuse in the application of this instrument was ***caused by a lack of transparency and controls*** and is said to cost the country hundreds of millions of US$ in claims.[41] The main question that arises in this context is: ***how could this fraud scheme – visible or observable at least***

[37] See also Giedion et al. (2001), "The impact of health reform on irregularities in Bogotá hospitals," IDB, Washington.

[38] According to the experts 70% of the local health authorities consulted for a yet unpublished study by the Colombian government conducted in 2009 did not send the requested information.

[39] The field work for this study was carried out four weeks before a huge scandal of corruption shook the Colombian health system and country as a whole due to the huge amounts of resources involved and the organized schemes. Interestingly, a number of the most prominent features of the scandal were repeatedly referred to already in the interviews, which leads to the question why action had not been taken earlier.

[40] Even though a predefined explicit benefits package exists, citizens can request services, through different legal procedures, that are necessary for them according to the treating physician's opinion. The costs for these services are reimbursed by the national health fund (FOSYGA) to the patient's EPS.

[41] See for example http://www.lasillavacia.com/historia/los-usos-de-los-medicamentos-otro-tema-pendiente-de-las-eps-23807?page=1 and http://www.wradio.com.co/nota.aspx?id=1483072

for the last 4 years – reach such levels without any of the actors intervening? The second set of charges indicates that ***the EPS are inflating their costs in their reporting to the public regulating and oversight agencies***. Some EPS are alleged to spend 3-5 times as much on drugs, for example, than the majority of the EPS. The reasons are yet to be established.[42] The final set of charges involve the ***affiliation of beneficiaries to the Contributive System with alleged fraudulent behaviors on the part of the EPS*** (they may affiliate "ghost" patients – those already affiliated with the RS – and pocket the capitation payments),[43] private sector agents (the pharmaceutical industry may pay for the affiliation of patients with high cost diseases and then benefit from selling the drugs), or the beneficiaries themselves (for example, they may elude or evade the payment of their contributions by sub-declaring their income). These practices are attributed in part to the complicity between the involved actors.

The public scandals in the Contributive System reveal similar weaknesses and corruption risks as those identified for the Subsidized System. The following features stand out: the insufficient and apparently captured regulation of the sub-system, the lack of transparent and public information, a great relaxedness and insufficient internal and external controls, fraudulent and collusive behaviors of the private health insurers (the EPS - which are mostly not the same as those of the Subsidized System), and the creation of criminal networks between agents of the private and the public sector. In other words, it evidences ***multiple systemic weaknesses of and criminal behaviors in the sub-sector with broadly shared responsibilities between public and the private sector agents***. A detailed analysis of what has happened, why and how would be required to address the problems with measures based on solid evidence instead of getting caught in ideological and/or populist responses.[44]

Some ***relevant lessons learned*** emerge with regard to the risks of corruption in the Subsidized System discussed above, these include:

- The Colombian case illustrates that in a system with payment-provider split and ***competitive health insurance mechanisms, vulnerabilities related in particular to fraud and corruption in claims processing and affiliation***, areas of vulnerability that do not exist in integrated public provision systems. It also shows that ***decentralization***, in particular in the administration of funds, of the Subsidized System seems to ***have implied a "decentralization of corruption risks".*** However, it is ***impossible*** with the available data ***to compare the impact on the health sector goals*** such as equitable access and quality of care. What should be noted, though, is that decentralization allowed to achieve high health insurance coverage (see points below). The case also shows that while the sub-system for the poor is vulnerable to corruption and fraud, the ***larger amounts of money in the***

[42] See for example http://www.semana.com/nacion/super-precios-medicamentos/156674-3.aspx.
[43] See for example http://www.eltiempo.com/justicia/ARTICULO-WEB-NEW_NOTA_INTERIOR-9432327.html
[44] The current public debate around the scandal has led to heated discussions about the role of the private sector, questioning the approach to "turn the health sector into a business". Although the questioning is legitimate, debates should not loose sight of the fact that i) private sector participation offers the potential to broaden coverage (which seems to have been achieved) and increase access to and quality of care (data here seem to be difficult to get by) and ii) that the public sector seems to have turned blind eyes – at least until recently – to some of the underlying but evident system failures. Finally, the public sector is far from being immune against corruption.

sub-system serving the richer population may make this a more attractive target for criminal activity.

- The ***subsidized health system and political legitimacy***, both at the sub-national and national levels, have been ***closely linked***. ***Sub-national governments achieved a high level of insurance coverage, but health subsidies have also become a source of political capital and abuse*** in the context of political, financial and administrative decentralization as well as of increased funding for health.

- After some years of political toleration, the government has initiated since 2009 reforms that, among others, ***address the greatest risks for corruption,[45] for example by recentralizing certain functions of the system*** (the flow of funds and beneficiary data base). However, the centralization of functions does not per se prevent corruption from happening as evidenced by the scandal in the Contributive System.

- The ***need for a solid institutional infrastructure at the local level*** for a decentralized subsidized health system ***was underestimated***. The risks of manipulations in return for political favors and support have not been taken sufficiently into consideration early on.

- ***Transparency, in the form of information management systems*** and ***access to informati***on both by sector oversight and regulatory agencies as well as by the public, ***cannot be overestimated***. Special emphasis should be paid to beneficiary affiliation, the flow and management of funds, the financial status of the different entities of the system, the costs and quality of health services delivered, contract management with health insurers and health providers, and the prices and quality control of drugs.

- ***The system of control and oversight has been evidently weak which*** was further aggravated by ***insufficient political will*** to address this crucial area with determined corrective measures and resources. ***How can this be explained from a political economy perspective***, for example what is the role, influence, lobby or resistance of those to be controlled?

- ***Armed and criminal actors have seemingly captured (parts of) the Subsidized System in certain local areas***. Especially groups associated with paramilitary forces seem to have ***penetrated parts of the health system through façade companies, cooptation of sector institutions*** and other mechanisms. This is evidently a highly sensitive and dangerous issue.

- ***The adoption of new laws to address system failures, including risks to corruption, is important***. However, before developing new laws, which may be more politically than technically indicated, it would be useful to do an in-depth review of ***why prior laws and norms have not been fully implemented***. In this sense, there are surely important lessons learned for the implementation of the health law from 2011.

[45] The Law 1438/2011 brings the earlier initiatives under one umbrella and adds further measures.

- Last but not least, the ***lack of serious studies*** to analyze in detail and on the basis of empirical data the risks to corruption ***make it difficult to identify, prioritize and monitor actions on problematic areas.*** This also increases the risk that both public and technical debates are politicized, especially in the context of scandals, which does not help to find and implement measures for sustainable change.

4.2 Peru: corruption risks in the sub-system for the poor of Ministry of Health (MINSA)

The Peruvian health system consists of the public sector comprising several sub-systems for different target populations and a much smaller private sector.[46] The sub-systems of the public health sector include: i) the Ministry of Health (MINSA) providing health services through its own service delivery networks to the poor and marginalized of which close to 40% are affiliated to the Integral Health Insurance (SIS), ii) the Social Health Security entity (EsSalud) provides health insurance and service delivery through its own institutions mainly to people with formal employment and covers roughly 20% of the population; iii) the armed forces and the police have their own corporate health insurance system and service delivery infrastructure. It should be noted that the Peruvian "non-institutional" private sector includes pharmacies that mainly sell drugs directly to the population (in late 2010, for example 18% of the people with health problems consulted directly with pharmacies, while 19% went to a health establishment operated by MINSA). The Peruvian health system is considered as fragmented and segmented with little inter-institutional coordination and strong interests by economic and professional groups (Petrera, 2007).

The sub-system of the MINSA maintains the traditional vertical integration of functions that have characterized Latin American health systems in the 70s and 80s. The MINSA has its own apparatus of public health service providers. One of its few organs with special status is the Integral Health Insurance (SIS – *Seguro Integral de Salud*). The SIS is a fund that reimburses the variable costs of a list of certain health services and drugs to be delivered to the poor. The fixed costs of the services, which constitute around 82%, are transferred directly from the national level to the health providers. In the proper sense of the concept, the SIS is not insurance but a subsidy.

It is also worth mentioning that the MINSA has been decentralized in the past few years in line with a general renewed process of decentralization, also called regionalization. The full implementation of this process is still under way in the health sector, for example, the public hospitals of Lima and Callao have as yet to be transferred from the MINSA to the respective regional governments. In general, the MINSA has the overall functions of stewardship and regulation of the sector (the other public health insurance sub-systems depend on other ministries, though). The main funding for the MINSA sub-system comes from general taxes. The decentralized public health providers generate some income through fees and co-payments for services not covered under the SIS. The SIS used to be mainly managed by service providers and local authorities with the central government being responsible for the reimbursement of the costs. However, the management of beneficiary identification has been transferred recently to the

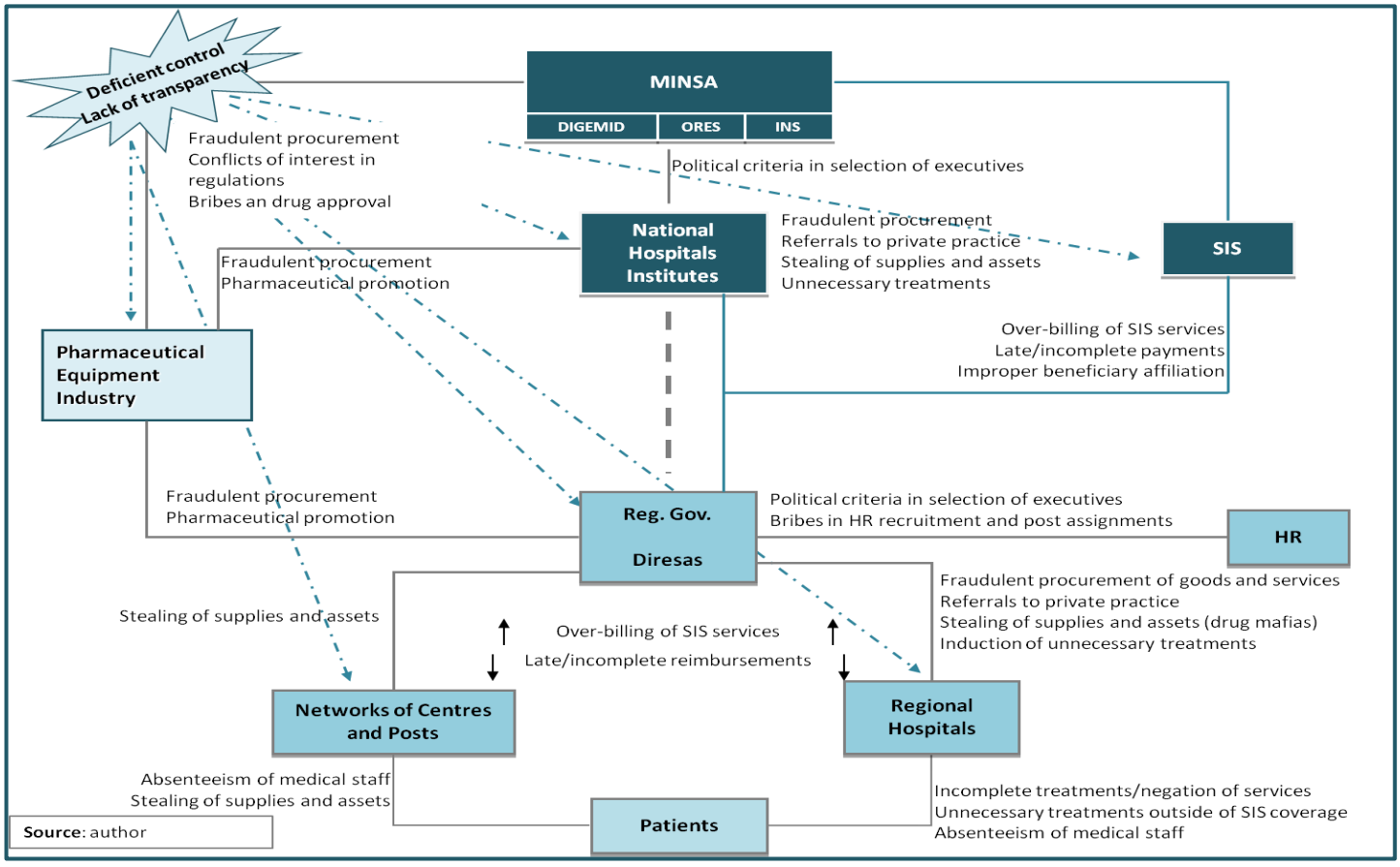
[46] The private sector consists of several private health insurance schemes, private clinics and practices attending the population with capacity to pay.

Ministry of Economy and Finance to combine it, at the national level, with an integrated targeting system for public subsidies in the social sectors. Within the Peruvian decentralized system of 26 regions, there are the corresponding 26 Regional Health Directorates (Diresas) which manage their networks of hospitals, health centers and health posts with high levels of autonomy. Finally the function of oversight and control is divided between local and national level authorities.

It is to be expected that increased levels of tax revenue from natural resource extraction that are transferred from the national to the local levels may increase rent-seeking opportunities and influence political economy dynamics. If it was possible to draw a parallel with the Colombian "story", some important lessons may be learned despite the profound differences of the systems.

In sum, the MINSA sub-system has been decentralized recently, a process yet to be finalized and it is an example of direct public provision of health care. Figure 4 presents the main corruption risks identified in MINSA sub-system while the discussion that follows below explains them in more detail.

Figure 4: Corruption risk map in the Peruvian sub-system of MINSA (simplified)



In the ***building block of governance and leadership,*** it was noted that the MINSA has as yet to strengthen its strategic planning capacity and that it is facing some limitations to fully exert its role as

steward of the health sector in general and the MINSA led sub-system in particular. There seems to be room for ***conflicts of interest among the competent authorities of the MINSA*** to influence the formulation and approval of laws and norms. Some of them are attributed to the "revolving door" (rotation in positions), for example public doctors or executives of public hospitals may become officials of MINSA and have then to regulate certain aspects of their former positions which they are likely to move back to. Conflicts of interest have also been alleged in some regulation(s) of private sector activities, such as clinical trials of drugs, in which some of the public officials with regulating authority may have a stake. A regulatory deficit repeatedly referred to in Peru is the lack of clear rules on pharmaceutical promotion which opens the doors for illegitimate and unethical practices to "align public sector agents". These practices are mainly aimed at influencing the procurement and prescription of drugs.

As in Colombia, the ***control and oversight system*** was considered by all consulted experts ***to be misdirected and weak***. This assessment was confirmed by corruption diagnostics conducted as part of four Regional Anti-Corruption Health Plans.[47] Control systems are considered as misdirected because they focus on controlling expenditures but pay ***little attention to determine whether funds are well spent, services reach citizens, or drugs and supplies exist at service delivery points*.** The control system is also weak because the MINSA does not have much control over the Diresas which respond to the Regional Governments. ***This weakness is not considered to be a result of decentralization as such but rather a lack of solid information systems, institutional management and control capacities at the national level***. At the service provider level, particularly in public hospitals, controls are weak because internal controllers used to lack independence and the resources and capacities necessary to fulfill their functions. Due to the weak control of the drug regulation authority (Digemid), in Peru almost any pharmaceutical product can be registered. In fact, the presence of counterfeit drugs is estimated at 20% of the market. Sanctions have little deterrent effect which is partly attributed to strong *behavioral norms* in the sector, where "nobody reports nobody", where alleged abuses are covered or minimized and where few (want to) get involved in the internal detection and investigation of cases.

There is ***little social accountability*** in the public health sector operated by MINSA. The National Health Council,[48] for example, does not have a working group on transparency, accountability and corruption control. Civil society organizations active in the sector are grouped in a coalition called ForoSalud and exert some external vigilance, but little attention has been paid so far to accountability and corruption control. Proética, the national chapter of Transparency International, developed in collaboration with Regional Governments a series of Regional Anti-Corruption Health Plans, but these do not seem to have been implemented by the Regional Governments. Finally, the experts noted with concern that the ***population is apparently fairly tolerant and accepting of the sector's inefficiencies, and the prevalence of unethical and corrupt practices***. This social tolerance was attributed to i) the lack of information and

[47] See Regional Anti-Corruption Health Plans for La Libertad, Lambayeque, San Martín y Uyucalí, 2008.
[48] The National Health Council is a coordinating body of the MINSA and the national health system and foresees the participation of civil society, see http://www.minsa.gob.pe/cns/default.asp.

knowledge of rights; ii) the relations of authority between doctors and patients; iii) information asymmetries between patients and other actors; and iv) the lack of complaints and reporting channels.

In the ***building block of health care financing***, the area of ***generating revenues*** for the MINSA sub-system evidences ***risks for fraudulent abuse***. As stated above, the sub-system of the MINSA is financed through two sources: i) mainly general government taxes; ii) directly generated funds levied at the service delivery points in form of co-payments and fees. Information collected for this study only allowed identifying risks in directly generated funds. Thus the lack of a good registry of them allows for leakages despite improvements thanks to the introduction of an electronic financial management system (SIAF). Official fees and co-payments may be managed fraudulently avoiding that the funds are even registered.[49] In the area of the SIS, which is referred to as ***health insurance***, problems of inclusion and exclusion in the beneficiary identification still need to be addressed despite the improvements achieved over the past years by reactivating the Household Targeting System (SISFOH) as a unified instrument for the targeting of social programs managed by the Ministry of Economy and Finance. The integration of different data basis is still problematic. "***Leakages***" in the affiliation, which amount to roughly 12% of the affiliated population, may be due to ***simple mistakes or fraudulent behaviors on the part of officials or beneficiaries.*** A further risk area is the reimbursement scheme under the SIS. While the Diresas are accused of delaying the transfer of funds to providers and of not transferring the full amounts, the health service providers are accused of over-invoicing and claiming payments for ghost patients. In terms of potential ***leakages in the budget management*** of the MINSA sub-system, the consulted experts ***did not perceive acute problems***. Given that Regional Governments do not have direct access to the funds but monitor their flow through electronic systems, there would not be much room for abuse. However, at the ***level of spending agencies***, the administrative units that manage the money, ***problems do occur***. For example, in some cases staff of health facilities at the sub-national level are accused of protecting their activities from scrutiny as they are alleged to resist more transparent budget and inventory management systems.

In the ***building block of health service delivery*** the ***major corruption risk areas seem to be concentrated in public hospitals,*** where more financial and human resources are managed, followed by lower level health centers and health posts, where capacity limits and "micro-corruption" are more of the order. Actually, a study on national level hospitals revealed that perceptions of corruption regarding absenteeism and the procurement of standardized supplies were more frequent in hospitals of the MINSA than in those of EsSalud (Alzar & Andrade, 2001). The ***procurement of drugs and supplies*** (see below) as well as goods and services is particularly prone to corruption risks. A number of public scandals in the press around hospital construction and remodeling, procurement on ambulances and the contracting of consultancies illustrate this risk area. The inflation of costs of goods and services seems to be a usual practice to hide kickbacks and graft. Informants said it is not unusual either for contractors to pay 10% of a contract value to a public official just to withdraw the payment check. At the service delivery level, ***health providers may establish systems of "extra-official" fees or other access barriers***

[49] Receipts for fees and co-payments may be sold several fold or receipts are not given at all to the patient, while patients do not demand a receipt for their records mostly due to their lack of knowledge about their rights.

(queues, preferential treatment, and different working hours) in order to extort bribes, to divert patients to non-SIS treatments or to refer them straight to private practice where higher fees are normal but often not accessible to the poor. Although these practices are rather common, it is ***difficult to determine whether they are intentional corrupt acts, unethical efforts aimed at compensating for inefficient health care management*** or if they fall somewhere into the grey zone in between. Given that medical staff is poorly paid, there seems to be a considerable social tolerance and acceptance of these practices. The management of ***drugs and supplies*** is an area for particular concern, as there is a ***significant degree of stealing and trafficking with accusations of small criminal gangs*** operating in and out of MINSA health establishments.[50] Last but not least, the ***management of capital goods is considered deficient.*** Embezzlement, manipulation and stealing of equipment are not unusual and mainly attributed to weak asset management systems. The Integrated System of Administrative Management (SIGA) is meant to address this issue among others. But full implementation and use have still to be rolled out to all spending agencies, some of which have reportedly shown "fierce and creative" resistance. The attitude "you buy, you use, you abuse, you throw away" is not uncommon. One telling example to illustrate this risk area is related with the purchase of five ambulances, four of which were "lost" for four months while one has still not "appeared" after one year from starting the search.[51]

In the ***building block of human resource management*** one of the main problems in the MINSA sub-system is ***absenteeism*** (or the "stealing" of public time) by the medical staff. Doctors ***spend up to 30% of their time outside of some public hospitals.*** It is noteworthy that doctors and other medical staff recruited under fixed-term contracts incur less frequently in this practice (Alcazar & Andrade, 2001). Low levels of pay are used as an excuse to justify such absences, which are used to undertake other jobs or positions. The ***lack of transparency, clear profiles for the positions, unclear vacancy announcements, and a multitude of different contracting arrangements with significant degrees of discretion*** expose the area of ***recruitment and geographical assignment of staff to bribery, favoritism and political interference.*** The lack of transparency in the selection of various public hospital directors in Lima caused great public debate, for example, due to the perception of political interference in the process.[52] In interviews, respondents reported that it is not uncommon for individuals to pay a share of the expected salary, one or several month's worth of salary or a fixed price, as bribe to get a job.

In the ***building block of drugs and medical supplies*** the MINSA has promoted a series of ***important reforms at the national level, such as corporate procurement, inversed auctions and a system of reference prices*** to address efficiency and corruption problems in this area by lowering costs and increasing transparency. But risks for abuse persist. Diresas reportedly use a series of ***legal "tricks" to bypass transparent competitive procurement rules and use direct or emergency procurement.*** These processes are particularly vulnerable to bribery, graft and collusion, sometimes involving the creation of cartels. 32% of surveyed doctors considered that the lack of transparency in the procurement of medical supplies was normal or very normal (Alcazar & Andrade, 2001). The ***procurement of medical equipment***

[50] See Regional Anti-Corruption Health Plans to be consulted with www.proetica.org.pe
[51] This information was provided in an interview with an expert from the Ministry of Finance and Economy.
[52] See http://limanorte.wordpress.com/2009/05/10/escandalo-modifican-bases-y-reglamento-del-minsa-para-mantener-a-4-directores-de-hospitales/

and technology was pointed out by informants as special risk area,[53] which has not received sufficient attention yet in light of the fact that the money moved in this market is deemed to be triple that of the drug market. Finally, clinical trials are an area for corruption risks as bribes are reportedly changing hands in their approval and because high level public officials of the health sector continue to receive income from the pharmaceutical industry as researchers for clinical trials, even though this may not be handled openly.

The ***building block of health information systems*** is ***acknowledged as one of the centre pieces for good health sector management and control***. However, the current health sector information systems are considered poorly utilized and ***weak.*** The information system is poorly utilized in part due to a "paper culture" that makes it hard to capture, retrieve and manage information. Interestingly, experts coincided in saying that both information systems and control within the health system were more effective during the government of Fujimori. Since then a ***tendency of relaxedness set in which was compounded by the decentralization process as the clear lines of accountability became blurred and the stewardship function of the MINSA was weakened.*** Efforts to improve the information systems are under way, including from the Ministry of Economy and Finance. It may actually have more leverage to introduce change due to its authority over budget transfers.

Although the Peruvian case study focused on the sub-system of the MINSA it is worth mentioning the ***corruption risks of other sub-systems*** that were referred to repeatedly by the interviewed experts. ***Procurement is considered a great risk area in other sub-systems, too.*** For example, a major scandal emerged over the construction of tens of hospitals by EsSalud which was in turn connected to an even wider corruption scheme that brought the Peruvian Cabinet down in 2008. The risks to corruption in the procurement of drugs are also considered to be greater in EsSalud than in the MINSA service system because it handles much greater volumes of funds. One study found that inducing unnecessary treatments is also more common in EsSalud and private hospitals than in MINSA facilities.[54] Further, the ***affiliation to EsSalud*** may be achieved through bribes which seem to be a practice used if ***patients suffer from high-cost diseases***. Finally, the consulted experts drew attention to the fact that in the EsSalud sub-system the term "corruption" is not used in any of the documents, neither as analytical concept nor as risk factor, although corruption risks exist at all levels.

As in the Colombian case, some relevant lessons can be drawn from the MINSA case study:

- The Peruvian sub-system serving the poor relies on ***public provision and public staff***. This creates a range of serious ***vulnerabilities in the area of human resources***. In particular, absenteeism is a serious problem, redirecting patients to private practice, and "buying" jobs. This kind of corruption is notably larger in the Peruvian system than in Colombia where managers have a stronger interest in functional facilities and greater discretion in managing staff. The ***management of drugs and supplies*** as well as ***asset management*** in health service establishments ***has also surfaced as***

[53] The procurement of supplies to make medical equipment work may be tied to specific products or the medical apparatus itself may even be provided as a gift, since the income for the company derives from the supplies.
[54] The delivery of new-born through caesareans constitutes of 25% of the deliveries in MINSA, 59% of those in EsSalud, and 78% in private clinics (Alcazar & Andrade, 2001).

particularly vulnerable to abuses, in contrast to the Colombian case. On the other hand, there are two issues similar to the findings of the Colombian case: The ***procurement of drugs and medical equipment continues to be an area of concern*** despite important reform efforts. And corruption risks as well as associated volumes of funds are perceived to be higher in the other sub-systems (see point below).

- ***Public procurement is a key area of concern but may be small relative to procurement in the other sub-systems***, such as EsSalud, where the amount of money involved is much larger. The introduction of ***corporate procurement and inversed auctions*** as well as the increased control of (some) high costs drugs has led to ***significant improvements***. Some drugs are bought in alliance with other countries and price observatories have been established.

- ***Poor information management helps hide corrupt practices*** in the public sub-system and there is some evidence that staff resist information improvements that would reveal their abuses.

- One interesting aspect is that ***corruption often dominates public and political debates but turns into a sort of a taboo in the technical health sector discussions. Why?*** A more open, non-politicized debate on the issues would be relevant.

- Three aspects of the organizational cultural in the sector impede a more open approach towards corrupt and unethical practices: i) a "***culture of fear" based on concerns over losing jobs***; ii) appropriate conditions to promote a "***culture of complaints and reporting" do not exist***, there is fear of retaliation both among public officials and providers; and iii) the relatively ***closed character of the medical profession***. Not only is there resistance to address corruption issues openly but there does not seem to be great enthusiasm for an increased focus on ethics and transparency either.

- Measures to strengthen transparency and accountability have been taken reactively and effective implementation depends to a good extent on the political cycles. A consciousness or ***willingness to address pro-actively the corruption risks*** in a systematic and prioritized way ***is not yet existent***.

- The ***segmented and fragmented nature of the Peruvian health sector hinders*** the introduction of ***reforms to improve transparency*** and address corruption risks across the sector. In fact, a sector-wide health reform to (re-)design a coherent national health system is still pending.

- The ***inexistence of serious studies to analyze*** in detail and on the basis of solid empirical data the ***risks to corruption have hindered to identify, prioritize and monitor actions*** on problematic areas.

EMERGING ISSUES

Chapter 5

Emerging issues

A surprising lack of well-founded diagnostics of corruption and corruption risks in national health systems hinders pro-active approaches to pursue the principle "prevention is better than the cure."

Perhaps one of the most notable issues emerging from the case studies and the desk review is the surprising lack of information, of serious studies of the risks to corruption as well as of diagnostics of the types and frequencies of different corrupt practices in the health sectors of Latin America (be they called inefficiencies, irregularities, or corruption) and the volumes of the resources involved, or estimates of the latter.[55] The absence of such diagnostics does not allow generating political will as evidence is largely anecdotal and can easily be neglected. It also increases the risk that both public and technical debates are politicized, especially in the context of scandals, which does not help to find and implement measures for sustainable change. Virtually all experts consulted agreed that a system wide diagnostic of corruption and the forms of how corrupt networks operate in the health sector would be useful and is needed. Also, more analysis of the impact of corruption on health outcomes and the social damage caused would help create a critical mass for reform and break through wide spread social tolerance.

Political economy analysis from a health systems perspective is useful to identify opportunities for reform and potential blockers or blockages.

The explorative case studies illustrate the value of a health systems approach to identify corruption risks and systems weaknesses or failures. They also highlight the need for political economy analysis in the health sector, both at national and sub-national levels, to understand the underlying political, economic and social dynamics which give rise to opportunities for reform and identify the factors and players that put up resistance. Despite the technocratic nature of the health sectors, they tend to be subject to strong political economy aspects, which vary depending on the degree of decentralization and the level of private sector participation.

Health systems reforms can "reform" corruption risks. Changes in the types of predominant risks as a result of system reforms should not lead to quick but probably erroneous conclusions that one system is more prone to corruption than another but 'simply' indicates that the focus of the risks may change.

[55] The evaluation of the overall efficiency and effectiveness of the Colombian Subsidized health system and the suggested corrective measures (see MPS, 2009), for example, is an interesting example on a health systems analysis that identified risks for irregularities, inefficiencies, collusion, filtrations, etc. but refrained from using the term "corrupt practices". The reasons for this are several-fold: i) the focus did not lie on analysing corrupt or bad practice but on evaluating the system as such; ii) as an internal document of the Ministry of Social Protection it was considered more conducive to generate a critical mass for reform if the more aggressive and confrontational term corruption was avoided and unpacked into different practices; iii) alluding to corruption or even corruption risks without sufficient documented empirical evidence was considered as problematic.

Different dimensions of the national health system design seem to have a significant impact on the nature of corruption risks in each system. These dimensions include i) the level of centralization versus decentralization of the political system and the health system (these do not have to go fully together); ii) the level of vertical integration (payer and provider separation, whether public or private),[56] and iii) the level of private participation in health insurance, health service delivery or both. For example, the decentralization of the Colombian Subsidized System increased opportunities for corruption (but achieving notable increases in health insurance coverage) while similar evidence has not emerged (yet?) in the Peruvian case. Or the increased participation of private sector actors in the Colombian health systems have changed their incentive structures, political economy and risks for abuse and rent-seeking. Also, both case studies indicated that risks to corruption and alleged corruption is considerably higher in the social security health sub-systems, those that are not targeted at the poor, due to the sheer volumes of funds and economic interests which create greater risks for capture and rent-seeking. If systemic failures of the system are discovered, for example through a systems wide corruption scandal as happened in the Contributive System in Colombia, even the loss of large sums of money should not lead actors to jump to conclusions about whether or not one system (for example public, decentralized) is better than another (for example private-public mix, centralized). The first question to be asked would be "better in terms of what"? Corruption control? Accountability and Transparency (which is certainly not the same as corruption control, as the latter goes much further)? Health outcomes? Access to quality health care? Health insurance coverage? Or a combination of all the before, and if so, which aspects is weighed how much?

Decentralization risks "decentralizing" corruption. Decentralized systems are not a "silver bullet" for increased transparency and effective accountability (nor is there evidence that centralized systems are necessarily less corrupt).

Although it is not possible with the available evidence to determine whether decentralized health systems are more or less vulnerable to corruption than centralized systems, decentralized systems are clearly vulnerable to corruption in particular ways. In Colombia, delegating financial management of the subsidized system to local governments has created opportunities to manipulate the system for political ends that would not be possible in a centralized system, while a centralized system would be vulnerable to other forms of abuse. In particular, in contexts where public health subsidies – through health insurance schemes like in Colombia or a public fund like in Peru – are managed at the sub-national levels, risks for abuse at the local level increase. Public (health) subsidies are closely linked to the political legitimacy of local authorities and thus may become a sort of political capital and source of abuse, especially if mechanisms to strengthen citizen participation and voice are not sufficiently built up. At the same time, it is worth recalling that the centralization of functions does not per se prevent corruption from happening as evidenced in the scandal in the Colombian Contributive System.

[56] This is the case, for example, in some private health insurers in Colombia that manage partly their own health care delivery networks and thus constitute a system of "private" vertical integration, a system which is actually hotly debated in the current Colombian context mainly due to allegations of illicit enrichment.

Furthermore, decentralization with effective citizen participation and local accountability can, in some cases, reduce corruption.[57]

The risk that laws, executive norms and regulatory or oversight agencies of the health sector may be "captured" is undeniable yet little researched.

The two case studies suggest that the perception of risks of capture of various parts of the health system (legislative processes, executive norms and procedures, sector agencies, decentralized authorities, etc.) differ depending on the nature of private sector participation as well as on the level of decentralization. These risks of capture by various actors (clientelistic politics, private companies, and in some cases illegal and/or armed groups) are best analyzed from a health systems perspective that identifies which players are involved (those "capturing" and those being "captured), their motivations (political, economic, both) and their nature (bordering legal influence or clearly illegal or illicit). Different solutions may be needed at different levels. Reducing risks of capture at the national level requires addressing conflicts of interest and undue influence in regulatory processes as wells as broader national issues such as campaign financing. At the sub-national level, reducing risks of capture may be related to increasing transparency and accountability of the use of health funds in particular in the realm of procurement.

Information systems and access to information are one of THE key components of efficient, effective, responsive health systems and accountability for results – the need for a sector wide transparency and information policy.

The relevance of health information systems has been widely recognized. Both case studies as well as the studies from Latin American hospitals show clearly the link between corruption risks and weak or non-transparent information systems. They indicate as well the inverse relationship that better and more transparent information contributes to reducing illicit practices. Transparent and coherent information systems that strengthen the conditions for control and accountability among the many different actors are particularly relevant in situations where more actors participate in the different functions of the health systems (in economic terms the typical principal agent challenges are multiplied) and where the functions are partially or considerably decentralized, or both. In the case of Colombia, for example, consulted experts agreed that a clear transparency and information management policy should be developed, encompassing all public as well as private actors with public functions of the health sector. Bringing the different efforts of improved information management and increased transparency together is crucial for the overall effectiveness of national health systems, but it is difficult. As illustrated by the case studies, there may be strong resistance for different reasons (economic, political, organizational culture) by different players (governmental or private) and at different levels of the administration (central, regional or local). Thus, the promotion of a health sector transparency and accountability policy is "more a need to guarantee system governance than 'only' one to fight corruption" as stated by one of the experts consulted for the study.

[57] See Gray-Molina, et al. (2001), "Does voice matter? Participation and controlling corruption in Bolivian Hospitals," IDB.

An integral strategy of internal and external control that ensures complementarity of and coherence between the different actors is essential and requires strong stewardship.

Increasing transparency and improving information management does not bring about change without an integral strategy for internal and external control. What sounds obvious is in practice fraught with challenges. General control and oversight mandates may be scattered among different agencies at the national and sub-national levels. Furthermore, inter-institutional coordination is usually weak among state institutions, particularly when they operate at different levels of a decentralized political and public administration system, as is the case of the national, regional and municipal comptroller offices in Colombia. Also, oversight and control agencies specific to the health sector (including health insurance oversight body, independent drug control agency, etc.) may be ill equipped (by design?) to perform their functions and to prevent or detect corrupt practices. Of particular relevance is their institutional design (for example systems to prevent capture and conflicts of interest among executives, size vis-à-vis attributed mandates) and organizational as well as technical capacity to perform their functions relatively independently. Finally, an issue of increasing relevance and complexity is the control of private actors, both in their function as health insurers and health providers, a task for which public sector institutions – with their logic of process control instead of risk control – are ill-equipped. The design and implementation of an integral control strategy requires doubtless strong stewardship of the relevant authorities.

Not surprisingly, the area of drugs, medical equipment and supplies has emerged as one of the prime risks for corruption in particular with regard to challenges in regulation and procurement.

Ensuring drug safety and an efficient allocation of resources in the very lucrative pharmaceutical sector involves government regulation at nearly every stage of the life cycle of medical products. Although this regulation should improve efficiency it also creates vulnerabilities for corruption at any stage of the regulatory process, including the manufacturing, registration of medicines, drug selection, procurement, prescription and dispensation. Regulators can easily be captured and the decision points and processes of the drug supply chain are open to abuse by individuals and corruption networks. Given that the analysis of transparency and accountability in the drug supply chain has been subject to a variety of international initiatives, such as the Good Governance in Medicines Program of the WHO and the Medical Transparency Alliance (MeTA),[58] this paper limits itself to referring to them as useful tools for analysis and action while not going into greater detail. It should be noted that Latin American emerging markets are becoming one of the focus areas of market expansion of the pharmaceutical industry, given the rather saturated first world markets.

Social accountability in the health sector is somewhat underexplored and faces challenges due to the technical complexities, information asymmetries, lack of publicly available information, and the apparent social tolerance of certain forms of abuse.

[58] See http://www.who.int/medicines/ggm/en/ and www.medicinestransparency.org

Civil society participation and social accountability mechanisms in the health sector seem to be focused mainly at the service delivery levels and, to a lesser extent, at monitoring the supply and prices of drugs. Civil society may participate in local health or hospital boards or national health councils, and monitor service delivery in particular for quality and access, including a view at different forms of abuse such as absenteeism. Universities or professional organizations of the sector may monitor drug prices, and other civil society organizations may promote transparency and accountability of certain parts of the health sector, such as large procurement processes of hospitals, drugs or medical supplies. Although it was beyond the scope of this study to conduct a more detailed review of social accountability mechanisms, the following challenges emerged. First, civil society organizations tend to lack adequate access to information and technical capacities in order to perform a meaningful watch-dog function. Secondly, professional associations of the health sector can play an important role in publicizing system failures but they are also influenced by the mandate to defend the legitimate interests of their members, which may sometimes conflict with the public interest (for example the controversies around standardized protocols for disease treatment and freedom of the doctors to choose the "right" treatment). Finally, social accountability is weakened by a degree of tolerance, with people accepting sector inefficiencies and abuse, specifically at service delivery points (such as small bribes, absenteeism, etc.). In both case study countries, consulted experts referred to the importance to design an independent civil society mechanisms or methods to monitor regularly corruption risks throughout the different building blocks and functions of the public health systems, in particular those targeted at the poor.

The need for integration: Anti-corruption efforts need to be systematically integrated into health sector policies and vice versa. Too often corruption risks are neglected in health sector policy work, while national and sub-national strategies to address corruption tend to neglect specific sectors, like health.

Despite widespread recognition that corruption is a serious obstacle to development, that it can affect all sectors and institutions and that it is a huge problem in most Latin American countries, addressing corruption in the health sectors of the region has been eclectic. Some factors that help explain, though not justify, the situation include that corruption in the health sectors may be perceived as less "severe" or "rampant" than in other sectors (such as justice, natural resources, or education),[59] that there is relatively little documented evidence, that implicit approaches dilute a clear unpacking of risks to unethical and corrupt practices. The experience of the Peruvian Regional Anti-Corruption Plans as well as the reforms to the Colombian Subsidized Health System on the basis of a system-wide evaluation that identified, among many other issues, corruption risks, are examples for a different approach. A key challenge and necessity is to integrate corruption prevention measures and / or corruption risk management approaches into the routine business of health sector institutions. On the other hand, national or sub-national policies to address corruption and/or to promote transparency and accountability tend to focus on cross-cutting public administration issues, such as procurement, merit-based recruitment, codes of conduct and conflict of interest rules while not necessarily building

[59] See case study on Peru for this paper, Gray Molina, et al. (2001) regarding Bolivian health reform, TI Global Corruption barometer, among others.

operational bridges to “ground” these essential efforts in specific sectors, such as health. The new Colombian Anti-Corruption Law of 2011 provides an example for a sector focus, as it includes specific provisions for the health sector. In sum, there is great room and need for integrating health sector and anti-corruption policies.

POTENTIAL AVENUES FOR ENGAGEMENT AND ACTION BY UNDP

Chapter 6

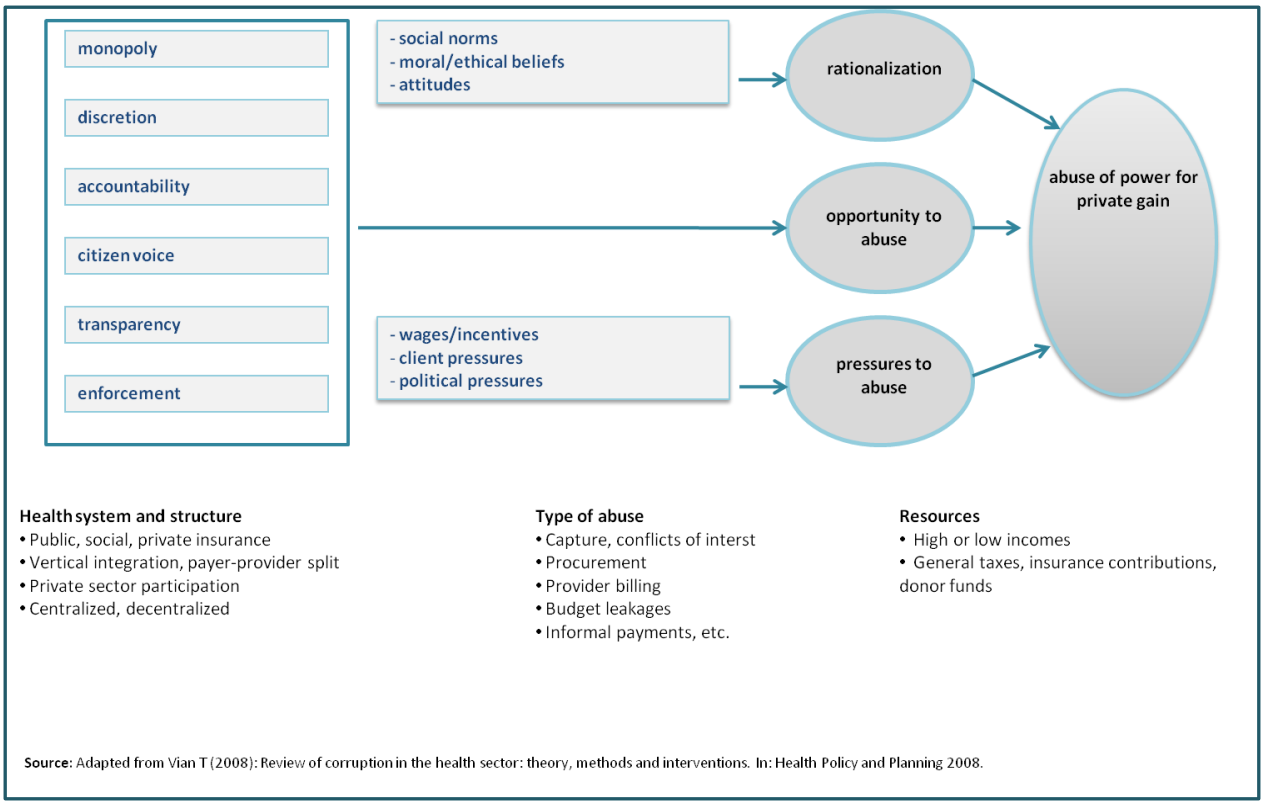
Potential avenues for engagement and action by UNDP

Corruption is a public health issue that will not disappear by itself, nor can it be ignored. In fact, experience from the region and the rest of the world shows, that it is possible to address corruption by changing the conditions that allow it to happen and support it. For comprehensive reviews of and suggestions for concrete mitigating strategies to address corruption risks in different areas of national health systems, readers should consult the existing literature.[60] This study lays out ideas on how UNDP, potentially in collaboration with the WHO/PAHO, the IDB, the World Bank and others, could become engaged in the area of health governance and accountability through the mainstreaming of the issue into programmatic work at the national levels, the initiatives to strengthen local governance and governments, support to civil society organizations, further research and partnerships with other organizations.

It seems useful to briefly pause and recall the essential elements for the design of mitigating strategies that would ***translate the main principles of good governance*** (information, transparency, integrity, accountability, participation) ***into action***. Figure 4 illustrates the different levers that facilitate or influence the fact that people or groups and networks of people cross the line between honest and corrupt behavior. This occurs specifically when they have ***opportunities to misuse their power, when they feel pressured to do so, when they can devise rationalizations to justify their behavior and when there is little possibility of being caught and/of being punished***. ***Opportunities*** for corruption are greater in situations where the government agent has ***monopoly*** powers (for example 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 behavior. Finally, government agents may feel pressured to engage in corruption. ***These pressures can be political, financial or social*** and need to be considered in anti-corruption measures.

[60] See Savedoff – IDB (2007); U4 Issues Paper (2008); Lewis and Pettersson - WB (2009); Vian, et al (2010); DFID Practice Note (2010); U4 Issues Paper (2011).

Figure 5: Levers to take into consideration when designing mitigating strategies



The United Nations Development Programme (UNDP) has been involved in accountability, transparency and integrity (ATI) programs since the early 1990s, through country office (CO) activities on accountability and transparency that were later reinforced by the Programme for Accountability and Transparency (PACT). The initiative was reinforced by UNDP's corporate policy paper 'Fighting Corruption to Improve Governance' (1998), which highlighted corruption as a development issue. In 2004, UNDP produced an Anti-Corruption Practice Note which was revised as new norms and standards to address corruption had evolved, in particular with the entry into force of the United Nations Convention against Corruption (UNCAC) in December 2005. The UNDP practice note on Mainstreaming Anti-Corruption into Development was subsequently developed in 2008.

The main rationale for UNDP's engagement to address corruption is to further its mandates on poverty reduction, realization of the MDGs and promoting sustainable development. Efforts to build an evidence base and conceptual underpinning to pursue "anti-corruption sector mainstreaming" have been initiated by UNDP headquarters in 2010 in the areas of health, education and water. In 2009, the Democratic Governance Practice Area at the UNDP Regional Centre for Latin America and the Caribbean based in Panama produced a region-wide review of the portfolio of UNDP country offices regarding accountability, transparency and integrity programs.[61] Taking this background into consideration,

[61] This review is currently being updated to reflect trends and issues from 2009-2011.

keeping in mind a series of initiatives by other international actors to address corruption in the health sector, and building on the above mentioned issues emerging from this study, the following ideas could be considered by UNDP for its future engagement and programmatic actions in the realm of health sector corruption. It should be noted, though, that a number of challenges with regards to mainstreaming have been identified in practitioners' discussions and literature. The tension between mainstreaming and the need to be strategic and focused has been pointed out for some time. Also, mainstreaming requires awareness, resources and skills of staff on the ground. On the other hand anticorruption sector mainstreaming could help prevent programs without an "anticorruption" label from being overly politicized, especially in situations where there is limited political will.

In general terms:

- ***Support diagnostic work on corruption risks in health (sub-)systems particularly those targeted at the poor and vulnerable***

Diagnostics of corruption risks from a health systems perspective would clearly help fill a current gap. Such diagnostics should take into consideration the different structural dimensions of national health (sub-) systems identified above (level of integration, decentralization, private sector participation) and explore the underlying political economy aspects, identifying the powerful actors as well as their motivations for potentially supporting or blocking reform. This analytical work could be carried out on a pilot basis in a few countries of the region and should be designed for more in-depth analysis than the two country studies of this report. Potential partnerships for such an approach could be sought with the World Bank, the IDB and Transparency International Latin America, the International Budget Partnership among others. Of particular interest for the UN System would be an alliance with the Pan-American Health Organization (PAHO) which to date does not seem to have focused on this area yet but would doubtless be an important partner.

- ***Collect recent existing governmental, private sector and civil society data and tools to assess experiences and perceptions of corruption in the health sector and identify gaps***

To generate a critical mass for sustained anti-corruption reform in the health sector and to assess progress, regularly produced evidence is necessary. Despite the widely known challenges in "measuring" corruption, the value of tools to track experiences with and perceptions of different actors in different areas of the health systems is undeniable. A collection of existing data and tools would be useful, including those from governments (for example audit reports, statistics of oversight bodies, public hospitals, etc.), from the private sector (for example health insurers), and civil society organizations (for example monitors of service delivery, anti-corruption NGOs, human rights organizations, professional associations, etc.). Such a compendium could be made available to all relevant actors in the region and serve as the basis to identify potential gaps. UNDP could collaborate for this purpose with wide array of organizations, including the PAHO, the World Bank, the IDB, Transparency International Latin America, *Latinobarometro* as well as national level umbrella organizations of civil society organizations.

- ***Collaborate with the PAHO and the WHO to integrate a "corruption risk lens" into the latter's health systems strengthening approach and build on the GGM progress.***

Except in the area of "access to essential medicines" where the WHO has been operating the Good Governance in Medicine Programme (GGM), the health systems strengthening approach of the WHO would benefit from a clear and systematic focus to address corruption risks. A "corruption lens" could be introduced into the organization's guidance and work on these issues, with a particular focus on the area of "Governance and Leadership". As part of the One United Nations System, collaboration between UNDP and the WHO would be natural for this purpose. Building on the lessons learned of the GGM in LAC, which currently covers Colombia and Ecuador in Phase I and Bolivia in Phase III,[62] and exploring if there is room and demand for expansion would also be useful. Given that the IDB and the World Bank have been the major international actors supporting health reforms in the region, collaboration with these institutions is key in this regard.

- ***Promote South-South exchange building on health sector integrity initiatives (like in Mongolia)***

Health sector wide approaches to address corruption risks are still relatively rare. One interesting experience comes from Mongolia where the government, which established in 2005 a 9th MDG on Good Governance and Human Rights, developed a health sector-wide integrity strategy, among others with the support of UNDP.[63] It would be worthwhile to review this experience in light of potential lessons learned and experience exchange with countries in the Latin American region, in particular those with similar health systems.

- ***Develop a methodology for "integrity screenings" of health sector regulatory or oversight bodies***

The institutional design of health sector regulatory and oversight bodies should include mechanisms to prevent and detect risks of capture by special interests as well as to identify and manage potential conflicts of interests of the main decision makers. A systematic "integrity screening" methodology could be developed consisting of a combination of a green-flag and red-flag approach. A green flag approach would imply to identify potential areas for capture ex ante and design the institution accordingly,[64] while a red flag approach would imply corruption risk management in the decision making processes including the development of indicators that would allow detecting the occurrence of corrupt practices. UNDP could consider developing such a methodology in partnership with other regional technical assistance organizations, such as the IDB and the World Bank.

Using opportunities in broader democratic governance strengthening programmes:

- ***Support to Parliaments could include a focus on strengthening the legislative support for health***

[62] See http://www.who.int/medicines/ggm/en/
[63] See http://www.undp.org/oslocentre/docs09/UNDPMongolia_web.pdf
[64] This idea was inspired by Frédéric Böhm (2011): Is there an anti-corruption agenda in regulation? Insights from the Colombian and Zambian Water Regulation. In: Susan Rose-Ackerman and Tina Soreide [eds.], International Handbook on The Economics Of Corruption Vol. II, forthcoming, Edward Elgar Publishing, chapter 10.

In a variety of countries in the Latin American region, UNDP has provided support to strengthen Parliaments in different functions. Considering the great relevance of health (and education) for the achievement of the MDGs, UNDP could consider including a specific focus on strengthening the legislative capacity of Parliamentarians in these specific areas in order to help prevent the "capture" of laws. In Colombia, for example several experts consulted for this study, indicated that the creation and/or strengthening of a technical support unit in Parliaments specialized on the enormous complexities of health sector regulation would be of great value.

- ***Support to sub-national governments could include a focus on strengthening their capacity to analyze, monitor and evaluate health policies sub-nationally. Also, the capacity of sub-national stakeholders to actively engage in national policy dialogue on health issues could be fostered.***

UNDP is already providing some support at the country office level and regionally to sub-national governments in Latin America and the Caribbean region. Considering the great relevance of localizing the achievement of the MDGs, UNDP could consider including a specific focus on strengthening sub-national governments' capacity to analyze, monitor and evaluate health public policies sub-nationally. Also, the capacity of sub-national stakeholders to actively engage in national policy dialogue on health issues could be fostered. For example, of great value would be to continue understanding and deepening the analysis of the decentralized health systems in the region to understand how health care financing, service delivery, human resources and oversight, among others, is managed at the sub-national level. Also, monitoring of how transferred and/or own-resource revenues are used in the health sector and analyzing what the major potential corruption risks are would be an avenue for action.

- ***Include special components to increase transparency and accountability in health (and education) service delivery into programs that focus on decentralization and/or the strengthening democratic governance, including for local governments.***

UNDP in the region has been actively engaged in supporting the strengthening of democratic governance and local governance, as well as of decentralization processes. While these programs tend to focus on increasing institutional capacities at the local level in general, there could be scope to include special components to focus on the administrative agencies/units, systems and processes that are relevant for health (and potentially also education) service delivery.

- ***Support civil society (both nationally and locally) to specifically promote transparency and accountability in the health sector***

Support for the capacity development and activities of civil society organizations in the realm of transparency and accountability promotion has been a long-standing area of engagement for UNDP in the region. These programs could also include specific components to help strengthen Civil Society (CSO) capacities to monitor health sector performance, in such areas as drug procurement, budget leakages, etc. In this regard, it would be useful to establish links with international information dissemination initiatives, including the International Aid Transparency Initiative (IATI) and drug price information

provided by Management Science for Health (MSH). The creation of a health information source book for CSOs might be a useful idea.

UNDP could further consider providing technical assistance and financial support for the creation of independent CSO health system monitoring mechanisms, which could include universities, national umbrella CSOs, sub-national organizations, etc.

Related to the prior point, UNDP could also consider strengthening the technical capacities of CSOs to more effectively engage in social activities in the health sector by producing evidence based monitoring reports and generating demand for accountability throughout the national health systems, in particular those targeted at the poor.

- ***Support the creation and performance of civil society networks between anti-corruption, human rights and health sector organizations***

UNDP could consider fostering the building of bridges between different "types" of civil society organizations, in particular of those that are already showing interest to join forces. For example, some CSOs mainly dedicated to fight against corruption may pursue common interests with human rights organizations defending the right to health and community groups engaged in local health boards.

In this context, program components and activities in support of citizen empowerment, the education on health rights and efforts to address the permissive culture towards certain corrupt practices in the health sector could be a valuable addition. UNDP could also the empowerment of patients and other users of the health systems to report abuses and outright corruption and to provide whistle blower protection. This may need to be combined with the strengthening of reporting mechanisms that exist with the health sector actors, ombudsman offices, and other public agencies.

- ***Promote collaboration with the private sector and professional associations of the sector***

Support to civil society, as non-state actors, is not enough. UNDP could consider promoting transparency, accountability and ethics initiatives with health sector relevant private sector actors, including professional associations representing the medical profession, the pharmaceutical industry, health insurers, etc. Facilitation of dialogue with the government and civil society may be a starting point.

- ***Promote the production and exchange of good practice examples, governmental, private sector and civil society driven in the health sector.***

One of the core cross-cutting areas of UNDP's development work is the generation and exchange of knowledge and good practice. In this sense, UNDP could promote the production of critical analysis of initiatives to address corruption risks and foster accountability, transparency and integrity in the health sector. In doing so, it would be useful to develop a strategic focus of such good practice analysis in view of generating documented evidence that may serve over time as the basis of comparative lessons learned.

ANNEXES

Annexes

Annex 1: Brief glossary of types and forms of corruption[65]

Types of corruption

Abuse of public property refers to the inappropriate use of public financial, human and infrastructure resources. For example, public labor might be diverted to individual use while public properties get hired out for private gain. Such abuse is more common with respect to services offered freely or at subsidized rates by the state and its subsidiaries where such services are either scarce or beyond the reach of the majority of the people. It also tends to be more prevalent where there are no citizens' oversight facilities and where there is obvious monopoly of power by public officials, which is exercised with impunity.

Bribery is the act of offering someone money, services or other inducements to persuade him or her to do something in return. Among the common synonyms for bribes are kickbacks, baksheesh, payola, hush money, sweetener, protection money, boodle and gratuity.

Cronyism/clientelism refers to the favorable treatment of friends and associates in the distribution of resources and positions, regardless of their objective qualifications.

Embezzlement is the misappropriation of property or funds legally entrusted to someone in their formal position as an agent or guardian.

Extortion is the unlawful demand or receipt of property, money or sensitive information through the use of force or threat. A typical example of extortion would be when armed police or military men demand money for passage through a roadblock. It is also called blackmail, bloodsucking and extraction.

Fraud is a misrepresentation done to obtain unfair advantage by giving or receiving false or misleading information.

Insider trading is the use of information secured by an agent during the course of duty for private gain.

A ***kickback*** is a form of bribe referring to an illegal secret payment made as a return for a favor or service rendered. The term is often used to describe in an 'innocent' way the returns of a corrupt or illegal transaction or the gains from rendering a special service.

[65] Source: Matsheza (2001); UNDP (2008); and U4 Resource Centre (Corruption Glossary, online at www.u4.no/document/glossary.cfm).

Money laundering involves the depositing and transferring of money and other proceeds of illegal activities, to legitimize these proceeds.

Nepotism is a form of ***favoritism*** that involves family relationships. Its most usual form is when a person exploits his or her power and authority to procure jobs or other favors for relatives.

Patronage refers to the support or sponsorship by a patron (a wealthy or influential guardian). Patronage is used, for instance, to make appointments to government jobs, facilitate promotions, confer favors, and distribute contracts for work. Patronage transgresses the boundaries of political influence and violates the principles of merit and competition because providers of patronage (patrons) and receivers (clients) form a network bypassing existing lawful systems, through which access to various resources is obtained.

Peddling influence occurs when an individual solicits benefits in exchange for using his or her influence to unfairly advance the interests of a particular person or party. The aim of transparency and disclosure laws is to expose such agreements.

Speed money is paid to quicken processes caused by bureaucratic delays and shortage of resources. It normally occurs in offices where licenses, permits, inspection certificates and clearance documents are processed.

Forms of corruption – corruption is often grouped into two overarching categories:

Often used terms such as “administrative/petty,” “grand,” “political” 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.

- 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*** 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.

- ***Political corruption.*** Political corruption is driven by those who make policy decisions on laws and regulations, and allocate basic resources of a state. Some of the common forms of political

corruption are vote buying and election rigging, non-transparent and illegal political campaign and party financing, and abuse of public property for political process. It is considered serious as it affects the rules of the game, creating systemic inequalities.

- ***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, for example) 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.

Besides several normative definitions, corruption should also be looked at as an ethical issue.

Annex 2: Tools to identify and track corruption in the health sector[66]

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 reform efforts. In addition to identifying potential entry points for changing the democratic governance equilibrium, it also provides a reality check on the feasibility of achieving reforms.

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 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 establishes a road map of warning signals throughout the implementation process. By focusing on analyzing the obstacles to deliver results (for example drugs to patients or funding to the health facilities) it provides a helpful management and policy tool. It also helps identify key vulnerabilities and prioritize potential solutions. The assessment methods used by the WHO GGM programme and the Medical Transparency Alliance (MeTA which counts with the support of the WHO, WB and DFID) assigns, for example, scores to each area of the drug supply chain under assessment.

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.

Sector accountability assessment*:* this is a systems approach looking at the accountability relations between the many different actors involved in the regulation, policy making, delivery of services and oversight of the health sector. By determining who is to be held accountable for what part of the health systems functions by whom and how, it is possible to determine whether there are any capacity gaps in

[66] Source: DFID How to Note on Addressing Corruption in the Health Sector (2010), and U4 Issue Paper (1/2011).

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.[67] The Swiss Tropical Institute in collaboration with the Basle Institute on Governance is also currently testing a health sector accountability framework. This may be an interesting tool to complement the above 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.[68] Performance indicators that offer the potential for tracking health performance are proposed, and provide the framework for the analysis of good governance 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: 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 worldwide 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.[69] 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 organizations. Some of these surveys may have information on corruption in the health sector as they often put specific focus on service delivery. It should be noted that perception surveys should ideally be complemented by other tools, such as experience based surveys and focus group discussion.

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 instruments relevant to Latin America include the *Latinobarometro* and

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

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

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

Transparency International's annual Global Corruption Barometer.[70] Another approach to capture experiences with and perceptions of health sector institutions is patient satisfaction surveys at exit. Moldova, for example has implemented an annual survey of patient satisfaction which includes several questions related to corruption (informal payments).

Focus group based qualitative studies: 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 useful.[71] As societies, their underlying norms and principles change, patterns and perceptions of corruption also change. Hence, such surveys/studies should be repeated from time to time.

[70] For the *Latinobarometro* see www.latinobarometro.org, and for Transparency International's Global Corruption Barometer see http://www.transparency.org/policy_research/surveys_indices/gcb.

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

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