Reinforcing the focus on anti-corruption, transparency and accountability in national health policies, strategies and plans
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Introduction

The top strategic priority for the World Health Organization (WHO) is to support countries to progress towards universal health coverage. To achieve this aim, WHO supports countries to develop health policies, strategies and plans aimed at increasing access to quality health services for all, without people needing to suffer financial hardship in paying for them.

Corruption causes significant losses of public money and may impede the ability of nations to make evidence-based policy choices and build consensus on the most effective approaches 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 resources wasted. Researchers estimate global average annual losses from health care fraud and error to be 6.19% of total expenditures, amounting to hundreds of billions of dollars (Gee & Button, 2015). Corruption is also a significant predictor of child mortality and other negative health outcomes.

One researcher calculated that 140 000 child deaths per year are attributable to corruption, more than those caused by Ebola, cholera and rabies combined (Hanf et al., 2011).

Recognizing that corruption may slow progress toward achieving universal health coverage, WHO Member States and development partners are working to prevent and control corruption (Mackey, Vian & Kohler, 2018). As part of these efforts, it is critical to advance a more coherent approach towards mainstreaming anti-corruption efforts into work to strengthen national health policies, strategies and plans (NHPSPs). The goal 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 ways to approach national health planning and the development of policies and strategies to identify corruption risk areas and help countries to decide which anti-corruption, transparency and accountability approaches should be deployed in response.
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Background

Transparency International defines corruption as the abuse of entrusted power for private gain (Transparency International, 2018). The health sector is particularly susceptible to corrupt activities as it involves many actors and provides varied opportunities for bribes, informal payments, embezzlement, nepotism and other forms of abuse of power. What makes efforts to address health system corruption especially challenging is that risks can vary based on many country-level factors. For example, a systematic review in 2017 found rates of informal payment range from 2% to 80%, depending on the country and specific type of health service (Khodamoradi et al., 2017). This means that anti-corruption efforts must be based on robust situation analysis, with interventions tailored to address specific problems in the relevant context.

Health planning, policy and strategy development activities can be designed to shed light on the risks of corruption given the particular institutions, political processes and contexts in each Member State. In this way, countries can tailor solutions that take into account their context-specific factors.

Certain levers and mechanisms have the potential to prevent corruption in the health sector. Some of the most important levers, which will be discussed in more detail in this document, include transparency, accountability and citizen participation. Transparency refers to unfettered access by the public to timely and reliable information on decisions and performance in the health system. Accountability refers to the obligation to report and to be answerable for meeting (or failing to meet) stated performance objectives. Citizen participation refers to the process of enabling citizens to share their views and influence public decisions.

These concepts are interrelated: transparency and accountability are critical for efforts to ensure integrity and to 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, and where citizens are engaged and have an opportunity to interact with public officials and participate in governance activities, it is more likely that officials and leaders can be held accountable, and there is less space for malfeasance or corruption.

Recommendations for incorporating a focus on anti-corruption, transparency and accountability in the development of NHPSPs are detailed in the following sections. 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 underway.
WHO’s *Strategizing national health in the 21st century: a handbook* (WHO, 2016) explains the steps and methods to develop and implement NHPSPs, using multisectoral participatory approaches. The steps in the NHPSP process include population consultation, situation analysis, priority setting, strategic planning, operational planning, estimating costs, budgeting, and monitoring and evaluation. Cross-cutting issues include laws and regulations, strategizing at the subnational level (for example, decentralized health systems), intersectoral planning for health and health equity, and strategizing in distressed health contexts. The approach focuses on dialogue and debate, employing a dynamic, pluralistic planning process owned by the full community of stakeholders.

The NHPSP process emphasizes a collaborative approach – a country-led, universally applicable monitoring and evaluation framework – to increase accountability. An area of focus is to expand and strengthen the role of the department of planning within the health ministry to be more active in communicating information. This department should play a “broker” role, convening stakeholders, engaging in bottom-up planning and communicating frequently with citizens (WHO, 2016). The department of planning might also become a coordinator for the integration of an anti-corruption, transparency and accountability focus in the NHPSP, which will entail collaboration with government institutions tasked with anti-corruption across all sectoral domains.
Population consultation

A population consultation is a special event involving interaction between members of a population and policymakers. It is a way to gather information from affected members of the community, separate from institutionalized mechanisms of representation or participation (such as elected or appointed individuals or local health committees). A population consultation captures information on the population’s opinions and expectations on health-related issues, in order to improve policy responses.

When conducting a population consultation to develop the NHPSP, national authorities may wish to consider the following anti-corruption, transparency and accountability approaches.

**Hold a population consultation on the theme of corruption and health**

Holding a population consultation is an especially good approach when the country is developing an overall anti-corruption strategy or plan, and has asked for input about health sector needs and goals. It also may be helpful to plan a population consultation at the start of a new national health policy or strategy process. Such a consultation may be framed as gathering information about citizens’ perceptions of corruption and the negative consequences of corruption, such as the problems or challenges it poses for access to health care or affordability of services. It is helpful to engage with civil society organizations, nongovernmental organizations or independent research organizations in organizing the consultation.

Multiple types of data collection can be used, depending on the context. For example, a consultation might attempt to gather survey data from selected population groups prior to a face-to-face assembly or forum to discuss the results. Organizers might consider gathering the opinions of clinical staff and health workers, as well as citizens and patients, on corruption and health. Perceptions of corruption may also vary between different population groups based on demographic or geographic factors (such as age, income, education or hard-to-reach).

When organizing a population consultation on corruption and health, it is important to frame the consultation as examining perceptions and opinions of the population, and to focus on areas where prevention efforts or health systems strengthening can help to deter corruption. Responses to surveys should be anonymous, and data collection organized in such a way as to reduce respondents’ reluctance or reticence to share opinions honestly. For example, when focusing on specific types of corruption, questions should not be about the personal experiences of the informant. Instead, questions should focus more generally on informants’ perceptions of corruption risk areas, enabling factors and systems-level issues. The population responding to the survey should know that what they say could appear in the assessment report, but would not be associated with their name or position title. Similarly, written notes from interviews or public forums should not include names.

Information obtained from the population consultation can be used when developing a new strategy or reform. Decision-makers can consider whether the strategy or reform is going to prevent some of the corruption risks and problems identified by the population. Box 1 provides an example of how the Medicines Transparency Alliance used consultative meetings to bring together stakeholders interested in access to medicines.
Box 1. Medicines Transparency Alliance

The Medicines Transparency Alliance (MeTA) initiative was implemented in seven countries (Ghana, Jordan, Kyrgyzstan, Peru, the Philippines, Uganda and Zambia) from 2008 to 2015. MeTA created a structure for a wide variety of government, private and nongovernmental organizations to collect, analyze and share pharmaceutical information in an effort to increase transparency and accountability in the pharmaceutical sector. The initiative sought to improve evidence-based policy making and access to medicines (see model below).

MeTA sought to develop a national-level multistakeholder platform to facilitate interactions among the diverse set of stakeholders. Stakeholders shared information, debated the evidence, engaged a wider audience and made policy recommendations. Evaluations of MeTA found that pilot countries had assembled data on multiple dimensions of access and that multistakeholder dialogue had built understanding and trust among participants. Several countries adopted policy change to advance access to medicines goals, including removal of VAT on medicines and improved efficiency in procurement procedures. MeTA consultation output and data analysis helped inform these policies.

Involvement of government oversight agencies

Most countries have government watchdog organizations in place, charged with carrying out responsibilities to prevent or curb corruption. Health officials may want to involve these agencies as they organize population consultations, so that oversight institutions can learn about population concerns and potentially collaborate with the health ministry on solutions. For example, the supreme audit institution is a constitutional body and the highest state institution responsible for conducting external audits of public entities. Concerns raised in population consultations could become the basis for an audit; conversely, audit staff may be able to educate the population on oversight procedures already in place.

The ombudsman or ombudsperson in a country is charged with protecting the rights and freedoms of citizens from illegal actions of public institutions. The office of the ombudsman uses “soft powers”, such as investigations and recommendations to line ministries and parliament, to achieve this mandate. In addition to investigating individual complaints, the ombudsperson can launch an investigation triggered by leads from citizens.

Other oversight institutions with an interest in curbing corruption include the anti-corruption agency, with responsibilities for enforcement, prevention and investigation of corruption (depending on the country), and the public procurement regulatory authority, responsible for assuring compliance with public procurement laws.

Gather data from spontaneous events

In addition to planned population consultations, it is important to consider methods for gathering opinions about corruption from spontaneous events such as demonstrations, strikes and internet campaigns. These can provide a different perspective compared to opinions of policy decision-makers. For example, a doctors’ strike may provide an opportunity to learn more about how people perceive or experience conditions such as poor pay or working conditions. Such issues may have roots in corrupt practices, or may lead to corruption.
The second major step in the NHPSP process is situation analysis, which applies methods to conduct participatory, inclusive and evidence-based assessment of the strengths, weaknesses and status of the health system as a first step in the planning cycle. A participatory process for situation analysis furthers the goals of transparency and accountability (WHO, 2016, p. 112). When stakeholders participate in the situation analysis, they gain a deeper appreciation of the problems facing citizens.

WHO has developed guidance for integrating a focus on anti-corruption, transparency and accountability into health systems assessments (WHO, 2018b). The various approaches follow the WHO health systems framework, which categorizes health system functions by using the analogy of “building blocks.” While the health systems framework is familiar to many, some problems and solutions may affect multiple building blocks and will require a cross-cutting approach. Below is a summary of the key points from WHO’s 2018 guidance relevant to performing a situation analysis informed by an anti-corruption, transparency and accountability approach (WHO, 2018b).

**Analyse stakeholders**

Stakeholder analysis may be useful for an in-depth situation analysis of the theme of corruption. If a team is conducting a broader stakeholder analysis for the health sector as a whole, it is important to remember non-health stakeholders who are interested in anti-corruption, transparency and accountability, and might be able to apply their influence or resources to health-related corruption issues. Non-health stakeholders might include those already mentioned such as the anti-corruption agency, ombudsperson and supreme audit institution, as well as umbrella coalitions of civil society organizations (for example, the Anti-corruption Coalition of Uganda is an umbrella nongovernmental organization that promotes transparency initiatives to fight corruption in many sectors).

**Review red flag indicators**

A “red flag” is a condition, event or set of circumstances that suggests a higher-than-average risk of corruption or unethical practices (see Table 1). These include the burden of informal payments, corruption perceptions, indicators of the adequacy of pay for health workers, and other conditions. Table 1 explains possible sources of these data, how to calculate the indicators, and possible thresholds for concern. While red flags are not the only types of data that are useful in a situation analysis, teams might want to review available data to see if red flag indicators are present.
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Table 1. Red flag indicators for vulnerability to corruption in the health sector

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Source of data</th>
<th>Calculation</th>
<th>Red flag level</th>
<th>Types of corruption indicated</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Burden of informal payments   | • Household health expenditure surveys
• National health accounts
• Afrobarometer survey       | • Out-of-pocket payments as % of total health expenditure
• Informal payments as % of out-of-pocket payments | > 50%
> 20% | • Demands for informal payments as condition of care
• Abuse of dual practice     | Would be helped by standardized definitions and methodology for surveys                                      |
| Transparency                   | • Corruption Perceptions Index
• Global Corruption Barometer | • Overall rank
• Responses to health and medical services questions | > #75
Is health one of the top three areas? | • All forms of corruption
• Informal payments
• Dual practice
• Procurement fraud         | 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 |
| International ratings         |                                                     |                                                                            |                |                                                                                               |                                                                                             |
| Adequacy of clinician salaries| • Civil service pay for clinicians
• Labour market surveys     | • Doctors pay as %
• Engineers, lawyers
• Nurses pay as % of
• College grads | < 90%
< 100%   | • Informal payments
• Dual practice
• Pharmaceutical irregularities |                                                                                             |
| Educational fraud             | • National ministry of education
• Higher education accreditation agency
• National boards of registration for professions (doctors, nurses, pharmacists)
• OECD databases          | • Annual rate of increase in graduating medical doctors, nurses
• Annual increase in medical schools | Growth of 5% per annum or more, over a 3-year period | • Corrupt certification
• Buying of places
• Buying exam results
• Leads to demand for informal payments | Could create a quality problem with new graduates. Triangulate with other data to assess risk. |
| Excessive                    | • Government health expenditure by level of care
• Life expectancy            | • Divide life expectancy into two year groups
• Calculate ratio of tertiary spending to total health spending | Top two quintiles for life expectancy groups | • Undue influence in capital spending, equipment and drug purchase | Will probably require special calculation of tertiary spending ratio for all states. Triangulate with other data to assess risk. |
| tertiary spending             |                                                     |                                                                            |                |                                                                                               |                                                                                             |
| Excessive medicine prices (public) | • National tender price for five selected common generic medicines
• Median price for same generics from international suppliers and buyers | • Ratio of tender prices to median price for same generics from international suppliers and buyers
• Compare prices paid over time and among facilities | Top two quintiles | • Procurement corruption
• Corruption in pharmaceutical licensing |                                                                                             |
| Excessive medicine spending   | • Household health expenditure surveys
• National health accounts | • Total drug spending per capita in relation to other countries at same level of GDP per capita | Top two quintiles | • Corrupt pharmaceutical marketing activity, or marketing resulting in undue influence
• Corruption in drug approval and licensure | May need to develop additional detailed categories for GDP per capita, finer than just "low-income" and "middle-income" |

Consider quantitative and qualitative data sources

Table 2 summarizes different sources that can be used to measure corruption including perception and experience surveys, household and public expenditure surveys, and review of control systems (Hussmann, 2011). In addition to quantitative indicators, it is helpful to review qualitative data on perceived barriers to access to care or gaps in financial protection, and check whether these may be facilitating factors leading to abuse of power. Actions must be taken to address integrity of data (see Box 2, and the subsection on Monitoring and evaluation).

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

<table>
<thead>
<tr>
<th>General tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cross-cutting</td>
</tr>
<tr>
<td>Political economy, including political settlement, analysis; vulnerability to corruption assessments; value chain analysis; sectoral accountability assessment; value for money audits; analysis of governance in health care systems; analysis of social norms and behaviours regarding corruption</td>
</tr>
<tr>
<td>Budget and resource management tools</td>
</tr>
<tr>
<td>Budget process</td>
</tr>
<tr>
<td>Public expenditure and financial accountability (PEFA) indicators; focus groups and interviews with public officials, recipient institutions and civil society</td>
</tr>
<tr>
<td>Payroll leakages</td>
</tr>
<tr>
<td>Public expenditure tracking surveys (PETS) and public expenditure reviews (PERS); household surveys; focus groups with public officials and health workers</td>
</tr>
<tr>
<td>In-kind leakages</td>
</tr>
<tr>
<td>PETS; quantitative service delivery surveys (QSDS); facility surveys; focus groups with public officials, recipient institutions and health workers</td>
</tr>
<tr>
<td>Pharmaceuticals</td>
</tr>
<tr>
<td>Good Governance for Medicines (GGM) transparency assessment tool; International Medical Products Price Guide; internet-based drug procurement price databases</td>
</tr>
<tr>
<td>Individual provider tools</td>
</tr>
<tr>
<td>Job purchasing</td>
</tr>
<tr>
<td>Official administrative records combined with facility surveys; interviews with public officials and former officials; World Bank Governance and Anti-Corruption Diagnostic surveys</td>
</tr>
<tr>
<td>Health worker absenteeism</td>
</tr>
<tr>
<td>QSDS; surprise visits; direct observation; facility records; focus groups or interviews with facility heads and patients</td>
</tr>
<tr>
<td>Informal payments tools</td>
</tr>
<tr>
<td>Informal payments</td>
</tr>
<tr>
<td>Household surveys (World Bank Living Standards Measurement Study, Demographic and Health Survey); facility exit surveys and score cards; focus groups and interviews with patients, providers and staff; World Bank Governance and Anti-Corruption Diagnostic surveys</td>
</tr>
<tr>
<td>Corruption perceptions and experience</td>
</tr>
<tr>
<td>Perceptions and experience</td>
</tr>
<tr>
<td>Transparency International Global Corruption Barometer survey; World Bank Anti-Corruption Diagnostic surveys (measure experience); national-level perception surveys by civil society organizations and others</td>
</tr>
<tr>
<td>Experiences</td>
</tr>
<tr>
<td>Afrobarometer; Latinobarómetro; Eurobarometer; Transparency International Global Corruption Barometer; national experience-based surveys; patient satisfaction surveys; report (score) cards; focus groups</td>
</tr>
</tbody>
</table>

Source: Hussmann, 2011.
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The World Bank’s Country Policy and Institutional Assessment (CPIA) is an annual report that describes progress in strengthening economic and social policies and institutions in sub-Saharan African countries (World Bank, 2018). The report scores countries on different dimensions of economic management, social inclusion policy, and public sector management and institutions. The report presents analysis correlating CPIA measures with health system performance, showing, for example, that better public sector management is associated with better health systems outcomes (0.71 correlation). Surprisingly, transparency, accountability and corruption had among the weakest correlations of any of the criteria (0.47) with health systems performance (World Bank, 2018, p. 30). Nevertheless, the report describes efforts in different countries to improve public financial management, enhance transparency and accountability, and combat corruption in the public sector. In countries where a CPIA report is available, it can provide insights for the NHSPSP and entry points for the incorporation of anti-corruption, transparency and accountability.

**Box 2. Data fabrication and falsification**

Information systems are the backbone of effective accountability systems. However, they may be vulnerable to acts of data fabrication and falsification, especially if performance measures are tied to financial incentives. Rules must be promulgated to clearly describe data fabrication and falsification as wrong-doing. Performance targets must be realistic and attainable to reduce incentives to falsify data. Consistent monitoring and periodic audit are needed to detect anomalies, and concerns must be investigated further to determine whether they constitute intentional fraud. Rules prohibiting data fabrication and falsification must be enforced with significant punishments, such as loss of funding, termination of employment or imprisonment.

**Draw from research on political settlements and the influence of social networks**

As part of the situation analysis, a political settlements framework may be appropriate to understand why policies within specific health systems can become corrupted/distorted and how more effective policies can be designed. Political settlements theory maintains that the distribution of power across organizations and individuals affected by a policy can help explain the dimensions along which policy is likely to be distorted (Khan, 2010 & 2018). Organizations can be formal, such as doctors’ associations, patients’ groups, political parties, and government departments or agencies, or they can be informal networks linking powerful individuals and groups.

The political settlements proposition is that if the policy delivers benefits that are strongly divergent with the interests of powerful groups affected by the policy, the policy is very likely to be distorted by informal practices and corruption. Standard anti-corruption strategies are then also unlikely to work, because the participants will not reveal information or support enforcement.
Including political settlement research\(^1\) in a situation analysis for an NHPSP can inform its design so that a substantial number of powerful groups affected by the policy support its implementation and enforcement.

Research that looks at the role of informal social networks and norms may also be valuable in the context of informing the NHPSP. To date, most efforts to reduce corruption have focused on policy solutions that follow a traditional economics or “rational” model of behaviour, such as increasing penalties or the probability of detection. However, research in the field of behavioural science show that people often do not make “rational” cost-benefit decisions. Behavioural approaches have the potential to focus on the factors that truly motivate corrupt actions, such as social, cultural or other quasi-rational influences on decision-making.

Research conducted by the Basel Institute on Governance\(^2\) has shed light on the role of informal social networks and social norms of reciprocity in driving corrupt behaviour. Informal social networks exert a powerful influence on behaviour, as they are associated with social norms regarding the obligation to share and to reciprocate favours and gifts received. Thus, bribery and the use of personal connections can be regarded as a socially acceptable and effective means to simplify access to health services. The research data indicate that such practices have a significantly regressive impact, because access to quality health services is influenced by personal contacts and the ability to pay, discriminating against the most vulnerable groups. Although social networks have been historically identified as fuelling and perpetuating practices of corruption, research is underway to see how they may also be harnessed to promote positive anti-corruption outcomes that can improve the accessibility of public health services, especially for the most vulnerable groups.

**Integrate region- or problem-specific approaches**

It may be helpful to adopt situation analysis tools developed for specific regions and problems. For example, the United Nations Development Programme (UNDP) has developed and tested a new approach to tackle corruption in the health sector as part of the Anti-Corruption and Integrity in the Arab Countries (ACIAC) project (UNDP, 2018). The resulting conceptual framework for corruption risk assessment at sectoral level includes implementation guides for different sectors that enables tailoring of the tool to the particularities of each sector and country (Hunter et al., in press). The approach applies a structured participatory and evidence-based method to identify corruption risks within institutions, focusing on decision points.

Problem-specific situation analysis tools, such as a health law review, can highlight specific gaps in anti-corruption legislation. The purpose of such an analysis is to identify weaknesses in institutions’ statutory or regulatory structures that may create opportunities for corruption. For example, an assessment of the national health insurance programme can identify places where clarification of language might reduce the risk of illegal or informal payments made by beneficiaries in order to obtain covered services. Table 3 summarizes the results of one such study, showing how an assessment can indicate the specific actions needed to strengthen health insurance regulations.

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1 The UK Aid-funded Anti-Corruption Evidence (ACE) research consortium, led by SOAS University of London, is applying a political settlements framework and approach to policy design to understand corruption problems in health care delivery in Bangladesh, Nigeria and the United Republic of Tanzania. By analysing evidence on the distribution of organizational power between the different stakeholders involved in health care delivery, the projects seek to better understand why and how certain types of corrupt behaviour (such as absenteeism and informal payments) occur, and to identify feasible solutions which may work given the configurations of power in these countries. For more information, see [https://ace.soas.ac.uk/](https://ace.soas.ac.uk/).

2 For more information on the work of Basel Institute on Governance on informal social networks and corruption, see [http://informalgovernance.baselgovernance.org/](http://informalgovernance.baselgovernance.org/).
Reinforcing the focus on anti-corruption, transparency and accountability in national health policies, strategies and plans

Table 3. Health law review and examples of corruption risks

<table>
<thead>
<tr>
<th>Corruption risk (examples)</th>
<th>Recommended legal or regulatory action</th>
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</table>
| No specific ban on patient payments in excess of those authorized | • Make compliance with rules on patient charges a specific condition of provider participation in the insurance programme.  
• Require return of unauthorized charges to patients.  
• Impose substantial penalties for charging violations.  
• Authorize termination or denial of contract for charging violations. |
| Language on covered hospital benefits is particularly vague | • Amend hospital laws and hospital contracts to make clear what, if any, patient charges associated with inpatient services are allowable. |
| No ban on charging patients for a referral | • Include an explicit ban on charging for referrals in all physician and hospital contracts. Make violations punishable by fine and loss of contract. |
| Hospital penalties are too low | • Include a substantial penalty (e.g. 100 times the standard consultation fee) for a single incident of inappropriate charging. For a pattern of violations, penalty should be a multiple of this amount.  
• Include clear language to explain that contract may be terminated for continued violations. |
| Exemptions from co-payments are loosely defined, and no reimbursement is indicated | • Define eligibility for co-payment exemption more precisely (relate to other benefit statutes, if possible).  
• Issue government identification for patients entitled to co-payment exemption.  
• Develop compensation mechanism for co-payment revenue foregone. |
| Regulations are unclear on what hospital inpatient services are chargeable to the patient | • Issue regulations defining what, if anything, may be charged to referred (or emergency) patients for inpatient care (nursing services, room and board), medical management, procedures (deliveries, anaesthesia, surgery), medicines issued while an inpatient, and medicines issued upon discharge.  
• Define which, if any, of these charges are to be waived for exempt categories of patients. |
| Therapeutic classifications used for medicine reference pricing system are not clearly defined, and basis for approving additional allowances for other medicines in the therapeutic class is unclear | • Specify in regulations the therapeutic classification system (and method for amending it).  
• Specify in legislation the criteria for allowing payment, in addition to the reference price, for another medicine in a therapeutic class.  
• Make current therapeutic classification system and price list readily available to patients over the internet. Specify amounts payable with and without exemption. |
| Complex system with no provisions for patient education or help in system navigation | • Develop internet-based system for communicating identity of contracted providers, chargeable services, current prices and allowable exemptions.  
• Require providers (initially high volume, ultimately all) to provide internet access terminals in waiting rooms and cash points so patients may query the system. |

Source: Adapted by author from Feeley, 2012, pp. 4–6.

Create a technical working group on corruption

Situation analyses are conducted by a core team supplemented by technical working groups [WHO, 2016, pp. 129–30]. Teams should consider whether there is enough expertise in the country to form a technical working group specifically to consider corruption risks.

Such a working group might include academic institutions working in this area, civil society organizations, media representatives, development partners, and central- and district-level government officials including staffs from the national anti-corruption agency and other related oversight institutions.
Priority setting

Priority setting is the political process whereby options are selected to address health needs. It is not only about making best use of financial resources, but also about signalling reform direction and how people should use their time and focus their attention. Priority setting provides an opportunity to apply insights from the situation analysis and take them a step further, to group the options into priority levels.

The pressing need to make progress toward universal health coverage requires countries to expand priority health services to more people, while reducing out-of-pocket payments and addressing key issues of quality and equity. It requires priority setting related to strategic partnerships, resources and tactics. Over 70 countries have requested assistance from WHO to set priorities and establish policies related to universal health coverage (WHO, 2014).

Consider how corruption affects priority-setting criteria

Prioritization is most important where resources are extremely limited. It can also help to generate additional resources by reassuring legislators and donors that resources are being well spent (Wikler, 2003). Five key criteria to consider in priority setting include: 1) the burden of the health issue; 2) the effectiveness, 3) cost and 4) acceptability of the intervention; and 5) fairness (WHO, 2016, p. 168). The burden of the health issue helps establish priority among different health problems, while effectiveness, cost and acceptability influence priority setting for interventions. Fairness is a concern in establishing priorities for both problems and solutions (WHO, 2014). For example, progressive universalism is a strategy for directing resources to the priority of improving access to health care for the poor (Neelsen & O’Donnell, 2017).

Corruption endangers the priority-setting process, and could result in unfair or unacceptable trade-offs, i.e. situations where, rather than priorities being set based on objective data and the criteria mentioned above, powerful interests influence the process to increase votes, advance political coalitions or trade favours unrelated to the health of populations (WHO, 2014).

The priority-setting process is applied to health problems (e.g., maternal mortality). The contribution of corruption to that problem, and the impact of an intervention to address the problem that incorporates a focus on anti-corruption, transparency and accountability, should be considered during priority setting. This can influence the effectiveness, cost and fairness of health programmes. Interventions likely to close off opportunities for corruption, or to change incentives in ways that reduce pressure for corruption, should be highlighted in discussions and receive higher ranking. Note that civil servants, administrators or providers who are benefitting from corruption may resist interventions to curb corruption. This, too, should be considered as discussions unfold.

Mitigate bias in priority setting

Major stakeholders whose interests affect priority setting include the population, providers and the State. A fair and transparent process for priority setting allows dialogue and debate on significant conflicts of interest and how trade-offs are made (WHO, 2016, p. 174). Planners should separately consider for-profit providers’ incentives as well as the role of vendors, i.e. private companies selling inputs to the health care service industry. For-profit pharmaceutical or medical device companies and hospital corporations have financial interests that may conflict with progressive universalism. These stakeholders may try to unduly influence public policy or tilt it toward their own financial interests.
Strategies adopted by large commercial food and beverage companies to increase sales, for example, have influenced dietary changes linked to rising rates of obesity and noncommunicable diseases (Igumbor et al., 2012). These companies often have strong ties to government, and they work hard to undermine public health responses such as taxation and regulation (Stuckler & Nestle, 2012). Industry may even introduce bias into the evidence base for policy-making: research studies funded by industry have been found to be four to eight times more likely to be favourable to the sponsors than articles funded by other sources (Lesser et al., 2007). These are factors that should be considered during the priority-setting process as trade-offs are weighed.
Strategic and operational planning

Strategic planning transforms priorities into sequenced plans for medium-term development actions and interventions. Operational planning transforms the NHPSP into actionable tasks. Integrating an anti-corruption, transparency and accountability approach into the strategic and operational planning processes should take into account the following considerations.

Connect Sustainable Development Goal (SDG) 3 and health-related targets in other goals

SDG 3 is to “Ensure healthy lives and promote well-being for all at all ages.” This includes target 3.8 “Achieve universal health coverage, including (...) access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.” Other SDGs also include health-related targets. SDG 16 is to “Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels.” This includes several targets related to anti-corruption, transparency and accountability, including target 16.5 to “Substantially reduce corruption and bribery in all their forms,” and target 16.6 to “Develop effective, accountable and transparent institutions at all levels.” Mackey et al. propose that strategic planning should integrate and align approaches to achieving these SDGs (Mackey, Vian & Kohler, 2018). The lead author suggests cross-cutting SDG sub-indicators to prevent, control and fight corruption to improve public health (see Annex).

Integrate health into anti-corruption strategies and plan

WHO defines strategic planning as transforming priorities into plans, “identifying, sequencing and timing medium-term interventions for the health sector in a comprehensive way” (World HO, 2016, p. 241). The starting point could be to integrate anti-corruption, transparency and accountability into the strategic plan for health, or to incorporate health priorities for anti-corruption, transparency and accountability into the government’s strategic plan for anti-corruption. For example, the Albanian Inter-sectoral Strategy against corruption 2015–2020 and associated anti-corruption action plan identified corruption challenges throughout government, including the health sector (Government of Albania, 2015). Box 3 shows health-sector-related aspects of the Government of Albania’s national strategy and plan.

Consider other strategies to deter corruption

A 2016 Cochrane Review systematically examined empirical evidence of the effect of interventions to reduce corruption in the health sector (Gaitonde et al., 2016). The review found that while evidence is sparse, several interventions seem promising. These include: 1) using an independent agency to coordinate efforts to detect and punish corruption (for example, programmes in the United States of America to detect fraud and abuse in reimbursement systems, and the use of an ombudsman for health in India); 2) implementing guidelines prohibiting doctors from accepting benefits from industry, or requiring transparency in these exchanges (for example, regulations governing physician–industry interactions in Europe and the United States); 3) adopting stronger internal control practices in health centres; and 4) increasing transparency and accountability for health co-payments and reducing incentives for informal payments (evidence from Kyrgyzstan).

Other activities to diagnose and deter corruption, documented in literature and summarized in a WHO discussion paper (WHO, 2018a) include: applying corruption risk assessment methodologies in the health sector; implementing health law and regulatory reforms; more active management of conflicts of interest; strengthening budgeting and accounting/audit systems in the health sector; changing incentives to make it more desirable to act with integrity (including increasing salaries);
Box 3. Albania’s intersectoral strategy against corruption 2015–2020 and action plan

The anti-corruption strategy in Albania adopts a three-pronged approach: prevent corruption through increased transparency; punish corruption through improvements in the legal framework, stronger law enforcement and effective investigation; and promote awareness of the consequences of corruption (de-normalize corruption) through continuing education, implementation of the law on whistleblowing, complaint mechanisms and cooperation with civil society organizations. Below are illustrative health-related objectives and activities in the Albanian strategic plan for anti-corruption.

Increase transparency and improve access to information
- Publicly post official hospital prices and the number of complaints received related to non-observance of official price schedule.
- Set up a public information centre within the health ministry.
- Put procedures manuals online for the Concessions Treatment Agency (including health-related concessions, or public-private partnerships, at high risk for corruption).
- Facilitate full implementation of the law on the right to information by helping line ministries put in place transparency programmes.

Strengthen the electronic infrastructure of public institutions
- Implement a “track and trace” electronic system for tracing medical products from procurement through to the end user.
- Install an electronic management system for advanced medical examinations.

Encourage cooperation with civil society
- Involve patient associations in drafting laws dealing with public health.
- Strengthen cooperation with media through monthly meetings with a reporters’ network.
- Involve civil society in monitoring implementation of the anti-corruption plan.

Operational planning defines a set of tasks assigned to responsible actors to implement activities. Guided by the overall NHPSP, operational plans are more concrete, short-term and actionable. The strategic plan defines the general direction, while the operational plan explains in more detail how to get there, transforming the strategic plan into actionable tasks (WHO, 2016, p. 297).

To illustrate operational planning for an anti-corruption, transparency and accountability intervention, Box 4 gives an example related to the strategic objective of increasing transparency and accountability through report cards. Evidence related to the use of citizen report cards has been collected in India, Malawi, Tajikistan and Uganda, and suggests that it can be an effective intervention (Bauhoff et al., 2016; Björkman & Svensson, 2009; Brinkerhoff et al., 2017). See Box 4 on ways to operationalize the strategy in the health sector; the included concrete activities would be part of an operational plan (WHO, 2018a).

Operational plans need to be adapted to the particular circumstances of the country, and responsibilities assigned to specific institutions and individuals for implementation. It may be helpful to look not only at units within the health ministry that have an interest in preventing corruption, but also at other institutions with government oversight responsibilities. Fig. 1 is a heuristic model of agencies and actors with an interest in anti-corruption, transparency and accountability goals. As corruption is a systems problem, entry points for corruption prevention are linked, and operational plans can help different institutions to reinforce one another’s goals through coordinated efforts. Decentralized systems pose special challenges and possible advantages in pursuit of stronger accountability at subnational levels and in subnational planning exercises. This situation is discussed later in the report (see the subsection on Decentralization).

Box 4. Plan to operationalize citizen health report cards

1. Create legal provisions for disclosure of health facility data.
2. Formulate a clear theory of change that makes the link between data and accountability.
3. Design an open data policy to mitigate power imbalances while considering cultural constraints.
4. Select data that are critical to monitoring financial, management and clinical accountability.
5. Encourage patients and citizens to take part in health facility accountability efforts.
6. Design mechanisms enabling fair comparisons between health facilities.
7. Simplify the presentation of data while maintaining their technical accuracy.
8. Create a range of avenues (both online and offline) for citizens to access data.
9. Train facility management committees, health workers, patient interest groups and selected community groups on how data can be used to demand accountability.
10. Introduce a legal grievance redress mechanism for patients and communities.
Reinforcing the focus on anti-corruption, transparency and accountability in national health policies, strategies and plans

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

National executive level

<table>
<thead>
<tr>
<th>Office of the Ombudsman</th>
<th>Prime Minister’s or President’s Office</th>
<th>Supreme Audit Institution/Inspector General</th>
<th>Anti-corruption Agency</th>
<th>Government whistleblowing mechanism</th>
<th>Others: Public Procurement Regulatory Authority; Central Inspectorate; Office for Declaration of Assets and Conflicts of Interest, etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helps citizens find right place to get answers; investigates human rights violations</td>
<td>Conducts audits; assures internal controls for compliance are in place</td>
<td>Receives tips; conducts independent investigations to provide evidence</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Legislative and judiciary level

<table>
<thead>
<tr>
<th>Members of Parliament</th>
<th>Law enforcement agencies</th>
<th>Prosecutors and courts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pass anti-corruption legislation; may request investigations</td>
<td>Investigate cases of corruption</td>
<td>Prosecute cases of corruption</td>
</tr>
</tbody>
</table>

Health ministry

<table>
<thead>
<tr>
<th>Internal audit</th>
<th>Human resources</th>
<th>Quality control</th>
<th>Grievance and redress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reviews own financial systems for compliance</td>
<td>Operates the disciplinary systems</td>
<td>Conducts clinical audits</td>
<td>Operates channels for patient complaints/employee tips; investigates and addresses</td>
</tr>
</tbody>
</table>

Civil society

<table>
<thead>
<tr>
<th>Boards and commissions</th>
<th>Community monitoring</th>
<th>Open public meetings</th>
<th>Media</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participate in governance of health institutions and policy dialogue</td>
<td>Monitor service delivery to enhance public accountability</td>
<td>Convey community needs and interests to policy-makers; disseminate information to the public</td>
<td>Promote civic understanding of public policy; investigative reporting of corruption</td>
</tr>
</tbody>
</table>

Put mechanisms in place to monitor answerability for changes in plans

While operational plans have to be flexible, changes in plans could be due to corruption. Good governance demands processes for holding decision-makers answerable for mid-course changes in plans. It may be helpful to involve external reviewers (whether government or civil society) to assess whether major shifts in plans are justified.

For example, in a hypothetical country context, the NHPSP could not mention a mobile clinic strategy, however, purchase of mobile clinic vehicles might suddenly become a priority for the health ministry. Later questioning may expose that this change in strategy was driven by the opportunity for high-level officials to engage in procurement fraud, accepting bribes from a vendor.
Estimating the costs of the NHPSP indicates the financial resources needed to execute and will promote feasible target setting. Once targets are established, budgeting is the process of defining the allocation of resources to produce the outputs. To integrate an anti-corruption, transparency and accountability approach into these steps of the NHPSP process, the following actions should be considered.

**Include estimates of verification costs and cost savings**

Initiatives such as performance-based financing can increase accountability; however, such initiatives require methods to verify that performance is real and not fraudulently inflated (McIsaac et al., 2018). While verification costs can be high in the early years, scaled-up programmes can begin applying risk-based verification methods that are more cost-effective. This was the case in Zimbabwe, where administrative costs associated with verification decreased by 47% in later years of the performance-based financing programme (Mayaka Ma-Nitu et al., 2018). (See also the section on Monitoring and evaluation).

Anti-corruption efforts can also yield cost savings. Fraud control efforts, in particular, generally have a positive return on investment. For example, the return on investment for the United States Medicare Integrity Program – in terms of settlements and penalties paid – is estimated to be US$ 12 per US$ 1 invested in fraud control (United States Department of Health and Human Services, 2018). When estimating the cost implications of anti-corruption, transparency and accountability activities in the NSPSP, it is important to include any expected savings that could offset total costs.

**Include funding to strengthen financial systems and regulate the private sector**

There are fewer opportunities for corruption when public financial management systems are adequately staffed, computerized and include strong controls (Asiedu & Deffor, 2017; Rensch, 2018). Strengthened financial management systems can close off possibilities for illegal diversion of funds. Planners should read the past financial audits of health sector institutions and take into consideration their recommendations on weaknesses of budgeting and financial reporting systems.

During the situation analysis phase, planners may commission a Public Expenditure Tracking Survey (PETS) to measure the amount of funds received at each point in the public service delivery chain down to the service delivery unit. Such a study can quantify pathways through which specific funds are being diverted or not reaching their destination (Sundet, 2008). Recommendations from the PETS report may affect the budgeting process. For example, the PETS may recommend professional development activities to train health personnel to read budgets and engage more effectively with financial management staff.

In estimating the costs of regulating the private sector, planners should consider technology and training to control the possibility of health inspectors being bribed by industry officials.

**Manage conflicts of interest**

Individuals doing the cost estimations should not have a financial interest in the policies or strategies under consideration. Specific interest groups lobbying for certain policies or reforms may provide financial estimates that underestimate true costs and overestimate cost savings, in an effort to make the favoured policies seem more appealing. Planners should commit to making available the underlying data used to estimate cost implications, so that independent groups can re-analyse data for evidence of bias.
Monitoring and evaluation of the NHPSP requires a comprehensive approach to assure steady progress in implementation and achievement of desired results. As described in the section on Situation analysis, Tables 1 and 2 present possible red flag indicators and methods to monitor corruption risks. Annual and mid-term reviews of progress and performance against targets can provide insights for planning and resource allocation (Mboera et al., 2015). Progress reports can be discussed at annual stakeholder meetings, providing an opportunity to make adjustments in operational plans to overcome unanticipated obstacles or re-direct efforts more effectively. Anti-corruption, transparency and accountability concerns related to monitoring and evaluation are discussed below.

**Incorporate data audit procedures**

Institutional conflicts of interest have the potential to bias collection and reporting of data. Institutions or individuals may falsify data so they look better. It is thus important to incorporate data audit procedures into monitoring and evaluation activities, especially where financing is tied to achievement of output targets (also see the section on Estimating cost implications and budgeting).

**Ensure linkages between SDG 3 and SDG 16**

Monitoring activities for SDG 3 should link to monitoring for SDG 16 on Peace, justice and strong institutions, including target 16.5 on reducing bribery (as highlighted in the section on Strategic and operational planning, and as shown in the Annex). Specifically, bribes in the procurement process and informal payments in health delivery systems are hindrances to the attainment of both SDG 3 and SDG 16. The red flag indicators (highlighted in the section on Situation analysis and in Table 1) should also be incorporated into the monitoring and evaluation framework.

**Consider corruption perception indicators**

Health workforce indicators (WHO, 2016, p. 463) could be supplemented by an indicator on staff perceptions of corruption. A set of studies funded by the Inter-American Development Bank in Latin America collected staff perceptions of corruption: differences were detected in how doctors perceived their own absenteeism rates, compared to how nurses perceived doctors’ absenteeism rates. In this way, researchers could triangulate problems (Di Tella & Savedoff, 2001). In addition, evidence suggests that reforms to improve governance tend to reduce perceived corruption (Arostegui et al., 2011; Vian, McIntosh & Grabowski, 2017). Thus, perception data may help to evaluate whether a reform is working.

**Connect output and cost data**

Computerized databases provide opportunities to connect output data with financial data, creating cost per output indicators. Outliers, or very high costs per unit, may indicate corruption or other types of inefficiencies that can then be investigated in more detail.
Establish a data intelligence unit

Insurance programmes should invest in advanced data intelligence units – with sufficient staffing, resources and independence – to prevent fraud through modelling of the likelihood of certain patterns of utilization or reimbursement requests. This is one aspect of estimation and statistical modelling (WHO, 2016, p. 471). It is important to secure data so that they are not manipulated or stolen.

In addition, it is important to consider how to permit public availability of data including, for example, non-confidential de-identified insurance claims databases. When data are available, external watchdogs can analyse the data, visualize patterns and raise issues. Pharmaceutical price and quality observatories are another mechanism that can promote transparency and accountability, as has been demonstrated in Peru (Vian et al., 2017). Such data may be queried by individuals or analysed by civil society organizations. For example, the Anti-corruption Action Centre in Ukraine used publicly available data on procurement tenders to identify over-priced bids. The Centre’s staff were then able to connect health procurement data with a database on beneficial ownership of the bidding companies, to detect corrupt dealings (Anti-corruption Action Centre, 2013).

Involving oversight institutions

As in the population consultation and situation analysis phases of an NHPSP process, government oversight agencies have a role in monitoring and evaluation. It is helpful to consider the roles and responsibilities of the supreme audit institution, ombudsman and other external public watchdog institutions in supporting the health sector’s strategies and plans. For example, it may be possible to incorporate monitoring questions related to access to care or financial protection into regularly scheduled public meetings held by the ombudsman’s office, or to suggest a reform-related topic for performance audit to the supreme audit institution.
Legal rules and regulatory requirements must be considered in the health planning process. As highlighted in the section on *Situation analysis*, lawyers should review health laws and regulations to identify weaknesses in the statutory or regulatory structure of the health system. This includes weaknesses in the insurance regulatory system that may provide opportunities for corruption by insurance officials or health care providers or suppliers. In particular, such a review should identify places where clarification of statutory or regulatory language might reduce the risk of illegal or informal payments made by beneficiaries in order to obtain covered services (see Table 3).

It is important to consider the legal and regulatory framework for specific corruption risks in the health sector, including: public procurement of medicines and durable medical equipment; other aspects of the pharmaceutical system such as laws governing registration of medicines, promotional activities of private industry, and approval of clinical trials; dual-job holding associated with unauthorized use of public resources and corruption; ownership and financial interests in ancillary services, such as a pharmacy or medical testing facility; health inspections; and disclosure policies and the legal framework for public release of health sector information and databases.

In addition to reviewing health laws, it is important to understand the strengths and weaknesses of the current anti-corruption legislation in the country, and the legal mandate for the ombudsman, supreme audit institution and other public oversight institutions involved in corruption control. This information is needed to provide context for proposed anti-corruption, transparency and accountability interventions in the health sector, and to identify enabling factors and constraints that may affect inter- and intra-sectoral collaboration in promoting anti-corruption, transparency and accountability.
Reinforcing the focus on anti-corruption, transparency and accountability in national health policies, strategies and plans

The WHO NHPSP handbook recognizes that some circumstances create special challenges for planning. Challenges include applying methods at the subnational level and in decentralized contexts, fragile settings and heavily aid-dependent contexts. When integrating a focus on anti-corruption, transparency and accountability in these settings, teams may face similar challenges.

Decentralization

Decentralization may be an asset to engaging in population consultations, as public offices and officials are closer to the people. Some of the same principles apply, such as ensuring that the consultations are inclusive of stakeholders at the decentralized level. Decentralized population consultations may need to consider new issues, including representation of different levels of government (if not found at local level) and translation into local languages.

Evidence is mixed on the relationship between decentralization and corruption. Studies have shown that fiscal decentralization is strongly correlated with lower corruption (Fisman & Gatti, 2002), and that health sector decentralization can improve health outcomes by reinforcing accountability (Ciccone et al., 2014). On the other hand, a systematic review in 2017 found that centralized health procurement achieves cost savings (Seidman & Atun, 2017), and select country-specific studies indicate the same (for example, see Baldi & Vannoni, 2017). Thus, it is not possible to say that decentralization will “solve” corruption problems. Rather, the corruption problems may differ in decentralized contexts. In countries where the health system is decentralized, the situation analysis phase should not assume all subnational units are alike in the level of risk for corruption.

Fragile settings

“Fragility” is defined to include situations of limited statehood, i.e. “where the state does not have the administrative capacity [...] to exercise effective control over activities within its own borders” (WHO, 2016, p. 82). Population consultations may be logistically difficult, and unsafe, in fragile settings. Government oversight agencies may not yet exist or be empowered actors for anti-corruption, transparency and accountability. As corruption is already a highly sensitive topic, in such a setting it may be advisable to rely more on nongovernmental and civil society organizations to facilitate population consultations, situation analyses and discussions about priorities (Cieslik, 2015; Witter, 2012). In the highly politicized context of fragile countries with fractionalized elites, it may be difficult to understand stakeholder interests and power, and people may not feel comfortable discussing sensitive topics. It may be important in such settings to combat corruption “quietly,” avoiding anti-corruption language in plans (Robillard & Robillard, 2018).

Although research on anti-corruption strategies in fragile states is limited, evidence suggests that combatting corruption to support good governance is a critical aspect of state building and a priority of donors such as the European Union, the World Bank and UNDP (Mungiu-Pippidi & Johnston, 2017). Corruption in such settings is a complex issue. According to one researcher, anti-corruption efforts in fragile states may fail more due to implementation challenges than to design problems: plans should therefore pay greater attention to context, such as investing in adequate staffing and avoiding bureaucratic competition (Johnsøn, 2016).
Aid-dependent contexts

Countries that are heavily dependent on aid face special challenges, including the risk of external partners’ priorities being emphasized over local needs and opinions, and favouring of vertical programming (WHO, 2016). Moreover, some evidence suggests that official development assistance is positively correlated with corruption, possibly because it can disrupt the relationship between citizens and the state, causing governments to feel less accountable to citizens; aid is also sometimes diverted for political purposes (Ear, 2012; Knack & Rahman, 2007; Marty et al., 2017). However, other analyses have shown that multilateral aid is strongly associated with lower levels of corruption, in part due to anti-corruption programming efforts (Charron, 2011). This implies that while care must be taken to mitigate risks of corruption from foreign aid, if appropriately targeted, aid can provide resources to support stronger governance and curb corruption.
Checklist for reinforcing anti-corruption, transparency and accountability in NHPSPs

This checklist can support review of the draft NHPSP for inclusion of a focus on anti-corruption, transparency and accountability. The checklist is divided into five domains.

1. Anti-corruption, transparency and accountability in the population consultation process and situation analysis.

2. Anti-corruption, transparency and accountability in priority-setting and planning.

3. Anti-corruption, transparency and accountability in cost estimation and budgeting.


5. Anti-corruption, transparency and accountability in legal reform.

Domain 1: Anti-corruption, transparency and accountability in the population consultation process and situation analysis

A. Is it possible to hold a population consultation on the theme of corruption and health? If so, is it best to use a population survey, or to hold in-person consultation meetings?

B. Have you identified relevant public watchdog organizations charged with carrying out responsibilities to prevent or curb corruption, and can you also involve them in the population consultation as resources and potential collaborators?

C. Have you identified and analysed the interests and power of stakeholders interested in fighting corruption (or not)? Can you apply their influence or resources to health-related corruption issues?

D. Does it make sense in the local context to gather opinions about corruption from recent health sector-related demonstrations, strikes or internet campaigns, in addition to organized population consultations?

E. Are you able to collect data and calculate any of the "red flag" corruption risk indicators included in Table 1?

F. Can you identify other quantitative and qualitative data sources on perceived barriers to access to care or gaps in financial protection that may inform the understanding of corruption risks and consequences?

G. Are there region-specific or problem-specific tools and approaches (better adapted to local contextual issues) that you may want to use in the situation analysis? Consider UNDP’s anti-corruption risk assessment approach for Arab countries; anti-corruption, transparency and accountability-related analysis of health laws; WHO’s Good Governance for Medicines transparency assessment tool, etc.

H. Does it make sense to create a technical working group on corruption and health to promote a focus on integrating anti-corruption, transparency and accountability into the NHPSP process?
Domain 2: Anti-corruption, transparency and accountability in priority-setting and planning

A. Have the priority-setting process and format been adapted to explicitly consider the negative consequences of corruption, and how interventions may increase anti-corruption, transparency and accountability by closing off opportunities for corruption or changing incentives in ways that increase integrity?

B. Have you considered the risk that corruption may influence priority setting, and are measures in place to ensure that data being used in the process are objective and unbiased? Other procedures may be needed to limit undue influence by those with financial interests in particular priorities.

C. Has the NHPSP team considered ways to connect strategic planning for achievement of SDG 3 (health) and SDG 16 (peace, justice and strong institutions)? Including targets for decreasing bribery and informal payments in the health sector could promote health goals while also achieving justice and increasing accountability.

D. Does the NHPSP identify medium-term interventions to address the challenges of priority corruption problems affecting the health sector, such as preventing corruption, ensuring enforcement, and promoting awareness of anti-corruption, transparency and accountability mechanisms and benefits?

E. Have planners considered empirical evidence and experiences of other countries in implementing interventions to control corruption in the health sector, including detailed activities, resources required and reasonable timelines?

F. Have planners adapted operational plans to the particular country context and assigned specific individuals and institutions to be responsible for implementation, recognizing that addressing any problem may require coordinated action across the health system building blocks?

G. Have health planners requested support and coordinated with public oversight agencies interested in anti-corruption, transparency and accountability goals? Are there processes in place, including external review, to hold decision-makers answerable for mid-course changes in plans?

Domain 3: Anti-corruption, transparency and accountability in cost estimation and budgeting

A. If your NHPSP includes performance-based financing strategies, have you included realistic estimates of the verification costs, adjusted for the roll-out phase?

B. Do you expect some of your anti-corruption, transparency and accountability activities, such as fraud control programming, to yield a return on investment, and if so, have you accounted for this in the cost estimation?

C. Does your NHPSP include adequate funding to address weaknesses in financial accounting and audit systems, or to address other systematic weaknesses that are creating opportunities for corruption?

D. Have you budgeted for resources needed to address findings and recommendations from the most recent PETS conducted?
E. Have you allocated resources to develop the skills and knowledge of health staff to oversee and scrutinize
   the budget and other financial reports?

F. Have you put in place controls to mitigate conflicts of interest that may bias the cost estimations used to set
   priorities or choose strategies for the NHPSP?

**Domain 4: Anti-corruption, transparency and accountability in the monitoring and evaluation framework**

A. Have you incorporated data audit procedures into monitoring and evaluation activities, especially where financing
   is tied to achievement of output targets?

B. Are indicators and targets related to SDG 16 (peace, justice and strong institutions), such as those on reducing
   bribery, considered in the monitoring and evaluation framework?

C. Does the monitoring and evaluation framework include staff and patient perceptions of corruption, as a way
   to monitor the impact of governance improvements?

D. Does the NHPSP aim to collect cost per unit indicators or targets and to analyse outliers as potential indicators
   of corruption?

E. For countries with health insurance programmes, do you have an advanced data intelligence unit with sufficient
   staffing, resources and independence to prevent fraud?

F. Are de-identified claims databases available to the public for analysis by civil society organizations?

G. Can you involve public oversight agencies in supporting the monitoring and evaluation framework, for example,
   by incorporating monitoring questions into regularly scheduled public meetings held by the ombudsman’s office,
   or coordinating on topics for performance audits by the supreme audit institution?

**Domain 5: Anti-corruption, transparency and accountability in legal reform**

A. Have lawyers reviewed current health laws and regulations to identify weaknesses in the statutory or regulatory
   structure of the health system that may allow corruption to occur?

B. Has the legal review identified areas where clarification of statutory or regulatory language might reduce the risk
   of illegal or informal payments made by beneficiaries in order to obtain covered services?

C. Does the NHPSP consider the legal and regulatory framework for specific corruption risks in the health sector, such
   as pharmaceutical and medical device procurement, registration and promotion of medicines, dual job-holding,
   physician ownership of ancillary services, and inspection services?

D. Does the NHPSP specify disclosure policies to signal public commitment to transparency, and identify the specific
   types of data for government to make available proactively?


Reinforcing the focus on anti-corruption, transparency and accountability in national health policies, strategies and plans


Annex

Linkages between SDGs 3, 16 and 17, and examples of cross-cutting indicators

Reinforcing the focus on anti-corruption, transparency and accountability in national health policies, strategies and plans