

# Integrating a focus on anti-corruption, transparency and accountability in health systems assessments



World Health  
Organization





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This document was developed through a cross-departmental technical collaboration led by Theadora Swift Koller (Technical Officer, Equity; Gender, Equity and Human Rights) and David Clarke (Team Leader, Universal Health Coverage and Health Systems Law; Health Systems Governance and Financing) of WHO headquarters. The document was subsequently commissioned to Taryn Vian, WHO Consultant and Professor of Global Health at Boston University School of Public Health. Dr Vian served as the lead author with conceptualization and co-authoring inputs from Theadora Swift Koller, David Clarke, Aurelie Paviza and Dheepa Rajan. It was produced through WHO APW Contract 201967992 with Boston University.

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# Introduction

The top strategic priority for the World Health Organization (WHO) is to support countries to strengthen health systems in order to progress towards universal health coverage. To achieve this priority, WHO supports countries to leverage domestic investments in health and strengthen their capacity to design and implement improvements to their health systems, aimed at increasing access to quality health services for all.

If unchecked, health system corruption represents a significant drain on domestic health resources and poses a major barrier to efforts to transform health systems as part of the universal health coverage agenda.

Corruption in the health sector has high costs both in terms of lives lost and financial resources wasted. Gee and Button (2015) estimate the global average loss rate from health care fraud and abuse to be 6.19% of total health expenditure, or US\$ 455 billion, per year (1). Other studies have documented a significant association between corruption and health outcomes; one study estimates that 140 000 child deaths per year are caused by corruption (2).

Recognizing the importance of this issue, WHO Member States and development partners are working to prevent and control corruption. As part of these efforts, it is critical to advance a more coherent approach towards mainstreaming anti-corruption efforts into work to strengthen and repurpose health systems towards universal health coverage. The goal of this work is to support the efforts of WHO Member States to prevent corruption through greater transparency and reinforced accountability mechanisms in their health systems.

To concretely support these efforts, this document proposes new ways to approach health systems assessment to help diagnose corruption risk areas and help countries to decide which anti-corruption, transparency and accountability approaches should be deployed in response.

# Background

Corruption is the abuse of entrusted power for private gain (3). The health sector is particularly susceptible to corrupt activities as it provides many opportunities for bribes, informal payments, embezzlement, nepotism and other forms of abuse of power. This is especially the case within procurement processes (4), during health inspections, as part of the recruitment process and in granting promotions, and in interactions between individuals and clinicians.

Addressing health system corruption is especially challenging because there are multiple corruption risks and practices, which means that anti-corruption efforts must be based on robust situation and problem analyses with interventions tailored to address specific problems and context. For example, a systematic review in 2017

found rates of informal payment ranged from 2% to 80%, depending on the country and specific type of health service (5). Surveys in 33 African countries showed rates of informal payment of less than 5% to more than 40% (6), while rates in Central and Eastern European countries ranged from 16% to 49% (7). Audit reports in some countries have found that more than half of audited municipalities or provinces had experienced at least one incident of corruption in health budgets.

Health systems assessments must try to understand the risk of corruption given the particular institutions, political processes and contexts of specific Member States in order to tailor solutions that take into account these unique factors.

# Health systems strengthening and the assessment approach

Health systems assessment helps to clarify interactions among the system functions, and shows how policies and regulations are related to the six core “building blocks” of the health system: service delivery; human resources for health; medical products, vaccines and technologies; health information systems; health financing; and governance. The process of assessment allows health professionals to create hypotheses about the causes of performance

variation and to develop policies and interventions that can improve the way the system works *(8)*. This in turn can lead to better performance and progress toward the universal health coverage goals of equity, access and financial risk protection. The UHC2030 alliance has a dedicated technical working group on health systems assessments, as described in Box 1. This brief contributes to and aligns with the tasks of the working group.

## Box 1. UHC2030 technical working group on health systems assessments

Having consensus on what constitutes a good health system assessment and on approaches to carry out an assessment is an important step for better coordination of health systems strengthening efforts and accelerating progress towards universal health coverage. It is well recognized that countries face challenges if multiple health system assessment approaches, designed to meet a variety of objectives, are used. This in turn makes it almost impossible to compare the results of different health system assessments or to measure changes in health system performance over time.

During multistakeholder consultations in 2016, UHC2030 partners decided to establish a technical working group to examine the feasibility of harmonizing and aligning health system assessment approaches. In addition, several UHC2030 partners have expressed the need to discuss and develop common benchmarking to compare health system assessment results and so develop a common understanding of how to measure health system performance over time.

During 2018, the technical working group advanced draft generic guidance for health systems assessment, organized according to the stages of a health system assessment and the system building blocks. This guidance was used as the basis for identifying where there could be entry points for further strengthening a focus on anti-corruption, transparency and accountability. The working group’s final generic guidance will be made available at the following website: <https://www.uhc2030.org/what-we-do/coordination-of-health-system-strengthening/uhc2030-technical-working-groups/health-systems-assessment-technical-working-group/>.

It should be noted that this brief is intended to support the work of the UHC2030 technical working group as guidance on conducting health systems assessments.

Transparency, accountability and integrity are intrinsic health governance values. Integrity refers to honesty or trustworthiness in the discharge of official duties, and serves as an antithesis to corruption or the abuse of office. Transparency refers to unfettered access by the public to timely and reliable information on decisions and performance of institutions. Accountability refers to the obligation to report on, and to be answerable for failing to meet, stated performance objectives.

These concepts are interrelated: transparency and accountability are critical for efforts to ensure integrity and deter corruption. Transparency requires that citizens be informed about their rights and entitlements, and how and why decisions are made, including procedures, criteria applied by government decision-makers and the evidence used to reach decisions. Transparency may deter corruption by “shedding light in dark corners” and making it more likely that corrupt acts will be detected. Accountability requires institutions to explain and make understandable their performance in achieving goals and addressing the needs of the public, in comparison to standards and commitments made. Accountability requires visible, responsive action if standards and commitments are not met. Where governance is transparent and data are available, it is more likely that officials and leaders can be held accountable, and there is less space for malfeasance or corruption.

A specific focus on diagnosing integrity problems and taking a preventive approach to address health system corruption is lacking in many health system assessments. This brief outlines recommendations for incorporating an anti-corruption perspective into health system assessments. Many of the approaches discussed are grounded in the concept of prevention, focusing on the identification of conditions and circumstances that may be conducive to corruption, even if no corrupt acts are currently taking place.

The various approaches follow the WHO framework that categorizes health system functions by using the analogy of “building blocks.” Although the health system building blocks framework is familiar, some problems and solutions may affect multiple building blocks and will require a cross-cutting approach.

# Preparing for an assessment and assembling the team

In the preparatory stages of a health system assessment, several steps are required to advance a focus on anti-corruption, transparency and accountability. These steps include: choosing experts to be part of the assessment team and sub-teams; integrating anti-corruption, transparency and accountability issues into preparatory workshops; engaging in preparatory discussions with government; and considering ways to manage access to and ensure confidentiality of data, including the protection of informants.

It is important to include experts on anti-corruption, transparency and accountability in the health system assessment team. Experts should have knowledge of both the health sector and anti-corruption strategies and tactics. Legal expertise is useful to review health laws and regulations in regard to conflicts of interest, regulation of the private sector, whistleblower programmes, and other legal and regulatory measures to deter, detect and punish wrong-doing, as well as to enhance transparency and accountability. It is advisable to partner international experts with country experts, as context-specific knowledge of informal and formal governance structures is essential.

The agenda for preparatory workshops should consider topics related to anti-corruption, transparency and accountability, including identification of stakeholders and their interests within the country context. Workshops should also consider legal and common-use definitions for the terms, including different types of corruption.<sup>i</sup> It may be worthwhile to have stakeholders provide their understanding of what corruption is, given the scope for wide interpretation of the terminology. The workshops can serve to build awareness and capacity of the wider assessment team on these issues, as the one or two experts will unlikely be able to gather all the data and information across all components of the assessment at once. The experts will need to support the sub-teams during the assessment (i.e., those teams looking at specific health

system building blocks) on knowing what to look for and how to adjust their instruments.

Preparatory meetings should also be held with governments to explain the purpose of the health system assessment. It is important to frame the aspect of the assessment addressed herewithin as focusing on areas inherently at greater risk of corruption, where prevention efforts or health systems strengthening can help deter corruption. This part of the assessment should be clearly understood as focusing on examining the *risk* of corruption.

Assessment sub-teams working across the different building blocks can incorporate a focus on anti-corruption, transparency and accountability through various methods including informant interviews, mapping of stakeholders and processes, data review, policy review and use of specific assessment tools, among others. With regard to informant interviews, it is important to assure respondents that they will remain anonymous, as is standard qualitative research practice. Data collection should be organized in such a way as to reduce the respondents' reluctance or reticence to share their opinions honestly. For example, when focusing on specific types of corruption, questions should not be directed at the informants' personal experiences; instead, questions should more generally address the informants' perception of corruption risk areas, enabling factors and system-level issues. The assessment team should explain how information will be stored and who will have access to it. Typically, informants are referred to by number to ensure they are not identifiable. The informant should know that what they say might be shared in the assessment report, but will not be associated with their name or position title. The interviewer should use their judgement to remove details that seem too specific (for example, personal or facility names used in a narrative). It also will help if the informant considers this issue before sharing information, and does not share details that would allow someone to identify them. Similarly, written notes from interviews should not include names.

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<sup>i</sup> For help in understanding the language of corruption and anti-corruption, please refer to Transparency International's glossary, <https://www.transparency.org/glossary>.

# Country and health system context

Contextual issues affecting the health system of a country are a starting point for assessment, including enumeration of stakeholders and their interests. When examining the country context relevant to corruption risk areas, the following points should be taken into account.

- **Consider citizens, civil society organizations and media as key stakeholders in promoting transparency, accountability and corruption control.** It is important that health systems assessments consider the role of civil society organizations and citizen engagement, in relation to health in general, and also in relation to issues linked to anti-corruption, transparency and accountability across all sectors. Citizen-led advocacy organizations and media reporting can help to increase transparency and government accountability. Community members can promote transparency by taking on active roles, including serving on government advisory committees or facility boards, participating in focus groups or open meetings, providing feedback through patient or household surveys, and lodging complaints about abusive care or suspected corruption. Social audits conducted by community groups and community monitoring of health facility performance are important mechanisms for increasing accountability and deterring corruption.
- **Identify government oversight institutions and external funding partners.** When mapping stakeholders, relevant government oversight institutions should be identified, such as the supreme audit institution, the office of the ombudsman, the procurement regulatory agency and the anti-corruption agency. These institutions have an important role in assuring transparency and accountability of the health sector's public (and sometimes private) institutions. Interview these stakeholders to understand their legal mandate and gather their perceptions of barriers to transparency and accountability, and on drivers of corruption in the health sector. Find out what happens if corruption is reported. How do these stakeholders respond? In addition, consider the funding provided by external partners for social auditing or support to these institutions, even if outside the health sector.

- **Identify where corruption risks could occur at the intersection of public and private sectors.** Usually in a health system assessment, consideration of context looks at issues related to the intersection of the public and private sectors. In 34% of corruption cases analysed as part of the *Report to the nations: 2018 global study on occupational fraud and abuse*, an unusually close association between an organization and a vendor or customer was a red flag.<sup>i</sup> For this reason, health systems assessments should consider vendors of services used by the health sector (pharmaceutical distributors, sellers of medical devices and equipment, entities responsible for building and maintaining health facility premises) as a key stakeholder group whose interests may be distorting current policies, institutional relationships, and quality and safety of care. Find out who the major vendor organizations are, and map the ways in which they interact with government officials. Ask how these close relationships and conflicts of interest are discovered and managed (for example, there may be government protocols for the declaration of conflicts of interest, and/or regulation of lobbying). This can be challenging; however, in some countries, existing data systems can help to detect conflicts of interest. For example, in countries where business entities are properly registered, specialized software can match vendor street addresses to the addresses of staff and other players in the health sector. Company profitability can be an indicator of corruption, i.e. extreme profitability of particular suppliers compared to the industry average is a red flag. In addition, procurement databases can be "mined" to identify different suppliers that use the same address. This may indicate that the procurement system is being rigged and contracts are being awarded to the same people under different names. This is also why it is important to involve the procurement regulatory agency, if such an institution exists in the country.

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<sup>i</sup> Association of Certified Fraud Examiners, <http://www.acfe.com/report-to-the-nations/2018/>. The other red flags for corruption were living beyond means, financial difficulties and a "wheeler-dealer" attitude.

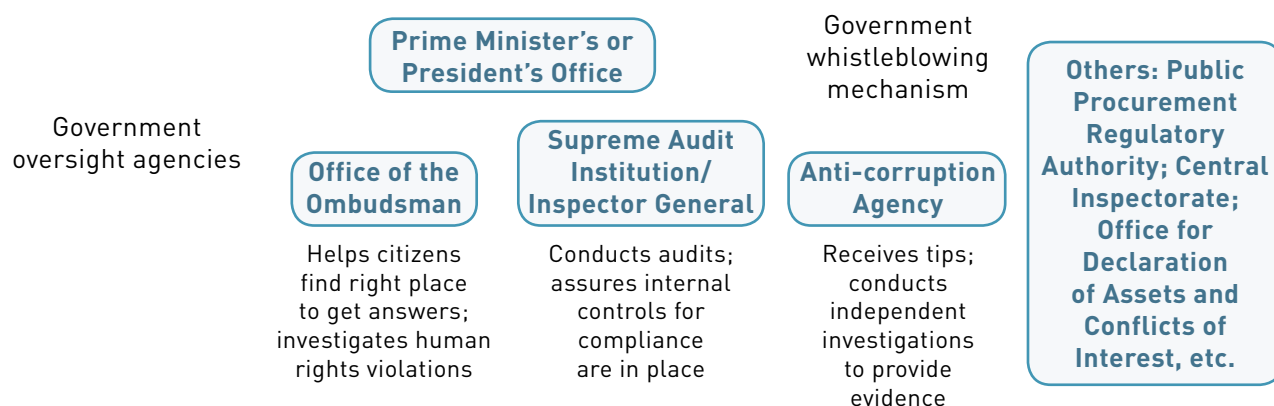
- **Consider whole-of-government legislation and policy related to anti-corruption, transparency and accountability.** Initial assessment interviews should ask about freedom of information legislation guaranteeing citizens' access to government data. However, freedom of information acts do not always guarantee such access: ask informants whether public institutions try to conceal information even when freedom of information legislation is in place. Identify the responsibilities of different levels of government and institutions with regard to fraud control, inspection services and complaint mechanisms. If these institutions are working well, there may be possibilities for further cross-sectoral anti-corruption work. Some countries may have a national strategy for anti-corruption, and others may have articulated a strategy for anti-corruption in the health sector. These documents should be considered in the health system assessment.
- **Obtain existing analyses of corruption.** An additional step in understanding the country context in relation to anti-corruption, transparency and accountability is to review country-specific data from Transparency International, the largest global nongovernmental organization working to fight corruption. For example, Transparency International's Global Corruption Barometer<sup>i</sup> surveys citizens' perceptions of corruption in the health sector and experiences of having to pay bribes to access health services. In addition, it is useful to obtain past studies of corruption risks, either in the health sector or in government as a whole.
- Create a diagram detailing the anti-corruption architecture in the country, as it applies to the health sector. This visual diagram should show entities responsible for fraud control, inspection, whistleblowing and citizen complaints (see Fig. 1 for an example). The strengths and weaknesses of the institutions can be further analysed as the assessment proceeds, through analysis of the health system building blocks (as detailed in the following sections). Steps to strengthen these institutions may be identified during the assessment process.

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i See: <https://www.transparency.org/research/gcb/overview>.

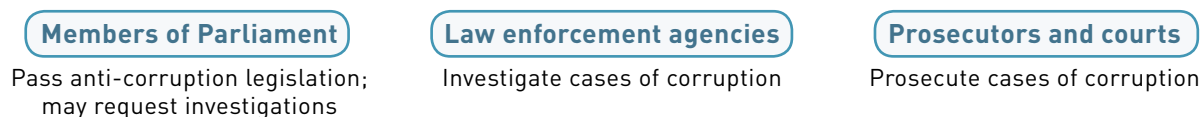
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## National executive level



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## Legislative and judiciary level



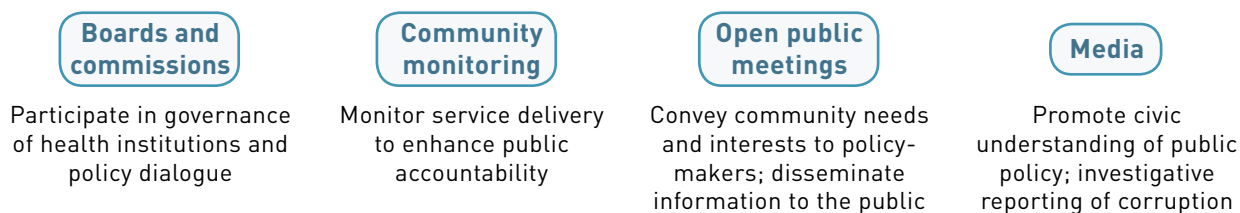
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## Health ministry



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## Civil society



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Fig 1. Example of anti-corruption architecture for the health sector

# Service delivery

Service delivery includes the provision of personal and non-personal health services, including promotion, prevention, treatment, rehabilitation, palliation and population health, as well as referral systems, quality improvement and community engagement.

WHO's *Framework on integrated, people-centred health services* (9) specifically emphasizes the importance of strengthening governance and accountability in the second of its five strategies:

- 1) empowering and engaging people and communities;
- 2) strengthening governance and accountability;
- 3) reorienting the model of care;
- 4) coordinating services within and across sectors;
- 5) creating an enabling environment.

The questions guiding the assessment team in the area of service delivery should aim to gather data on potential places where corruption *could* occur, based on an understanding of the entry points and circumstances. Common service delivery issues include asset misappropriation (cash and non-cash), fraudulent billing, ghost employees, conflicts of interest affecting management decisions, and risks associated with dual practice (health professionals practicing in public and private sectors at the same time). Service delivery points may also experience forms of corruption that can be assessed under the other health system building blocks; for example, absenteeism is discussed under human resources for health, biased prescribing practices are discussed under medicines and technologies, and informal payments are discussed under health financing.

The appearance of corruption at service delivery points is in some sense not the primary problem, but rather the result of upstream issues such as influence from outside government on service delivery policies and health workers, inadequate payment of health workers combined with low risk of detection of corruption, poor incentives, lack of guidelines, and so on.

The assessment sub-team working on service delivery can incorporate a focus on anti-corruption, transparency and accountability by exploring the lines of enquiry listed below.

- **Enquire about the transparency of performance data**, including mechanisms to gather patient feedback, and the use of report cards or other summaries of performance indicators, and how these data are shared with patients or citizens. Are data on pharmaceutical stock outs or health worker absenteeism collected and shared? Do citizens in service delivery catchment areas know the budget allocated to the health facility, when it was received and how it was spent?
- **Determine the availability and effectiveness of complaint mechanisms**. Complaint mechanisms are an important way that an organization can get a “tip” about fraud or misuse (10). Information shared during the complaint process can reveal corruption, but it can also allow an organization to identify and address potential trouble spots, including careless or incompetent staff or unworkable official procedures, which may lead to abuses or unaccountable actions down the line. Are there ways for staff and beneficiaries to give anonymous or confidential feedback? Are effective actions being taken based on the feedback? Ask for examples. Is there a whistleblower protection law, and how is it being enforced?
- **Evaluate past audit findings and remedial actions taken**. A financial audit is an official inspection of an organization's accounts to determine whether financial statements are correct and complete, and represent a true and fair view of the financial situation of the organization. A compliance audit assesses whether an organization is following its own rules and procedures. A performance audit assesses the outputs achieved by an organization in relation to plans and inputs expended. An important issue for the assessment team is to find out if there have been financial, compliance or performance audit findings issued by the internal audit department or the supreme audit institution. Ask whether other government offices, such as the office of the ombudsman,

have conducted special inspection reports related to health service delivery. Most importantly, find out what remedial actions, if any, have been taken in response to the findings.

- **Assess whether waiting times are a risk factor for corruption.** Long waiting times and inefficient processes can create opportunities for bribery even before a patient reaches the clinical provider. Mapping processes for patient appointments, registration and how patients move through the health system may help to reveal bottlenecks that increase the risk of informal payments.
- **Consider corruption risks in the referral system.** The processes for patient referral or for obtaining a medical report (required by some employers to determine sick leave benefits) are further areas where a financial interest could bias decision-making. For instance, unnecessary referrals may be made if a physician receives a “kickback” from certain providers. During the assessment, the team should ask questions to determine specific ways in which the referral processes may be increasing risk of corruption or controlling and managing risks.

- **Consider corruption risks in the selection of sites for health facilities.** Another important service delivery issue is the process for deciding where to build hospitals or health facilities, especially when using external funding. Corruption risks may include kickbacks or undue influence in the selection of sites, resulting in facilities being built in non-priority locations. Probes during the assessment can discern whether control mechanisms to prevent such problems are sufficient.
- **Consider whether abusive practices are affecting quality of care,** and whether mechanisms are in place to detect such problems. One consequence of uncontrolled corruption is lower quality of care [11, 12]. Assessing health systems to improve quality may help to identify whether corruption is a factor. Is there a mechanism in place for checking the quality of service delivery (see Box 2)? Do inspectors try to learn what is really happening on the ground? Spot checks and site inspections can help to prevent the diversion of resources. It is important to understand how the inspection service operates to assess whether it is adequate to control the risk of corruption.

## Box 2: Improving quality through anti-corruption, transparency and accountability

WHO's *Handbook for national quality policy and strategy: a practical approach for developing policy and strategy to improve quality of care* [13] reflects the growing acknowledgment that quality health services across the world should be:

- *effective* – providing evidence-based health care services to those who need them;
- *safe* – avoiding harm to people for whom the care is intended;
- *people-centred* – providing care that responds to individual preferences, needs and values.

In addition, in order to realize the benefits of quality health care, health services must be:

- *timely* – reducing waiting times and sometimes harmful delays for both those who receive and those who give care;

- *equitable* – providing care that does not vary in quality on account of gender, ethnicity, geographic location and socioeconomic status;
- *integrated* – providing care that is joined-up across levels and providers and makes available the full range of health services throughout the life course;
- *efficient* – maximizing the benefit of available resources and avoiding waste.

One way of exploring the relationship between quality and anti-corruption, transparency and accountability is through the dimensions or drivers listed above. For example, how does corruption contribute to insufficient safety, low effectiveness, lack of patient centredness and integration, inadequate timeliness, and inefficiencies?

# Human resources for health

Assessment of human resources for health looks at the availability, accessibility, acceptability, coverage and quality of the health workforce. WHO's *Global Strategy on Human Resources for Health: Workforce 2030* focuses on the policy levers that shape health labour markets (14). It is important to analyse these policy levers in terms of how they can influence – or be influenced by – corruption, transparency and accountability issues.

The current stock of 43.5 million health workers in 165 Member States comprises a leading economic sector (14). However, this number is inadequate for meeting countries' health needs and goals, and in many countries workers are inadequately compensated or incentivized. The lack of anti-corruption measures, combined with inadequate funding and pressures caused by health worker shortages, creates risk for corruption.

As the assessment team creates a profile of human resources for health and related indicators, they should consider forms of abuse such as ghost workers and occupational fraud, as well as the issue of transparent and meritocratic systems for recruitment, assignment, transfer and promotion. Corruption risks include unofficial market/spoils systems for assigning jobs in attractive duty stations, as well as health workers having to pay to obtain or keep *any* position.

The assessment sub-team working on human resources for health can incorporate a focus on anti-corruption, transparency and accountability by exploring the lines of enquiry listed below.

- **Assess possible corruption areas or “schemes” that affect human resources for health.** The problem of ghost workers or unexcused absenteeism can result in health workers not being present to deliver care. Or, health workers may be present, but are extorting money from patients by charging informally. In addition, health workers may be present, but are underqualified because they have used bribery or nepotism/favouritism to obtain their credentials or posting. Finally, health workers may have to pay higher level officials in order

to keep their jobs. The assessment team could seek to discuss each of these schemes, and set priorities based on the relative scope and seriousness of their findings.

- **Review policies for potential to control corruption.** The assessment team should look for policies requiring disclosure of conflicts of interest (for example, for clinical guidelines committees), and assess how effectively such conflicts are managed. Find out whether dual-job holding is allowed and, if so, whether there is policy to regulate the practice. Dual-job holding can incentivize staff, but may also lead to staff inappropriately referring patients to their private practice or shirking public sector duties in favour of private practice. Examine the policy on allowances (per diems) and travel reimbursements to determine if adequate controls are in place to prevent abuses.
- **Assess whether unexcused absenteeism is a problem.** Health systems should have a mechanism in place to measure absenteeism, determine when it is unjustified, and implement disciplinary procedures when needed.
- **Assess corruption risks in the medical education system.** The assessment team should integrate questions on the existence of a merit-based appointment and promotion system for faculty in medical schools and training institutions. Are there concerns about purchasing of diplomas, grades or admission? If so, have efforts been made to control such practices, and what has been the result? Ask whether industry representatives target medical students with promotional messages, and whether this is inappropriately influencing prescribing or treatment practices.
- **Document policies related to dual practice** (clinicians practicing in both the public and private sector). Determine the frequency and distribution of dual practice. Where dual practice is frequent, find out if evidence or concerns exist about potential associated problems such as increased doctor absenteeism in the public sector, or inappropriate referral of patients to doctors' private practices.

- **Consider corruption risks in licensing and credentialing systems.** Licensing and credentialing systems may be compromised by conflicts of interest or through bribery, which could result in unqualified individuals providing health care services. The assessment team should ask key informants to share their perceptions. At the same time, however, it is important to acknowledge that weak systems may take time to change.
- **Analyse the adequacy of health workers' pay and access to commodities needed to perform their work.** Although other factors are important in motivating health workers and controlling potential for abuse, low pay can be a reason for workers engaging in corruption. One way to measure adequacy of pay is to analyse the relative

pay rates of public health sector workers compared to the private sector. Private sector data may be available through a country's Bureau of Statistics or Department of Labour. Global differentials in compensation are important and influence the global health workforce labour market. For Member countries of the Organisation for Economic Co-operation and Development (OECD), these differentials are available through OECD resources.<sup>i</sup> It is also important to assess the adequacy and timely supply of resources (medicines and other health commodities) from central levels that workers need to do their jobs. Lack of basic materials/commodities may lead to health workers requesting informal payments to help purchase commodities for the facility where they work.

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<sup>i</sup> See: [https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2017\\_health\\_glance-2017-en](https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2017_health_glance-2017-en).

# Medical products, vaccines and technologies

This health system building block is at high risk for corruption. The pharmaceutical industry is worth more than US\$ 1 trillion worldwide and, as noted during the Seventy-first World Health Assembly in 2018, lack of transparency and accountability, unclear roles and responsibilities, and lack of oversight leave the pharmaceutical sector vulnerable to undue influence, corruption, waste, fraud and abuse (15). Given the complexity of the pharmaceutical system and the main core decision points (clinical trials, manufacturing, procurement and service delivery), assessment of this area will need to be conducted by experts.

In this building block, a key risk area for corruption is the interaction between government and the private sector. Both centralized and decentralized health systems can be vulnerable to corruption. In centralized health systems, government-endorsed facilitation of markets may result in monopoly, higher prices and weaker quality controls, while in some decentralized systems it is more difficult to control how resources are spent and prioritized, which can lead to an increased risk for abuse of power and diversion of resources for private gain.

Assessment team members should consider applying WHO's Good Governance for Medicines (GGM) approach for identifying and assessing transparency and corruption risks in the pharmaceutical sector (16). The GGM assessment tools were updated in 2018. If time does not permit detailed data collection, ask whether the country has already applied any of the GGM tools and indicators. If so, use the reports as the basis for further discussions with key stakeholders to assess corruption risks in this area. Bring multiple stakeholders together to discuss possible areas where there are risks of corruption or financially biased decision-making. These may include national level officials, and representatives from government hospitals, central medical stores and the private sector.

The assessment sub-team working on medical products, vaccines and technologies can incorporate a focus on anti-corruption, transparency and accountability by exploring the lines of enquiry listed below.

- **Analyse transparency and accountability using the GGM approach,<sup>i</sup>** which considers standard setting, monitoring, answerability and consequences.
  - First, are comprehensive standards and safeguards defined and made transparent for the pharmaceutical sector decision points (manufacturing, registration, selection, procurement, distribution, etc.) to prevent undesirable practices?
  - Secondly, does documentation exist to monitor whether decisions and processes are carried out according to the agreed-upon standards, and to document whether results are achieved?
  - Thirdly, is information publicly available that explains why standards have not been met/results have not been achieved?
  - Finally, is there publicly available information showing that those responsible are held accountable if standards have not been met, or that remedial or responsive actions have been taken to assure problems do not happen again? What policies and practices have been changed? Are the changes fully implemented and sustainable?
- **Conduct a full analysis using the GGM transparency tool,** provided the assessment team has time and resources. The GGM transparency tool can assess risks of corruption in the pharmaceutical sector in specific detail (17). If there is not enough time or resources to implement a full assessment using the tool, consider prioritizing relevant areas of the pharmaceutical system to apply a subset of GGM diagnostics. As a minimum, it is important to try to answer the four general questions listed above.
- **Analyse procurement prices.** It can be difficult to assess procurement prices paid, particularly if there are multiple purchasing agencies. Where price data are available, it can be helpful to analyse past tenders to determine outlier prices (very high prices paid to procure medicines or medical devices). High outlier prices are a possible indicator of corruption. WHO/Health Action International tools (18) can be used to analyse price data and compare

<sup>i</sup> See: <http://www.who.int/medicines/areas/policy/goodgovernance/en/>.

prices paid locally with international prices, although such analyses take time. The assessment team should check whether researchers or civil society organizations have analysed price data in the past, as recent reports may contain relevant findings.

- **Consider risks for medical device and durable medical equipment fraud.** Types of fraud may include illegal payment arrangements, off-label marketing, defective medical devices, unnecessary durable medical equipment, and unlicensed technicians dispensing durable medical equipment (19). The assessment team should determine whether a country is using standardized templates. The templates can support accountable procurement (20, 21).
- **Review procurement audit data.** Previous procurement audits can serve as a data source for assessing corruption risk in procurement of medicines and medical devices. If the country has an open government database of past health procurements, assessment teams might consider using experts to analyse the data to detect red flags for bid-rigging and beneficial ownership of bidding companies.
- **Evaluate systems to measure stock outs and detect prescription fraud/medicine diversion schemes.** Assessment teams should consider if systems are in place to deter diversion of medicines (especially controlled substances and very expensive medicines), and to promptly identify diversion and intervene when it is occurring. Health systems also need policies and procedures to investigate complaints/suspicion of medicines diversion, and to manage outcomes of a confirmed diversion. The team should consider possible problems with fake prescriptions and whether the government has guidelines or an inspection system to control for patients falsely recorded as having received medicines.

Measuring stock outs using sampling is one way to detect possible medicines diversion. The inspection system should conduct random spot-checks; health workers should know that their facility may be inspected at any time, but not know exactly when.

- **Consider the health technology assessment process.** Ascertain how new and existing medicines and technologies get into the country. This process is vulnerable to conflicts of interest and undue influence by industry. Countries should conduct regular health technology assessments. Does the country have independent information on which to base technology assessment, such as the National Institute for Health and Care Excellence (NICE) technology appraisal system in the United Kingdom of Great Britain and Northern Ireland, or other databases that can provide advice on whether to buy new technology or add a covered benefit to the entitlement package?
- **Assess the risk of biased prescribing.** For the clinical workforce, prescribing medicines can be a risk area. Ask whether prescribing clinicians are allowed to hold financial interest in pharmacies, or if there is evidence that prescribers may be receiving kickbacks from pharmacies or industry sales representatives. If so, determine what controls are in place to prevent biased prescribing and ask about their functionality. Industry representatives may visit prescribers under the guise of education, but really to try to generate business. Government policies to control industry influence on medical education should be considered. Finally, ask if the government requires industry to report gifts and other payments to doctors (for example, sunshine acts (23–25)), and whether data are collected in an open database that can be searched (26).

# Health information systems

A country's health information system should integrate data collection, processing, reporting and use of information to improve health service effectiveness and efficiency through better management at all levels. A strong health information system supports effective planning of reforms towards universal health coverage. It encompasses data sources such as institute-based records (administrative data), census, vital registration (civil registration and vital statistics system), household surveys and surveillance systems.

The assessment sub-team working on health information systems can incorporate a focus on anti-corruption, transparency and accountability by exploring the lines of enquiry listed below.

- **Consider the risk of fraudulent data.** Assessment teams should be aware of the risk that reports are relying on fraudulent data, or are distorted by ghost facilities and ghost patients. Intentional fraud is a possible issue, and the assessment team should try to ascertain whether it is a perceived problem. Some contextual factors may lead to falsification of data; for example, an over-designed and under-resourced information system with staff who are asked to fill out too many forms. Tools can help to triangulate data and shed light on risks of false data. For example, in Albania, the Government put in place a system whereby hospital patients receive a text message after a facility visit, asking whether they received care and if they had to pay a bribe. Likewise, electronic procurement and open contracting systems may reduce opportunities to alter or suppress data (see below).
- **Assess the level of e-government and open government implementation.** E-government refers to the use of electronic communications devices, computers and the Internet to provide public services to citizens and other persons in a country or region. E-procurement is one aspect of e-governance. E-government facilitates transparency and citizen involvement in governance. As governments open up their data to public scrutiny, citizen organizations can begin to hold government

accountable through data analytics (27). Assessment teams should explore how e-government is affecting the health sector and health procurement processes. What is being measured, what government functions or processes are included, and what lessons have been learned in e-government implementation to date?

- **Examine prior social audit results and facility report cards.** Social audit and facility report cards are an additional data source which involve community members in data collection, analysis and interpretation (28).
- **Assess capacity for data analytics and data mining on corruption, transparency and accountability issues.** Corruption can be detected by applying data analytics to insurance claims databases. Are claims databases made publicly available? Are they reviewed for fraudulent patterns? What is this process, and what happens when fraud is detected? Assessment teams should ask about the security of data, to ensure data are not being manipulated. Is it possible to make claims databases confidential (remove personal identifiers) so that external watchdogs are able to analyse them (for example, the Centers for Medicare & Medicare Services de-identified claims database, in the United States of America (29))? Data mining can be used to make documents transparent and help to visualize patterns. It can automate the continuous monitoring of claims data to identify anomalies or patterns that are potentially fraudulent. Assessment teams should query whether data mining is being used and whether the data mining unit has sufficient technical capacity, resources and independence. Can health procurement data be linked to databases on beneficial ownership of companies (a strategy used by the Anticorruption Action Centre in Ukraine to detect HIV/AIDS and tuberculosis medicines procurement corruption (30))?
- **Probe on protection of electronic patient information from theft.** Stolen patient information can be used for false billing by unscrupulous entities often posing as providers.

- **Determine whether other information strategies are used to promote transparency.** For example, several European countries and the Centers for Medicare & Medicaid Services in the United States maintain databases to document payments from pharmaceutical and medical device companies to doctors and health organizations (23–26). Innovative technology approaches to consider include blockchain,<sup>i</sup> a digital innovation with potential to provide an immutable audit trail and strengthen integrity in government (31).
- **Ask whether indicators are collected on corruption risks, or related to transparency and accountability.** Where do the data reside and can they be aggregated? Indicators available from external partners include Transparency International surveys (as previously mentioned) and the World Bank Worldwide Governance Indicators.<sup>ii</sup>
- **Consider external databases that incorporate performance indicators.** For example, the World Bank’s Service Delivery Indicators<sup>iii</sup> for health is a database that provides a set of metrics for benchmarking service delivery performance in select African countries. It includes measures of absenteeism and the availability of key resources needed to deliver health services. For countries included in the database, these indicators can help promote accountability.

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i A blockchain is a continuously growing list of records, called blocks, which are linked and secured using cryptography. It is “an open, distributed ledger that can record transactions between two parties efficiently and in a verifiable and permanent way.” Wikipedia. For a graphic explanation of blockchain, see <http://graphics.reuters.com/TECHNOLOGY-BLOCKCHAIN/010070P11GN/index.html>.

ii See: <http://sdg.iisd.org/news/world-bank-updates-governance-indicators>.

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iii See: <http://www.sdindicators.org>.

# Health financing

As explained in WHO's *Health financing country diagnostic guidance: a foundation for national strategy development*, the key functions of health financing are: revenue raising, pooling, purchasing and benefit design (32). Corruption, transparency and accountability issues can arise in any of these functions and, as a result, can adversely affect financial protection, equity in finance (the distribution of the burden of financing the health system across different socioeconomic groups), quality of services, and equitable use of health services. Public sector budget formation, distribution, financial control and expenditure reporting are important contextual factors.

The assessment team working on health financing can incorporate a focus on anti-corruption, transparency and accountability by exploring the lines of enquiry listed below.

- **Determine whether patients are paying informally for care.** The rate of informal payment is an indicator for financial access to health services. Assessment teams should identify whether patients are paying out of pocket for services or medicines that should be free of charge, or paying higher rates than specified by entitlement policies. Calculate the proportion of patients who had to pay for services that should be free and how much they paid, and collect other information on types of payments and the scope and seriousness of the problem. It is helpful to try to separate data on gifts given freely to express gratitude from other kinds of voluntary or non-voluntary (extorted) informal payments to receive services. Gift-giving may be a way to establish socially important relationships, although the perceived need to give gifts can still be a financial barrier to access. It is also helpful to separate hospital versus primary care settings, as the scope of the problem, drivers and solutions could differ by setting.
- **Assess transparency in the budget process.** Corruption risks in the budget formulation and execution process include misallocation of funds based on political preferences rather than population need, in addition to embezzlement risks. Budget transparency can help to

reduce such risks. Budget transparency initiatives often are combined with open government to allow civil society organizations to have timely access to proposed budgets and actual spending data, and to apply data analytics to these data. The International Budget Partnership<sup>i</sup> is an international nongovernmental organization working in this space.

- **Review past financial audit reports.** Financial audit reports are an important source of information to detect potential problem areas and system weaknesses that need strengthening. However, the findings from audit reports are often not addressed. Assessment teams are advised to meet with auditors from the supreme audit institution to discuss recommendations from prior reports, and assess whether the institutional response has been adequate (for example: have most recommendations been carried out?).
- **Consider extent to which financial data are contained in silos.** Assessment teams should consider the extent to which health professionals work with financial management staff and feel they are members of the same team. Siloing of financial responsibilities can increase the risk of corruption. Medical personnel need to be permitted to read a budget status report.
- **Review measures to ensure that all people are aware of their entitlements and obligations.** From a health financing perspective, it is important that people are aware of their entitlements and obligations (for example, which services they are entitled to access free of charge). If this information is readily available at different levels of the health system, it contributes to prevention of corruption (for example, providers asking for payments for services that should be given without out-of-pocket expenditure by the patient).

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i See: <http://www.internationalbudget.org>.

- **Assess risks according to core health financing functions.** Examples of corruption risks under the key health financing functions are listed below.

*Revenue raising (aims to raise revenues for the health sector across different sources)*

- Companies manipulate “assessable salaries” lower, to avoid taxation.
- Employees are kept in informal status, to avoid taxation/paying of benefits.
- State capture (for example, lobbying by industry officials influences public policy on air pollution fines and penalties, or taxation of unhealthy products).
- Tax evasion by individuals.

*Pooling revenue (aims to maximize the redistributive capacity of prepaid funds)*

- Manipulation of eligibility criteria for benefit packages (for example, so that someone who is more affluent gains access to benefit packages designed for the poor).
- Intentional misclassification of individuals for preferential premium and access to entitlements.
- Altering and influencing risk adjustment formulas. If a country has multiple pools, this can be a problem. For example, if an insurance company has a low-risk pool in a risk-adjusted system, the company would be asked to contribute to paying the added cost of the high-risk pool. In such a case, the incentive for the company is to pretend that it has high-risk patients so it can get money from a low-risk pool.
- Embezzlement. Misrepresenting pooled fund amounts through data manipulation, or misusing pooled funds (for example, a director using funds to invest in a personal scheme to make money).

*Purchasing (aims to transfer pooled funds to health service providers)*

- Opaque benefit design.
- Non-transparent processes for enrolment in insurance networks and negotiation of provider agreements (possibly allowing non-qualified providers to be included).
- Non-transparent reimbursement claims management and incentives. A risk is that providers are told they need to “pay to be paid,” i.e. claims managers are extorting or receiving payments from providers in order to get reimbursement ahead of others.
- Reimbursement of uncovered procedures, or ignoring clinical guidelines.
- Undue influence of the pharmaceutical industry in how medicine prices are regulated (see also the section on Medical products, vaccines and technologies).
- Abuse of the coding system (“up-coding”) for reimbursements.

*Other*

- Inadequate controls on lobbying. Assessment teams should appraise controls on lobbying from a legal and ethical perspective. Industry representatives should not be allowed to have a formal role in negotiations (negotiating prices, clawback procedures,<sup>i</sup> and so on) while also lobbying government. Lobbying is not necessarily corruption. What is important is ensuring controls on how lobbying is done. For example, is there a requirement that lobbyists must be registered?

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<sup>i</sup> A clawback provision refers to money or benefits that have been given out but need to be returned due to special circumstances or events, which are mentioned in a contract. Clawbacks are sometimes used in contracts to fund prescription drug benefits. Procedures can be complicated and may be designed in ways that disadvantage patients.

# Governance

WHO defines governance as ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system design and accountability. The health systems assessment approach focuses on three processes of governance: 1) the processes by which governments are selected, monitored and replaced; 2) the capacity of governments to effectively formulate and implement sound policies; and 3) the process of facilitating productive interactions among citizens, private organizations and the state (such as politicians, policy-makers and other public officials) (8). Health governance at the national level is aligned toward the mission of achieving universal health coverage (8).

As noted in the section on Country and health system context, stakeholder interviews should include the anti-corruption agency, the supreme audit institution and the office of the ombudsman. In some countries, there is a special overall oversight agency (outside of the health sector) to examine procurement, and there may be a central inspection office which oversees all inspectional services at sector level. Any institutions involved in establishing rules and procedures that are applied in the health sector should be consulted during the assessment, with the goal of maximizing transparency, accountability and control of corruption in health policies and interactions among citizens, the state and the private sector.

The assessment team working on governance can incorporate a focus on anti-corruption, transparency and accountability by exploring the lines of enquiry listed below.

- **Seek out government laws related to open data.** Visit open data websites, and identify civil society organizations working on this issue (see also the section on Health information systems).
- **Seek out data on country experience with multistakeholder initiatives.** The Medicines Transparency Alliance (<http://www.medicinestransparency.org>) is one such governance initiative. Such initiatives are specifically designed to facilitate transparent interactions among

civil society organizations, private sector and the state in order to enhance accountability. Does the state engage in dialogue with local actors to identify feasible, high-impact health strategies where policy change can influence incentives? At what levels, and around what issues?

- **Check for specific provisions in laws related to compliance.** Health insurance laws and regulations may encourage hospitals and other service organizations to create compliance programmes to control fraud and informal payments. Regulations should provide for fines or punishment if facility directors fail to implement compliance measures.
- **Assess whistleblowing laws and their implementation.** The assessment team should determine whether there are mechanisms to gather and process patient complaints, and assess their effectiveness in resolving individual problems and identifying systemic weaknesses that need to be addressed.
- **Ask about disclosure policies.** A disclosure policy sets out what information should be available to the public, and whether transparency is active (i.e. information is made available by the government through active strategies such as posting on a website) or through a request model (individuals must request the information). Is government making its policies, legal framework and performance data publicly available? Are there gaps in the disclosure policy?
- **Consider how the country is affected by global governance mechanisms.** For example, is the United Nations Convention against Corruption being implemented? How have these global treaties and governance mechanisms influenced corruption? This is a large area for investigation, and the assessment team may not have the capability and time to delve into these issues. However, the team should find out whether recent assessments have been done that may have a bearing on health. Health corruption can affect many Sustainable Development Goal targets in the areas of health, corruption and social justice.

- **Assess informal power structures and informal norms that govern sector interactions.** These are the unwritten “rules of the game” and include beliefs, attitudes and mental models regarding corruption. The Fletcher School of Diplomacy at Tufts University in the United States of America has developed a tool for mapping informal social norms that create and perpetuate corrupt practices.<sup>i</sup> The Basel Institute on Governance, Switzerland, and the Overseas Development Institute, United Kingdom of Great Britain and Northern Ireland, have created tools to analyse power and influence and the political economy, to assist in determining where informal power may be influencing policy decisions (33–35). Political settlement and political economy analyses for some countries are available on the websites of these institutions, as well as through the University of Manchester’s Effective States and Inclusive Development programme.<sup>ii</sup> Network mapping and political economy analysis may be helpful to determine which key people could make anti-corruption efforts succeed or fail, especially in the areas of finance, procurement and monitoring.
- **Assess how decentralization may affect corruption risks.** Health system decentralization may enable responsiveness to local needs and values (greater accountability), and thus could contribute to controlling corruption. A study in Bangladesh showed that decentralization reinforced monitoring systems, which allowed increased accountability through reporting on quality of services (36). In Brazil, decentralization resulted in better health outcomes in one state, possibly due to more reliable office hours of public officials, personal connections of the community to the health council, and local leaders who could better relate to staff and patients (37). Fiscal decentralization in highly corrupt countries was associated with decreased government deficit spending in one study (38), and with lower reported frequency of bribery in another (39). It is important to consider the decision-making autonomy of local governments, and to ask stakeholders how this may be affecting the government’s power to extract bribes from firms or citizens. It is also important to ask about different mechanisms for accountability including citizen participation. What oversight is being exercised over decision-making?

i See: <https://sites.tufts.edu/ihs/how-to-deal-with-the-complexity-of-corruption-four-recommendations-for-programming/>.

ii See: <http://www.effective-states.org/?s=health+sector>.

# Analysis across the building blocks

After experts have assessed vulnerabilities in each health system building block, it is important to consider any problems and priorities as a whole, across the system, and feed this into cross-analysis for the wider health systems assessment that is underway. Weaknesses and gaps in control mechanisms for one subsystem may allow corruption to arise in other areas. Mapping of how a weakness in one subsystem affects another is important to implement effective anti-corruption strategies and tactics. For example, the issue of informal payments was described under the health financing building block, but enabling factors may include gaps in governance, human resource management policies or service delivery systems.

At this stage in the assessment, experts should return to the figure that they created showing the anti-corruption architecture in the country, as it applies to the health sector. They should review how the structures and institutional responsibilities for anti-corruption could be strengthened, based on cross-analysis from the building blocks.

Based on the analysis, experts should create a set of possible priority interventions to improve anti-corruption, transparency and accountability in the country's health system. Resources for anti-corruption, transparency and accountability are not unlimited, and each country will need to decide on a focused strategy that would yield the greatest value in terms of reduced waste/loss of resources, and improved health outcomes.

Table 1 describes a set of red flag indicators for vulnerability to corruption in the health sector. These include the burden of informal payments, measures of corruption perception, indicators of the adequacy of health workers' pay, and so on. The table shows possible sources of these data, how to calculate the indicators, and possible thresholds or "red flag" levels at which concerns should be raised. Table 1 also suggests how these indicators may be related to specific types of corruption. Assessment teams might review available data to calculate red flag indicators.

**Table 1. Red flag indicators for vulnerability to corruption in the health sector**

Indicator	Source of data	Calculation	Red flag level	Types of corruption indicated	Comments
Burden of informal payments	<ul style="list-style-type: none"> <li>Household health expenditure <a href="#">surveys</a></li> <li>National <a href="#">health accounts</a></li> <li><a href="#">Afrobarometer survey</a></li> </ul>	<ul style="list-style-type: none"> <li>Out-of-pocket payments as % of total health expenditure</li> <li>Informal payments as % of out-of-pocket payments</li> </ul>	> 50%  > 20%	<ul style="list-style-type: none"> <li>Demands for informal payments as condition of care</li> <li>Abuse of dual practice</li> </ul>	Would be helped by standardized definitions and methodology for surveys
Transparency International ratings	<ul style="list-style-type: none"> <li><a href="#">Corruption Perceptions Index</a></li> <li><a href="#">Global Corruption Barometer</a></li> </ul>	<ul style="list-style-type: none"> <li>Overall rank</li> <li>Responses to health and medical services questions</li> </ul>	> #75 Is health one of the top three areas?	<ul style="list-style-type: none"> <li>All forms of corruption</li> <li>Informal payments</li> <li>Dual practice</li> <li>Procurement fraud</li> </ul>	May also consider the World Bank's Worldwide Governance Indicators or the Index of Public Integrity, but would need to set the red flag levels
Adequacy of clinician salaries	<ul style="list-style-type: none"> <li>Civil service <a href="#">pay for clinicians</a></li> <li><a href="#">Labour market surveys</a></li> </ul>	<ul style="list-style-type: none"> <li>Doctors pay as % engineers, lawyers</li> <li>Nurses pay as % of college grads</li> </ul>	< 90%  < 100%	<ul style="list-style-type: none"> <li>Informal payments</li> <li>Dual practice</li> <li>Pharmaceutical irregularities</li> </ul>	

Indicator	Source of data	Calculation	Red flag level	Types of corruption indicated	Comments
Educational fraud	<ul style="list-style-type: none"> <li>National ministry of education</li> <li>Higher education accreditation agency</li> <li>National boards of registration for professions (doctors, nurses, pharmacists)</li> <li>OECD databases</li> </ul>	<ul style="list-style-type: none"> <li>Annual rate of increase in graduating medical doctors, nurses</li> <li>Annual increase in medical schools</li> </ul>	Growth of 5% per annum or more, over a 3-year period	<ul style="list-style-type: none"> <li>Corrupt certification</li> <li>Buying of places</li> <li>Buying exam results</li> <li>Leads to demand for informal payments</li> </ul>	Could create a quality problem with new graduates. Triangulate with other data to assess risk.
Excessive tertiary spending	<ul style="list-style-type: none"> <li>Government health expenditure by level of care</li> <li>Life expectancy</li> </ul>	<ul style="list-style-type: none"> <li>Divide life expectancy into two year groups</li> <li>Calculate ratio of tertiary spending to total health spending</li> </ul>	Top two quintiles for life expectancy groups	<ul style="list-style-type: none"> <li>Undue influence in capital spending, equipment and drug purchase</li> </ul>	Will probably require special calculation of tertiary spending ratio for all states. Triangulate with other data to assess risk.
Excessive medicine prices (public)	<ul style="list-style-type: none"> <li>National tender price for five selected common generic medicines</li> <li>Median price for same generics from international suppliers and buyers</li> </ul>	<ul style="list-style-type: none"> <li>Ratio of tender prices to median global price for same medicine</li> <li>Compare prices paid over time and among facilities</li> </ul>	Top two quintiles	<ul style="list-style-type: none"> <li>Procurement corruption</li> <li>Corruption in pharmaceutical licensing</li> </ul>	
Excessive medicine spending	<ul style="list-style-type: none"> <li>Household health expenditure surveys</li> <li>National health accounts</li> </ul>	<ul style="list-style-type: none"> <li>Total drug spending per capita in relation to other countries at same level of GDP per capita</li> </ul>	Top two quintiles	<ul style="list-style-type: none"> <li>Corrupt pharmaceutical marketing activity, or marketing resulting in undue influence</li> <li>Corruption in drug approval and licensure</li> </ul>	May need to develop additional detailed categories for GDP per capita, finer than just "low-income" and "middle-income"

Source: Personal correspondence, Frank G. Feeley to Taryn Vian, 26 March 2018.

Notes: Data may need to be triangulated to determine if a red flag really indicates corruption. Other sources of data can provide insight; however, it is not always clear how to set red flags. See Annex 2 for a list of anti-corruption indexes relevant to the health sector. Countries participating in the GGM programme can use data from the WHO transparency assessment instrument, which provides scores to rank the pharmaceutical functions at highest risk for corruption. Countries such as the United States

of America may share Department of Justice<sup>i</sup> data on civil and criminal settlements for health care fraud and abuse. Such data can help identify areas of focus for anti-corruption resources, such as durable medical equipment or certain geographic areas. Finally, several countries (including Belgium, France and the United States of America) have created open payment databases to record payments from industry to physicians (40). Where transparency laws make such data public, they can help to increase accountability.

i See: <https://oig.hhs.gov/reports-and-publications/hcfac/>.

# Reporting on anti-corruption, transparency and accountability findings

The final report of the anti-corruption, transparency and accountability assessment should be organized as described below. It can be a standalone piece, or be integrated into the wider health systems assessment report. Assessment teams should be careful to ensure the confidentiality of key informants. The report should not use informants' names or titles, or very specific examples if they could be used to identify a particular individual. Interview notes or transcripts should use codes to identify key informants. These files should be destroyed within some months of completion of the final report (allow some time in case questions about data require revisiting of files: 6 months to 1 year after the report is released should be adequate).

1. **Introduction.** Include an introduction explaining the purpose and objectives of the assessment. Be sure to emphasize that this is an assessment of inherent risks or possible areas where abuse *could* occur, and that it is not an audit or an attempt to identify actual cases of corruption.
2. **Methods.** Give a general description of the methodology. Describe the types of informants, average length of interviews, and site visits. (Note: it is appropriate to exclude a description of site visits if this could lead to identification of a key informant). Include a list of the public documents consulted, as an annex.
3. **Findings.** The findings can be organized by building block, or by problem/issue.
  - a. Building blocks – include a short description of the health system building block, the institutions involved, and the key findings for each building block.

- b. Issues/problems – these might include informal payments, theft of medicines, procurement corruption, conflicts of interest, and so on. This structure may help to avoid repetition if the assessment team finds that issues involve several different building blocks. It also might be helpful if the government is already aware of specific issues and is looking for specific solutions.

4. **Recommendations.** Consider recommendations at several levels, including policies, institution strengthening, programmes, training and awareness raising. Where possible, suggest which institution should take the lead, and which other institutions or stakeholders should be involved. Consider the feasibility and cost of implementation, and provide examples of possible comparators or models from other countries where available. This will help to generate evidence-informed policy.
5. **Limitations.** If data were not available to document certain problems or issues, or to fully assess corruption risks in certain building blocks, make this clear and recommend further studies.

In conjunction with the government counterparts and leads for the health systems assessment, determine in advance who will read and review the draft report, and with whom the draft and final report can be shared.

# Annex 1.

## Key informant interview questions

Annex 1 includes key informant interview questions that have been used in country-level assessments of health sector corruption risks. This tool can be adapted to the particular issue or health sector building block of interest.

### Overall questions on perceptions about corruption and health

1. How is corruption defined? What kinds of actions or characteristics does it include, in the health sector in particular?
2. What are main reasons for corruption in the health sector in your country?
3. Regarding corruption in the health sector, are things today the same, better or worse than 3 years ago? Why?
4. What are the areas in the health sector that are most vulnerable to corruption?
5. What forthcoming health reforms could make the health system, or aspects of it, more vulnerable to corruption?

### Vulnerable areas

For each of the six high-risk areas, the goal of key informant interviews is to find out more information related to:

- characteristics of and potential weaknesses in current systems;
- existence of data, including objective or subjective evaluations of the extent or likelihood of corruption;
- ways in which corruption operates or is manifested;
- negative consequences of corruption;
- past experience with anti-corruption efforts;
- resources for anti-corruption (e.g. advocates, information, watchdog organizations).

Specific questions for each high-risk area are given below. These may need to be modified based on the organization of the health system in the country and the specific institutions involved.

### 1. Purchasing of equipment and supplies, including promotional efforts by industry

*(See also the more detailed tools for transparency assessment produced by WHO's Good Governance for Medicines (GGM) programme.*

#### Equipment

- i. How is need for equipment established and quantified?
- ii. How are technical specifications determined? Are there controls in place to assure that technical specifications are not biased towards certain companies? Have there been problems of "fingering procurements" in the past, i.e. tender documents that have been written to point to a certain company as best qualified?
- iii. What are the risks of corruption in procurement? Are there problems with bid-rigging, collusion or conflicts of interest? Can you describe these problems?
- iv. Are procurement data made public? If so, do you have price data available for recent equipment procurements? How do the prices paid compare to international prices? Is there evidence that prices are excessive?
- v. Can you describe the processes in place for monitoring the equipment purchase process?

#### Medicines and supplies

- i. Do you have an Essential Medicines List? How do medicines get added or removed from the List? Is the process transparent?
- ii. How are conflicts of interest managed for members of the committee that updates the Essential Medicines List?
- iii. Do you feel the procurement process for medicines has problems of corruption? If so, can you describe what kinds of problems?
- iv. Are procurement data made public? If so, do you have price data available for recent medicines or supplies procurements? How do the prices paid compare to international prices? Is there evidence that prices are excessive?
- v. Can you describe the processes in place for monitoring the medicines procurement process?

### **Promotion by industry**

- i. Are there guidelines in place related to allowable industry hospitality practices?
- ii. Are companies allowed to offer to pay travel to conferences, or to give gifts and free samples to clinicians?
- iii. Are there financial limits on hospitality or controls on pharmaceutical promotional activities at the system or facility level?
- iv. Are physicians allowed to own or have a financial interest in a pharmaceutical company, pharmacy or medical device company? Are there limitations on the practice of a doctor referring patients to a pharmacy or ancillary service (e.g., diagnostic testing) in which the doctor has a financial interest?
- v. Is the pharmaceutical industry the major provider of information about medicines? Are there other sources of medicines information? If so, what are they, and how objective are they?

## **2. Distribution of medicines and medical supplies, and transportation**

### **Medicines and medical supplies**

- i. Is theft of medicines by health workers a problem? If so, what kind of evidence is available to document this (audit findings, stock-out data, perceptions of health workers)? Where in the system does theft occur, and who is involved? What do you think are the drivers of this practice?
- ii. Are stock control systems adequately resourced and staffed?
- iii. Is there any evidence that records are being falsified, such as false recording of patients who did not really attend the facility ("ghost patients") or false recording of prescriptions ("ghost prescriptions")?

- iv. Sometimes corruption occurs because there is inadequate separation of responsibilities. It is helpful to review whether checks and balances are in place. For example, is the person who writes the prescription the same person who fills the prescription and gives the medicine to the patient? If there is a co-payment, is the person who takes the payment the same person who records how much was paid, takes funds to bank or other depository, and compiles the report? Is there adequate separation of responsibilities?

### **Transportation**

- i. Does the institution have a transport resource management system with performance indicators?
- ii. Are log books used consistently to record work trips and kilometres travelled? Are there fuel controls in place to check that the fuel purchased is consistent with the kilometres travelled? Are there controls to assure that vouchers to purchase fuel are safeguarded from theft and misuse?
- iii. Is there evidence of misuse of transport resources? If so, what type of misuse, and by which level of employees?

## **3. Regulatory system**

### **Facilities**

- i. Is there evidence or suspicion of corruption in licensing of facilities, accreditation and quality assurance, or inspection of facilities?
- ii. If so, can you describe the types of corruption and possible drivers?

### **Food and sanitation**

- i. Is there evidence or suspicion of corruption in licensing of restaurants or food production facilities, or inspection of these facilities?
- ii. If so, can you describe the types of corruption and possible drivers?

### Medical personnel

- i. Do complaint mechanisms exist for citizens or patients to complain about poor quality of care or other problems with providers? How well do they work?
- ii. Is there a system and procedures for investigation and adjudication of complaints? If so, how well does the system function?
- iii. Is illegal payment (informal payment) an offense that can be punished with license limitation?
- iv. Are there codes of conduct governing behaviour of medical professionals? If so, are the codes updated and disseminated to employees regularly?
- v. Are there procedures in place to define and manage conflicts of interest among medical personnel? How well does the system work to manage these conflicts?

## 4. Human resources management, medical staff issues

- i. Is there an issue of people having to pay to obtain a post, promotion or transfer? If so, can you describe this? Does it affect types of personnel differently (e.g., nurses versus doctors)?
- ii. Are all hires permanent employees, or are there also contract-based employees? How does employment status affect the ability of managers to discipline employees?
- iii. Is there evidence of favouritism in appointments and promotions? If so, can you describe how this happens? Is it specific to health staff, or a general civil service administration problem?
- iv. What accountability measures are in place to assure that personnel are doing their job? Examples include supervision systems, output measures, pay-for-performance, board oversight, social audit, and so on.
- v. Does current law allow for dual practice (i.e. are public sector doctors also allowed to engage in private practice)? If so, are there rules or guidelines governing this practice to control possible misuse? Do doctors use public facilities for private medical practice? Do doctors refer patients from government facilities to private practice? Are there concerns about the appropriateness of such referrals?

- vi. Are there controls in place to reduce incentives for unnecessary medical interventions (e.g., caesareans, extensive testing)?

## 5. Budget and financial management

- i. Please assess the level of transparency and participation in the budget development process. Is there a time period for public input into the budget development process? How is public consultation handled? Is a draft budget made available for review by civil society groups?
- ii. When a budget request from a facility or district is not fully funded, is the facility or district required to submit a revised plan?
- iii. Please assess the level of transparency and participation in the budget monitoring process. How are reports showing budget versus actual spending made available, and to whom?
- iv. Ask for past health sector audit reports from the government Supreme Audit Institution or Inspector General. Did past audit reports indicate gaps in financial controls? If so, have remedial actions been taken? Are there findings from prior audits that have not been resolved? Do these problems create risks of corruption?
- v. Review the formal user fee and co-payment policies to determine how are fees set, collected and controlled. Determine who supervises the system, and who puts the money in the bank. How much money is kept and at what levels? Is there any evidence that embezzlement of funds by the collection agents or other staff is a problem? Are there controls against overcharging patients?
- vi. Has the government conducted flow of funds analysis or a public expenditure tracking survey to reveal discrepancies in funds reported as transferred to lower levels in the system (i.e. national level funds transferred to district level, but the district does not report having received funds from national level)? Have the findings and recommendations of these studies resulted in responsive actions? If not, why not?

## **6. Service delivery (including absenteeism, shirking and informal payment)**

- i. Are there any data to document rates of unexcused absence (e.g. perceptions, hard data, differences among categories of personnel)?
- ii. Has an audit been conducted to determine whether payroll includes any ghost personnel (employees who are receiving salary, but do not exist or have not assumed their post)?
- iii. Is shirking a problem, i.e. purposefully not fulfilling one's job responsibilities? Do health workers do other jobs during working hours?
- iv. Are there any data documenting informal payments (perceptions; hard data on proportion of population who pay, and how much they pay; differences by type or location of facility/provider, or nature of payment

e.g., requested or offered)?

- v. Do you have a sense of the motivation for informal payments, or the reasons why patients try to give or providers are willing to take such payments? Examples might include skipping the queue, hoping to obtain better quality of care, being fearful that if one does not give an informal payment then one will not receive any service at all, and so on.
- vi. Are there sanctions and conditions in the national health insurance plan or civil service regulations to control informal payments?
- vii. How complex is the system of health insurance benefits? Are there ways for patients to determine what benefits are covered, or whether they are entitled to a specific service? Are patients paying for referrals or to bypass the gatekeeping system?

## Annex 2.

# Anti-corruption indices and tools in the health care and pharmaceutical sectors

Index	Created by	Objective	Methodology	Frequency	Costs	Observations
Access to Medicine Index	Access to Medicine Foundation	To analyse how companies make medicines more accessible in low- and middle-income countries. It highlights best and innovative practices, and areas where progress has been made and where action is still required.	20 of the largest pharmaceutical companies with presence in 106 countries. Based on 69 indicators that measure and analyse company policies, divided into seven different areas.	Biennially	€ 1 395 183 total expenses in 2016 annual report	Methodology reviewed every 2 years; highlights where action is needed and where progress is being conducted; done since 2003.
Access to Vaccines Index	Access to Medicine Foundation	To analyse how vaccine companies are increasing their access to more children. Indicates to companies where they can improve and where action is needed.	Eight companies with presence in 107 countries. The indicators are divided in three main areas. Indicators measure policies, strategies and transparency.	Done once so far, in 2017; pending further funding	€1,995,577 total expenses in 2017 annual report	Methodology based on opinions and insights from experts in government, nongovernmental organizations, researchers and UNICEF, among others. First benchmark to do this analysis.
AllTrials Transparency Index	BMJ Best Practice	To rank the largest pharmaceutical companies by their clinical trial transparency policies, measuring their commitment to transparency.	42 companies analysed; 65 yes/no questions in four main domains.	One off	N/A	Researchers sent emails to receive feedback from all companies studied. Small team of researchers that reached consensus and had no other reviews.
Good Governance for Medicines (GGM)	World Health Organization	To strengthen and prevent corruption in health systems by promoting good governance in the pharmaceutical sector.	Launched in 2004, it now comprises 37 countries in the programme. The programme is implemented in a 3-step strategy to institutionalise good governance in the pharmaceutical sector.	First launched in 2004	N/A	GGM is a programme, not an index. Measures strengths and weaknesses within the pharmaceutical sector to develop appropriate interventions.
Study on Corruption in the Healthcare Sector	European Commission	To develop a better understanding of the extent, nature and impact of corrupt practices in the health care sector across the European Union (EU), to assess the capacity of countries to prevent and control corruption within the health care system and its effectiveness.	Covers all 28 EU Member States, based on desk research, online surveys and interviews.	2012 and 2017	N/A	Gives detailed analysis of types of corruption and policies implemented to address it.

Index	Created by	Objective	Methodology	Frequency	Costs	Observations
Measuring Transparency in the Public Pharmaceutical Sector: assessment instrument	World Health Organization	To help stakeholders carry out assessments to measure the level of transparency and the vulnerability to corruption in the procedures and structures of eight functions of the pharmaceutical sector.	A tool that includes yes/no questions, binary with follow-up questions, and open questions. Eight main areas of assessment.	N/A	N/A	Assesses strengths and weaknesses in the pharmaceutical sector. Gives qualitative and quantitative information. Requires document support for the answers.
Special Eurobarometer 470 Report on Corruption – corruption in health care	European Commission	To present a good understanding of the experiences and perceptions of the EU citizens relating to corruption, as well as their attitudes towards the various institutions in their countries responsible for tackling it.	28 EU Member States. More than 28 000 face-to-face interviews, 1000 on average for each country.	Biennially	€ 5.31 million*	Includes questions related to perceptions, attitudes and experiences of corruption. It is a survey and does not present analysis of institutions.

Source: Miguel Ángel Gómez Jácome. Analysis of anti-corruption and health indices. Unpublished report to Transparency International.

\*2018 budget for all Eurobarometers.

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