SELECTED SUMMARY

Governance in healthcare

BASHIR MAMDANI

Retired physician, 811 N Oak Park Avenue, Oak Park, Illinois 60302 USA e-mail: bmamdani@comcast.net

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Institutions and governance are critical to sound economic policies, income growth and development. To achieve the UN's Millennium Development Goals (MDG) of raising global living standards, governments in developing nations have invested heavily in education and health. However, poor governance and corruption impede achievement of MDG goals.

Healthcare systems differ from one region to another. Therefore it is difficult to develop a single measure to assess quality. We have to rely on gross indirect measures such as life expectancy, mortality rates, spending levels, etc. In developing countries, even such data are often limited. Moreover, governments often fail to implement public policy to assure efficient delivery and adequate distribution of health resources.

Many factors distort healthcare markets. The consumers (patients) cannot adequately assess the quality and appropriateness of their care. The poor and the uninsured, in particular, are generally sicker, most in need of care and have to rely on government-funded institutions. They are also the least able to voice their disaffection with public healthcare systems.

Public healthcare systems involve capital (infrastructure, equipment, etc), labour (medical staff) and governance. Changes in capital and labour influence outcomes but governance can blunt or enhance the effects of the two. Measures to assess the performance of public systems, such as staff productivity, availability of drugs and supplies, condition of the physical structures and equipment, comprehensive medical records, etc, would allow us to evaluate efficiency and quality. Such data are simply not collected in developing countries.

Governance in healthcare delivery

Corruption reflects poor governance and can be used as one proxy measure. Good governance includes the capacity of governments to formulate and implement sound policies, manage resources and provide services efficiently; the process that allows citizens to select, hold accountable, monitor and replace governments; and the respect of government and citizens for the institutions that govern economic and social interaction.

Measures of good governance include voice and accountability; political stability and lack of violence; government effectiveness; regulatory quality; rule of law; and control of corruption. Voice and accountability reflect the degree to which citizens can influence government decisions and be involved in decisions and oversight of healthcare services. Government effectiveness includes efficiency of the bureaucracy, roles and responsibilities of local and regional governments, the administrative and technical skills of the government, effectiveness of policy and programme formulation, governing capacity, and effective use of resources.

Corruption can be defined as "use of public office for private gains." Control of corruption includes limiting the extent and nature of corruption among public officials, tracking the incidence of nepotism, cronyism and bribes among civil servants, irregularities in public purchasing and oversight, and the nature and extent to which governments manage corruption.

Correlates of poor governance and public healthcare across countries

Many investigators have shown a correlation between corruption indicators and child and infant mortality, immunisation, etc, even after controlling for mothers' education, healthcare spending and urbanisation. Thus, under-5 mortality has been shown to improve with additional funding only with good governance and low corruption. Therefore, improved per capita income is unlikely to improve public health indices unless it is accompanied by good governance.

Corruption in public healthcare systems

As corruption does not lend itself to straightforward data collection, perceptions of corruption provide the basis for assessing governance. In corruption surveys in 23 countries, health ranked amongst the top four in half the countries surveyed. Lack of transparency, accountability and monopoly were cited as the main reasons. In Uganda, for example, leakage of high demand drugs (eg anti-malarials) in public clinics was found to be as high as 94 per cent. In China, about 30 per cent of public drug supplies are expired or counterfeit.

The constant need for drugs and supplies creates opportunities for petty theft. Misuse of funds often occurs in the process of tendering and payment. The contracting process for construction and the purchase of supplies is a rich source for kickbacks, over-invoicing or outright graft.

Even though basic supplies should be available in a hospital, it is not uncommon to require patients to provide bed sheets and bandages or buy drugs. In Udaipur, only a quarter of the facilities surveyed had sterilisers. A third of sub-centres lacked a stethoscope, thermometer or scale.

Corruption in staffing of healthcare delivery

Staffing is arguably the single most important element of healthcare delivery. Absenteeism, low productivity and outright buying and selling of public positions are the most troublesome. Absenteeism is a chronic, often unmeasured problem. It limits patient access and undermines quality of service. Sometimes management shortcomings lead to absenteeism, such as when health workers have to travel to larger towns to receive their paycheck, fetch supplies or drugs or when they are delayed by poor roads and bad weather. Some have other commitments and don't show up. In effect they receive a salary but provide minimal services if any. This is a form of "public office for private gain."

Absenteeism rates are reportedly around 35-40 per cent for physicians. In an 18-month study in Rajasthan, in rural clinics, village nurses were present only 12 per cent of the time, even though on paper all clinics were fully staffed. Absent health workers face almost no consequences. Absenteeism is symptomatic of an unaccountable and ineffective government. When unpunished, it undermines morale and compromises productivity. "Accountability is meaningless or doesn't exist without sanctions ..."

The selling of healthcare positions and demanding bribes for promotions are endemic problems in Eastern Europe and Central Asia, countries where healthcare was once a state monopoly.

Where incentives for strong performance don't exist or are undermined by ineffective management, productivity and performance suffer. For example, if staff advancement caps after a single promotion, a common pattern in many countries, then the incentives to excel are diminished. The inability to fire public sector staff even in the face of embezzlement erodes managers' ability to hold staff accountable.

Overall management of health systems, hospitals and clinics typically fall to physicians, few of whom have the management training necessary. Disincentives to good performance include rigid civil service rules that limit promotion and pay differentials that could be used to reward superior performance. Low wages encourage additional outside employment. A study in Nigeria showed that the greater the lag in paying salaries, the more likely health workers were to engage in pharmaceutical sales and seek other employment. Family survival therefore plays a role in absenteeism and low productivity.

Ensuring timely availability of funds, hiring and deploying staff, maintaining basic record systems, and tracking facility performance are basic ingredients for improving management and overall healthcare delivery.

Corruption in flow of funds

Subsidised healthcare is meant to rely on public funding. In many places, bureaucratic problems, corruption and mismanagement lead to inadequate public funds at the point of service. The informal charging of patients compensates for inadequate salaries. For example, In Uganda, 87 per cent of funds never reached the schools. In Zambia it was 60 per cent. In Ghana and Peru, the leakage was 70 per cent.

Informal payments are defined as "cash or in kind payments to individual and institutional providers made outside official channels or... purchases meant to be covered by the health care system." These include under-the-table payments to doctors, nurses and other medical staff. These payments are illegal and unreported, yet widespread. Where providers insist on direct pre-payment without involvement of official cash windows, refuse patient care without a fee, receive direct payments for specific tasks, or refuse basic services (eg, moving patients from room to room) without a "tip", "informality of payment" is likely. Frequency of informal payments to public healthcare workers varies from three per cent in Peru to 96 per cent in Pakistan. Regionally South Asia relies heavily on informal payments. A study in Bangladesh, India, Nepal, Pakistan and Sri Lanka showed that bribes are required for admission to the hospital, to obtain a bed, and to receive subsidised medications. In Bangalore, 51 per cent of those interviewed indicated they had paid bribes in government hospitals, 89 per cent in hospitals in small cities, and 24 per cent in private hospitals. Bribes were paid to nurses in maternity homes so mothers could see their infants.

Physicians argue that low pay, irregular salary payments, lack of government attention and the need to keep services going makes patient contributions necessary. Patients also see low pay as an impetus to contribute, but traditions of gratitude as well as concerns for some future need also play a role.

User fees

Numerous studies document the extent of hardship poor households face in meeting healthcare costs. Inpatient costs can exceed annual family income compelling families to sell assets or incur debt. Donors and governments have urged banning user charges to promote equity. However, the strategy could simply encourage under-the-table payments. Data from Kyrgyz Republic and Cambodia suggest that formal fees can effectively curtail informal payments.

Policy options for promoting better governance

The system is only as good as its management. The centralised hiring, promotion and deployment of public health workers in all countries effectively neutralises the role of local supervision. If the consequences of absenteeism, taking bribes and stealing drugs are beyond the authority of local oversight bodies then they will have no influence over the centrally managed health staff, or service delivery responsiveness and access.

Even where systems exist to promote accountability it does not necessarily mean that they are effective. To be effective

community leaders need authority, and they need to be accountable to the local citizenry. Tying reimbursement of healthcare staff to productivity enhances performance. Studies show that physicians who receive a flat salary, to facilitate cost control, rather than fee-for-service, bonus payments or capitation, have lower productivity, lower levels of care and higher complication rates. Low wages lead to temptation. Workers hold additional jobs, feel entitled to demand payments from patients, and may engage in pilfering drugs and supplies. While higher pay by itself will not address corruption, improved pay may raise productivity, allowing the same staffing to provide more services. Contracting out services often improves performance, partly because holding contractors accountable is far easier than doing so with public workers. The challenge is ensuring oversight and accountability of contractors.

Controlling corruption

The potential for getting caught offers a strong disincentive for corrupt behaviour. Corruption in the health sector is unlikely to be an isolated public service failure. Therefore, corruption must be addressed throughout the public sector. This requires an integrated, mutually reinforcing anti-corruption strategy with strong political backing. Higher salaries alone will not work. Employment security, clear recruitment and promotion criteria, and effective management are more important. Drug procurement poses multiple challenges given the ease and lucrative nature of drug corruption. Nigeria has strictly ensured that drugs meet a basic standard of potency, labels are clear and correct, and distribution is achieved through legal channels. Oversight of provision, storing and handling are systematically regulated. More information to citizens about resource flows from central and local governments and clarity on the roles and responsibilities of local authorities empowers them to oversee the process as they have both a financial stake and the tools to enforce policies.

Voice

Although not strongly associated with health outcomes, voice captures citizens' ability to get information, challenge government and ensure that services meet their needs. The record is mixed on the effectiveness of voice in improving service delivery. Voice can take many forms and none by itself will control corruption. Community oversight can work; an NGO experiment in India using cameras to record teacher attendance, which is tied to bonuses, resulted in a dramatic improvement. As cellular phones become cheaper and functional in rural areas photos sent electronically offer another alternative for monitoring attendance at the rural level.

Conclusions

Evidence from many countries suggests that governance plays an important role. In lower income countries with poor governance, as incomes rise, the private sector steps in to replace public service, as in India. Even the poor select to pay significant amounts of disposable income to obtain private care, as public services are shoddy and underutilised. To improve healthcare delivery, first and foremost is better accountability. Greater professionalism among health staff, effective training and supervision of staff at all levels, routine audits of all aspects of fiduciary transactions, improved records and recordkeeping to provide systematic data to managers and the bureaucracy, and procedures that can facilitate service delivery in a more user friendly fashion, all need to be addressed. Running hospitals and clinics as a business would be particularly helpful. The discipline implied and the need to be accountable provides the incentives that improve productivity, patient satisfaction and performance.

Commentary

This report by Lewis examines studies on corruption in the public healthcare sector in middle- and low-income countries. The study paints a bleak picture. Neither rising incomes nor increasing education root out corruption. Corruption has to be addressed in all spheres of government, not just the health sector. It is difficult to imagine the electoral process in India yielding a party with the strength and determination to rid us of corruption in the foreseeable future.

Is corruption a problem only for poor countries? Lewis uses a somewhat restricted definition of corruption. Corruption "... takes many forms with different types of participants, settings, stakes, techniques and different degrees of cultural legitimacy; it is not only about stealing: ... It is a form of behaviour that deviates from ethics, morality, tradition, law and civic virtue." (www.anticorruption.info/corr_def.htm).

In my 35 years in Chicago, three of the eight governors of the state (an elected office roughly equivalent of the chief minister) went to jail for corruption. In Operation Greylord in Chicago in the 1980s, 92 people including 17 judges, 48 lawyers, 18 police officers, eight court officials and a state lawmaker were charged with racketeering, bribery, etc. Most were found guilty and served prison terms. Corruption is a universal phenomenon. What sets corruption in middle- and low-income countries like India apart is that corruption here is democratised, touching people in their everyday life, and goes unpunished. In the West when public officials are indicted and found guilty, they serve jail time. When corrupt Indian politicians and bureaucrats go to jail, we will know that corruption is about to depart everyday life of India.