



Assessing governance for eliminating Corruption in the health sector in Pakistan

PROJECT COMPLETION REPORT

Partnership for Transparency Fund Support to Civil Society Initiatives for
Governance

Sania Nishtar

Poor governance, mismanagement, inefficiencies and corruption are often used synonymously in a health systems context. The connotation of corruption makes it distinctive though as the other three may be inadvertent and without the intent to benefit whereas the nuance corruption has is one of deliberate and illegal gains. Notwithstanding the vague separating lines between these expressions, it is best to address them together in a health system's context as they have complex interdependencies. It may also be important to note here that corruption may be exacerbated by poor management and lack of accountability within a system whereas on the other hand, there may also be a disincentive for administrators and managers to strengthen management and mainstream mechanisms that compel accountability. Both these factors complement each other in a vicious circle.

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Executive Summary

Heartfile is a Pakistan-based non-profit, health-sector NGO think tank, recognized for its contribution to *improve health outcomes within the country*. *The organization is currently focused on mainstreaming health reforms in Pakistan on a health systems approach. One of the main thematic areas of health systems strengthening is to improve governance and address corruption. Within this context, Heartfile applied for funding in response to the Partnership for Transparency Fund Support to Civil Society Initiatives' call for proposals in 2006 and was successful in receiving funding.*

The objective of the project was to “to carry out an anti-corruption intervention in one health facility setting in NWFP in collaboration with the NWFP Health Reform Unit, drawing on the existing evidence of corruption in the health sector with a view to developing assessment and intervention tools that can later be utilized and institutionalized in other health facilities of the province”

The envisaged outcomes of the project included getting an institutional buy-in into an anti-corruption agenda within the health sector in one province in the country; for this purpose Heartfile fostered collaboration with the NWFP Government Department of Health. The objective was to develop a pilot site, where anti-corruption intervention will enable bringing down the costs of corruption in financial and human terms. It was also decided to develop an Agreed Action Plan for the NWFP Government Department of Health on an anticorruption strategy and to help institutionalize anti-corruption assessment and intervention tools. These parameters were reflected in a Memorandum of Understanding between Heartfile, the Department of Health (DoH) of NWFP and German Technical Cooperation – the agency supporting the DoH in NWFP.

The Lady Reading Hospital, Peshawar was named as the facility where assessment was meant to be conducted. The project was meant to be conducted in four phases: assessment, intervention using a set of tools, institutionalization of the anticorruption strategy and dissemination of tools.

However during the project its course had to be changed. Discussions with the DoH of NWFP pointed to the need for a corruption mapping as that had not been done in the country. It was perceived that interventions can only be structured when there is clear indication of what needs to be intervened on. During the planning process, the DoH changed the management of the Lady Reading Hospital, which spurred controversy in professional and administrative circles not just in the hospital but also in the department of health of NWFP. In view of this the department of health felt that an anti corruption assessment by name in one facility may not be appropriate and therefore felt that it would be best to conduct a sectoral analysis of corruption within the health sector

A detailed assessment was therefore conducted; analysis showed that corrupt behaviors fall on a spectrum and although it may be difficult to categorize them, it is useful to draw a distinction between the two forms of corruption from the point of view of the feasibility of anti-corruption reform in Pakistan. On one end of the spectrum are corrupt practices, which fall in the operational/administrative domains; most of these represent *individual coping strategies* and are relatively, more readily amenable to reform. At the other end of the spectrum, corruption involves a level of state capture, which is rooted in weak capacity of state institutions along with lack of control and accountability and vested economic interests of the powerful elite. The determinants of state capture are not amenable to reform within an isolated sector.

The action plan presented two action items; those relevant to addressing corruption in the operational and administrative domains and those relevant to addressing state capture. The action plan stated that corruption in the administrative and operational domains can be addressed to some extent if attention is paid to three aspects of reform, which strengthens the incentives-performance-accountability nexus. Lessons learnt from police reforms in the federal capital can be instructive in this regard and show that where systems of compensation adequate to sustain appropriate livelihood are set up, and where services generate incentives for performance, it is possible to implement ethical and administrative codes of conduct. The action plan stated that such examples can be used as evidence to structure transparent systems of public service that safeguard accountability and can be strengthened further by mainstreaming technology. The action plan also stressed on the need to promote market harnessing methods in regulation using contracting and self regulation as these mitigate reliance on discretionary command and control mechanisms. Some level of success in this approach has been shown in the domain of taxation reforms and needs to be further build upon in other areas, particularly the social sector where governments can leverage markets to deliver services in new models of service delivery.

The other kind of corruption – much harder to fight is rooted in state capture, which is a broader phenomenon in policy and decision making, where the laws and regulations of the land are made to favor a select few – usually cronies of powerful with access to the corridors of power. In this form of corruption, decision makers use state resources and leverage for patronage either for personal or institutional gains. In addition to straightforward commissions on large transactions, this form of corruption also manifests itself as preferential treatment to well connected individuals. This form of corruption also overlaps with regulatory capture which results in regulation to be self serving.

The action plan stated that here an anticorruption agenda needs to go beyond the traditional technocratic approach focused on administrative reform to a more overarching set of measures to address many issues related to structural reform, which creates a number of policy and institutional imperatives. In the first place, it necessitates reform of political institutions and building mechanisms of oversight. *Secondly* there is need for judicial and prosecutorial reforms; within this context, the current emphasis to ensure an independent judiciary is well placed, however it must also be ensured that the judiciary is transparent in view of the evidence presented in Transparency International's World Corruption Report of 2007, which focused on corruption in the judicial system. In the *third*

place, there is a greater need to expand the use of consumer voice by creating avenues for seeking redress, rejuvenate the civil society and ensure that the media remains open. In addition it must also be recognized that economic reforms can be one of the most powerful anti-corruption strategies; by promoting competition and market entry, it can enable a vibrant sector of small and medium enterprise to weaken the concentration of economic interests promoting state capture.

The action plan stated that in order to implement these approaches, Pakistan needs neither new statutes nor another set of institutional mechanisms. A number of federal and provincial laws exist, including the *Ehtesab Ordinance 1996*. What is greatly required is strengthening of the institutional framework as well as the implementation and application of the existing laws and procedures. However it must be ensured that new laws do not dampen the spirit of existing anti-corruption efforts; in particular the National Reconciliation Ordinance has been a set back to anticorruption work in Pakistan, at least in spirit.

Pakistan also does not need new institutional mechanisms to counter corruption. The Federal Investigation Agency (FIA) and the National Accountability Bureau exist and must be strengthened further and where needed depoliticized. The office of the *Wafaqi Mohtasib*, which is currently not mandated to deal with corruption but has a related role should be broadened and closer synergies created between institutional arrangements.

The project has also taken a number of steps to disseminate findings and to help institutionalize anticorruption measures. Findings of the assessment were presented at a National Meeting organized by the National Accountability Bureau on December 8, 2007; the meeting was chaired by the Prime Minister of Pakistan. NAB is a statutory national institutional entity of high visibility which is mandated with anti-corruption work in Pakistan; it was created in 1999 through the promulgation of the *Ehtesab (accountability Ordinance) 1999*. To date, NAB has recovered billions of Rupees and prosecuted many corrupt officials in the past including many renowned politicians and high ranking officials. NAB is yet to begin anti-corruption work in the health sector and the possibility of building further on the work of this project is very strong, with deliberations currently underway with NAB at the time of compilation of this report.

The department of health of NWFP will initialize action on this action plan. The health policy forum as a watch dog and as an organization committed to providing technical support will continue to focus in this area. For Heartfile the outcomes of this project are of strategic importance as the mapping of malpractices and the determinants highlighted form the basis of the health reform agenda being articulated in the new publication of Heartfile – Gateway Paper III entitled ‘Health Reform in Pakistan’

During the course of implementing this project, there was considerable variation from the initially agreed implementation plan. Notwithstanding, this project has had significant achievements in the anti-corruption domain in the health sector. Firstly it has mapped corrupt practices for the first time in the health sector in Pakistan and has brought clarity to what is needed to address them; these form a critical component of the health reform strategy envisioned by Heartfile as an agency. Secondly, the findings of the study have been

presented at high level forums where they are catalyzing change in terms of guiding anti-corruption measures; thirdly the action plan developed will guide the scope of the work of the DoH of NWFP over the long term; in the fourth place, the project forms an important benchmark for the scope of work of the Health Policy Forum in the area of governance and health systems. And finally, the publication of the assessment in an international peer review journal will enable the sharing of this experience with a much larger audience. There is therefore a significant follow up component of this project, which the Principal Investigator commits to sharing with the *Partnership for Transparency Fund Board*, not just in grateful recognition of their contributions to this strategic effort but also to get their inputs and guidance, to appraise them of the change that this project will continue to catalyze and for their understanding of the need to change the project direction.

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Assessing governance for eliminating Corruption in the health sector in Pakistan

1. Background of the Project

Heartfile is a Pakistan-based non-profit, health-sector NGO, recognized for its contribution in the area of health policy, public health planning, and disease prevention and control. Its *scope of work within Pakistan* involves catalyzing change within the health sector through technical and policy support and its *global scope of work* focuses on developing innovations in the health sector. Heartfile contributes to knowledge in the areas of health policy and public health planning for resource-constrained settings, and forms the empirical basis for health system reforms within the framework of an integrated approach to the prevention and control of chronic diseases.

In its capacity as the only health sector think tank in the country, *Heartfile makes strategic contributions to improving health outcomes within the country* and is currently focused on mainstreaming health reforms in Pakistan on a health systems approach.¹ Heartfile also uses its stakeholder leverage through the Heartfile-hosted Health Policy Forum² to mainstream these reforms within the country. One of the main thematic areas of health systems strengthening is to improve governance and address corruption – an area which necessitates a detailed understanding of several issues and challenges.

One of the strategic partners in the health reform agenda within the Province of North West Frontier Province of Pakistan (NWFP) in Pakistan is the Government's Health Sector Reform Unit, which is technically supported by German Technical Cooperation (GTZ). Heartfile is currently working with both to develop a new health policy for the province (Appendix F). Building further on that collaboration to work in the area of corruption appeared to be the logical next step.

Within this context, Heartfile applied for funding in response to the Partnership for Transparency Fund Support to Civil Society Initiatives for Governance in 2006 and was successful in receiving funding. The proposal leveraged a powerful strategy to collaborate and collectively advocate for change; it was envisaged that in doing so it will strengthen the voice of the civil society in the decision making process at a governance and accountability level.

1 Nishtar S. The Gateway Paper. Health Systems in Pakistan – a Way Forward. Heartfile and Health Policy Forum, 2006 accessible at <http://heartfile.org/pdf/phpf-gw.pdf>

2 <http://heartfile.org/hpf.htm>

The objective of the project was to:

“to carry out an anti-corruption intervention in one health facility setting in NWFP in collaboration with the NWFP Health Reform Unit, drawing on the existing evidence of corruption in the health sector with a view to developing assessment and intervention tools that can later be utilized and institutionalized in other health facilities of the province”

The envisaged outcomes of the project were as follows:

- Institutional buy-in into an anti-corruption agenda within the health sector in one province in the country.
- The development of a pilot site, where anti-corruption intervention will enable bringing down the costs of corruption in financial and human terms
- Agreed Action Plan for the NWFP Government Department of Health on an anticorruption strategy within their jurisdiction of authority
- Development and institutionalization of anti-corruption assessment and intervention tools.

The project was meant to be implemented in the following phases:

Phase	Activity
Assessment	A generic review of existing data and evidence; literature search and key informant interviews and focus group discussions using a validated instrument and development of indicators
Intervention	Site specific assessment of corruption Strategizing interventions and the development and application of tools. Development of an Agreed Action Plan for the NWFP Government Department of Health on an anticorruption strategy within their jurisdiction of authority
Dissemination	Sharing of results with members of the Health Policy Forum and other broad based groups of public health professional, health-policy makers, media, community groups, international experts, agencies involved in civil services reform such as the National Commission on Government Reform, with which Heartfile has collaborative linkages.
Institutionalization	A train the trainer's workshop

The envisaged outcome and actual outcomes at the end of project

The project at inception aimed to get Institutional buy-in into an anti-corruption agenda within the health sector in one province in the country. For this purpose, Heartfile leveraged the collaboration of one of its strategic partners in the Health Policy Forum,³ the Department of Health of NWFP (Appendix A). Here collaboration was developed with the Government's Health Sector Reform Unit, which is technically supported by German Technical Cooperation (GTZ). Heartfile is also working with both to develop a new health policy for the province (Appendix B). Building further on that collaboration to work in the area of corruption appeared to be the logical next step. A formal Memorandum of Understanding was therefore developed.

³ <http://heartfile.org/hpf.htm>

The objective of this project was to assess corruption in one health facility setting in NWFP in collaboration with the GTZ supported NWFP Health Reform Unit of the Department of Health of NWFP; intervene through anticorruption interventions *as may be feasible* during the project duration; develop an agreed Action Plan for the NWFP Government Department of Health on an anticorruption strategy within their jurisdiction of authority; and develop and institutionalize anti-corruption assessment and intervention tools. Through this MOU it was envisaged that the project would develop a pilot site, where anti-corruption intervention will enable bringing down the costs of corruption in financial and human terms. The Lady Reading Hospital, Peshawar was named as the facility. However even at inception it was felt that for the scope and duration of the project, a specific intervention might not be feasible.

Discussions with the DoH of NWFP pointed to the need for a corruption mapping as that had not been done in the country. It was perceived that interventions can only be structured when there is clear indication of what needs to be intervened on. During the planning process, the DoH changed the management of the Lady Reading Hospital, which spurred controversy in professional and administrative circles not just in the hospital but also in the department of health of NWFP. In view of this the department of health felt that an anti corruption assessment by name in one facility may not be appropriate and therefore felt that it would be best to conduct a sectoral analysis of corruption within the health sector. Preliminary discussions on the subject also alluded to the various patterns of corruption in the public and the private systems and reiterated the need to bring clarity to those patterns as a first step. It was also envisaged that corrupt activities were deeply entrenched in the system and were therefore, not amenable to reform through isolated measures but needed a synchronous set of coordinated reform measures. It was therefore unanimously decided to focus on assessment as an entry point on the premise that that would form the evidence base for anti-corruption work.

A detailed assessment was therefore conducted and results have been included herewith. based on this an agreed action plan has been developed for the NWFP Government Department of Health on an anticorruption strategy within their jurisdiction of authority and many steps have been taken to institutionalize anti-corruption measures in state systems mandated with the task. Linkages have been developed with the National Accountability Bureau to institutionalize the plan developed. The National Accountability Bureau held a national seminar on anti-corruption to mark the international anti-corruption day on December 9th; the seminar was chaired by the Prime Minister of Pakistan. The Principle investigator of this Study, Dr Sania Nishtar was asked to talk about corruption on the health sector; findings of the study were presented, which form a reference point for the scope of work of NAB in this area. The same evening, the findings of the study were also presented on a program on Pakistan Television, in a talk show with national outreach organized to mark the anti-corruption day.

This project consisted of four phases: a phase of assessment, intervention, institutionalization and dissemination. The following sections describe each of these in detail.

Table 1 Envisaged outcome vs. actual outcomes – a snap shot

Envisaged outcomes	Status at end of project
The development of a pilot site, where anti-corruption intervention will enable bringing down the costs of corruption in financial and human terms.	<p>Achieved: a formal MOU exists with the Government of NWFP with institutional commitment to address this issue (Appendix A)</p> <p>Has not been achieved: post MOU, discussions with the DoH of NWFP pointed to the need for a corruption mapping as that has not been done in the country. Interventions can only be structured when there is clear indication of what needs to be intervened on. DoH NWFP was also reluctant to have a facility named especially after the political turmoil in Lady Reading Hospital which was named in the MOU</p>
Agreed Action Plan for the NWFP Government Department of Health on an anticorruption strategy within their jurisdiction of authority. Development and institutionalization of anti-corruption assessment and intervention tools.	<p>Achieved: action plan has been developed and recommendations have been endorsed by the Government of NWFP.</p> <p>Is on its way to being achieved: Linkages have been developed with the National Accountability Bureau to institutionalize the plan developed. One of the main talks scheduled by NAB on the occasion of the National Anti-corruption day on December 8 in a high level national seminar is based on this work.</p>

2. Project phases

2.1 Assessment Phase

2.1.1 Literature review - why is corruption important for being addressed in the health sector?

Pakistan needs to pay special attention to corruption in the delivery of social services and health in particular for a number of reasons.

Firstly, of particular relevance to the health sector is evidence, which shows that countries with higher indices of corruption have poorer health outcomes. A study carried out by the International Monetary Fund (IMF) using data from 71 different countries showed that countries with high incidences of corruption have higher Infant Mortality Rates (IMR).⁴ Moreover, various studies have shown that corruption has a significant negative effect on health indicators such as IMR and Under Five Mortality Rates even after adjusting for income, female education, health spending and level of urbanization.⁵ On the other hand, there is ample evidence that reducing corruption can improve health outcomes by increasing the effectiveness of public expenditures.⁶ Within this context, it is important to

4 Sanjeev Gupta, Hamid Davoodi, Erwin Tiongron. Corruption and the Provision of Healthcare and Education Services. IMF Working Paper 00/116, Appendix Table 9 p.27

5 Gupta S, Davoodi HR, Tiongron . Corruption and the Provision of Healthcare and Education Services, Governance, Corruption and Economic Performance, Washington D.C.: International Monetary Fund.

6 Omar Azfar, Corruption and the delivery of health and education services, Chapter 12 in Bertram Sector (ed.) Fighting Corruption in Developing Countries. Bloomfield, CT: Kumarian Press, 2005

recognize that Pakistan's key health indicators significantly lag behind international targets and also do not compare favorably in comparison with other developing countries, despite significant enhancements in fiscal allocations in recent years,⁷ and improvements at a process and output level.⁸ There is a consensus that in the absence of health systems reform, progress at the outcomes level will be limited.⁹ Addressing corruption is one of the fundamental area of such a reform.

The *second* reason why corruption needs to be addressed is because of its sheer magnitude. Transparency International's recent World Corruption Report of 2007 with its focus on corruption in the judicial system is of contemporaneous relevance to Pakistan with respect to the spotlight on the judiciary. However, its findings have also opened a debate in many sectors in the country owing to its inclusion of Pakistan amongst the 37 countries studied and the sectoral comparative rankings. In addition, almost all comparative country rankings whether originating from the World Bank or Global Competitiveness Report of the World Economic Forum or other think tanks and institutions consistently rate Pakistan low in public sector management, institutions and governance. Pakistan also ranks low on the World Bank's CPIA score (country policy and institutional assessment measure which is scored between 1-5 depending upon performance, part of which regards corruption and governance).^{10, 11} This has also been supported by evidence gathered in Pakistan; a recent population-based survey shows that 43% of the urbanites believe corruption is prevalent in the country.¹² Another perception survey of civil servants conducted by the Pakistan Institute of Development Economics (PIDE) shows that 93% of the respondents think that the performance of the civil services has deteriorated over the years.¹³ Perception surveys relevant to the health sector also support these views. A cross-country survey of the public gauging perceptions of corruption in public service showed that 95% of the population perceives that the health sector is corrupt in Pakistan.¹⁴ Another survey showed that the frequency of informal payments to public health care providers amongst the users of services is 96% in Pakistan; most of these are *ex ante* demands from providers.¹⁵ Yet another study which assessed average informal payments as a percentage of half monthly

7 Government of Pakistan. Economic Survey 2007. Islamabad, Pakistan: Ministry of Finance; 2007. website: <http://www.finance.gov.pk/survey/home.htm>

8 Nishtar S. Health Indicators of Pakistan; Gateway Paper II. Islamabad Pakistan: Heartfile; 2007. p-189-223.

9 Nishtar S. The Gateway Paper, Health Systems in Pakistan; a Way Forward. Islamabad Pakistan: Heartfile; 2007.

10 The World Economic Forum. Global Competitiveness Report 2006. Geneva, Switzerland: The World Economic Forum; 2006.

11 The World Bank. Country Policy and Institutional Assessment Measure. Washington DC, USA: The World Bank; 2006

12 Gallup Pakistan. A survey on corruption in Pakistan. www.gallup.com.pk/pollshow.php?id=2007-07-20

13 Pakistan Institute for Developmental Economics. Working Paper 4 of 2006. Perception Survey of the Performance of Civil Servants in Pakistan. Islamabad Pakistan: PIDE; 2006.

14 Transparency International. Corruption in public services; perceived corruption in health sector. Berlin, Germany: Transparency International; 2002

15 Transparency International. Corruption in public services; informal payments among users of health services. Berlin, Germany: Transparency International; 2002

per capita income showed that informal payments are 70% of the half monthly per-capita income in Pakistan (fig 1).¹⁶

A report by Transparency International, entitled *Corruption in South Asia - Insights & Benchmarks from Citizen Feedback Surveys in Five Countries*, has identified high levels of corruption as perceived by citizens attempting to access seven basic public services in Pakistan with 100% of respondents reporting having encountered corruption during the last one year.¹⁷ The survey results showed that even when public services were meant to be freely available, bribes and delays keep many from receiving them, and it is most often the poorest in society that suffer the most. When asked about the source of corruption, most respondents answered that public servants extorted bribes. Middle and lower level civil servants were identified as the key facilitators of corruption in all sectors probed. Similarly issues of management and governance have also been identified as one of the key impediments to leveraging the potential within Pakistan's extensive health infrastructure by the World Health Organization.¹⁸ Within the health system itself, there is irrefutable anecdotal evidence of corruption at all levels of the health system and although isolated reports cannot be generalized, the potential for exploitation within the system that they point to should merit careful attention. Sitting governments should therefore accord high priority to corruption within the health sector because of the potential that this has to compromise public investments in a highly constrained environment.

Thirdly, attention to corruption is also especially needed because of the increase in fiscal space in Pakistan over the last several years with enhanced allocations for the social sector, from which health has also benefited.¹⁹ Although in relative terms, allocations for health in terms of it being a percentage of the GDP has declined over the last 10 years from 0.8% of the GDP in 1997 to the current level of 0.67% of the GDP in 2007,²⁰ there have been aggregate increases in allocations, which have increased from Pak. Rs. 20 billion to the current levels of Pak. Rs. 50 billion over the same duration. Within this context, corruption stands as the key impediment to the impact of well intentioned spending. In addition, it is well established that a range of governance related issues also act as an impediment to the utilization of funds, 20% of which is known to go underutilized.²¹ Furthermore, although the amount of funds pilfered from the system remains unestimated, it is perceived to be significant, based on inferences drawn from the prevailing commission rates on procurements alone, as has been described in a later section.

¹⁶ Transparency International. *Corruption in public services; informal payments among users of health services* Berlin, Germany: Transparency International; 2002

¹⁷ Transparency International. *Corruption in South Asia - Insights & Benchmarks from Citizen Feedback Surveys in Five Countries*. 2006.

¹⁸ World Health Organization. *World Health Report 2000: Health Systems: Improving Performance*. World Health Organization 2000, Geneva, Switzerland.

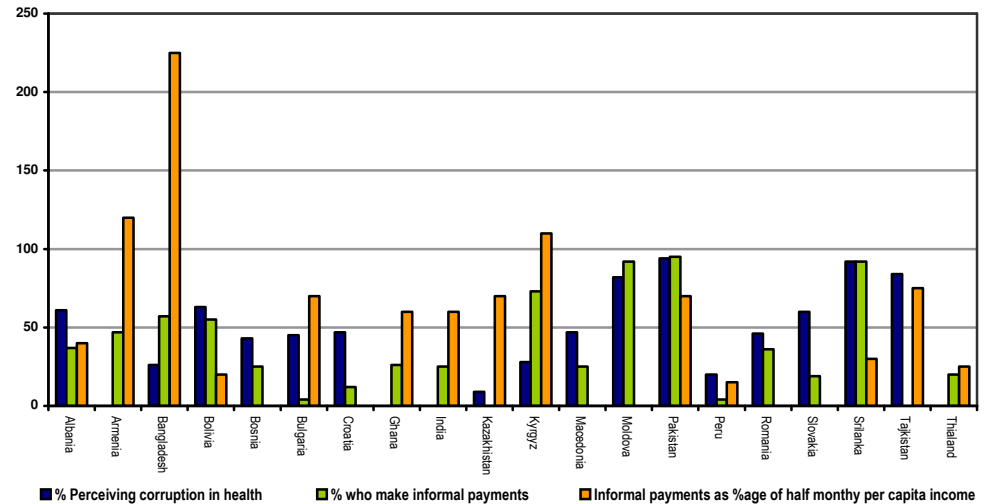
¹⁹ Planning commission of Pakistan. <http://www.planningcommission.gov.pk/>

²⁰ Nishtar S. *Health Indicators of Pakistan; Gateway Paper II*. Islamabad Pakistan: Heartfile; 2007. p-225-38.

²¹ DFID national health facility in G II – under utilization. *National Health Facility Budgetary Review for the year 2006*. Department for International Development, UK, 2006.

The present study is the first step in catalyzing action to develop mitigating solutions at an anti-corruption reform level in the health sector

Figure 1. Cross country comparisons of corruption in health based on selected indicators



And finally, another reason why attention to corruption is needed *now* is because anti-corruption reform in the social sector may be contemporaneously opportune because of there being *some* evidence of reform measures having been initialized in the fiduciary arena such as the Fiscal Responsibility and Debt Servicing Reforms and Taxation and Banking Reforms;²² these overarching reforms – a sine-qua-non of reform in the social sector – if implemented in their true spirit and sustained can complement reforms in the social sector. However the recent passage of the National Reconciliation Ordinance and the prevailing political and geo-strategic vulnerability at a more overarching level can be a barrier to the implementation of these reform measures.²³

Notwithstanding these limitations, it was decided to conduct a study to map corruption patterns in the health sector in Pakistan with the hope that the evidence would be the first step in catalyzing action to develop mitigating solutions at an anti-corruption reform level.

22 www.pep-net.org/NEW-PEP/HTML/Meetings/Lima/Fichiers%20pdf/mpia11062-Ahmed.pdf
 23 Government of Pakistan. National Reconciliation Ordinance; Islamabad. Ministry of Law and Parliamentary Affairs; 2007.

2.2 How was corruption ‘measured’ and studied in this analysis?

Corruption measurement is one of the most challenging areas in governance diagnostics because of definitional ambiguities, complexities in categorization, overlap of forms and its linkage with the cultural and social milieu within which activities can be perceived as being corruptive. In corruption assessments, scientific insights that are within the purview of health systems and policy research are usually not sufficient and often there is a need to incorporate lessons from political science and sociology and the public policy process in general. However, these complexities do not mean that corruption assessments should not be attempted. A number of multi-national agencies, World Bank and the Asian Development Bank in particular and international NGOs such as Transparency International have extensive experience in assessing corruption using common tools for within country diagnostics as well as cross-country comparisons. Most of these rely on aggregate indicators such as the Worldwide Governance Indicators (WGI), Doing Business and the CPI ratings, Governance Diagnostic surveys, Investment Climate surveys (ICAs), and Public expenditure tracking systems (PETS). Some of these instruments have included Pakistan in their cross country assessments and yield useful data on the magnitude of corruption; however these data provide limited insights into indigenous corruption patterns, which can be instructive for developing mitigating policy interventions. Here it is important to note that despite the plethora of well established corruptive practices in every health systems arena, no attempt has previously been made to describe and map these practices. The objective of the study reported in this paper is therefore to describe corruption patterns in Pakistan’s health system.

The objective of the study reported in this paper is to describe corruption patterns in Pakistan’s health system.

2.2.1. What was the definition of corruption employed for this study?

In an attempt to outline a clear definition of corruption to be employed for this study, various definitions proposed to label corruption in literature and used by existing analytical instruments were studied. Most of these suffered from limitations owing to their lack of ability to encompass every facet of what might be classified within the purview of corruption. The two most commonly used definitions in the international literature are: use of public office for private gain;²⁴ and the sale by government officials of government property for

²⁴ Bardhan P. Corruption and development: A review of issues. *Journal of Economic Literature*, 1997;35(3):1310-46.

private gain.²⁵ However, both of these exclude the private sector from the definition and would, by characterization, exclude for example, the corrupt practices in the domain of pharmaceuticals, to which the private sector is also a party and which have been alluded to in the relevant sections (procurement of pharmaceuticals, unethical marketing and pharmaceutical regulation)

A broader definition of corruption characterizes it as a pattern which is seen to exist when a power holder, responsible functionary or office holder is, by monetary or other rewards not legally provided for, induced to take actions, which favor whoever provides the rewards and thereby does damage to the public and its interests.²⁶ Although this definition is broader than the previous one, an important caveat here is that this fails to appropriately allude to the ethical, moral and intellectual aspects of corruption, which have been described in this publication. These dimensions of corruption in the health sector are difficult to quantify and even separate from what is regarded as conventional behavior in the health and administrative systems as is described in the sections hereunder.

Another definition of corruption defines it as privatization of public policy.²⁷ However, this definition does not make a distinction between legal and illegal actions; here it is important to note that corruptive practices can sometime be through actions that are legal as for example in the case of making election campaign contributions in many western developing countries – which though legal can seriously influence the ethical rules of the game.

**Definition of corruption
employed for the study: an
action of a stakeholder
within the health which is
not legally provided for and
which does or have the
potential to do damage to
the public or its interests**

An analogy in the health sector can be made with the case of marketing pharmaceutical products, where 'legal' marketing tends to cross unethical lines. In view of these considerations, which necessitated the inclusion of the private sector dimension and the

25 Shleifer A, Vishny RW. Corruption. Quarterly Journal of Economics, 1993;108(3):599-617

26 Klavoren JV. The Concept of Corruption. In Heidenheimer AJ, Johnston M and LeVine VT: Political Corruption: A Handbook. New Brunswick, 1989.

27 Kaufmann D Kraay A. and Mastruzzi M. Measuring Corruption: Myths and Realities. Washington DC, USA: World Bank Policy Research Working Paper; May 2006.

ethical, moral and legal perspectives of corruption, this paper employs a broad definition of corruption in health within the following confines: an action of a stakeholder within the health system mandated with governance and regulatory roles, or those that have a stake in the delivery of services and/or providing inputs to the system, which is not legally provided for and which does or have the potential to do damage to the public or its interests.²⁸

2.2.2 Methodological options for the study

International corruption assessments have largely used four methods for corruption assessment. These include perception surveys, measuring indices of corruption activities, expert opinions, and other surveys. While these approaches indicate the spread of corruption in a society, it would be difficult to label any of these strictly 'scientific' because the real volume of corruption cannot be measured or calculated given that it rarely leaves a paper trail. Each of these also has its limitations. General perception, which is regularly used as a sensitive core indicator of the feeling of lack of justice and public transaction, is dependent on how corruption is displayed in the media and can be influenced by the actual events surrounding data collection. The incidence approach is more independent from these limitations; however in this approach, the exact ratio between actual corruption attempts and the reported number cannot be known. Similarly, expert evaluations can be severely biased for many reasons but largely because these are carried out by international experts, who are usually not accustomed to local customs and language. Conventionally, multilateral agencies adjust for these biases by combining methods. In addition to these four unconventional methods for corruption studies other methods for corruption assessments

The survey methods adopted for this study have yielded important insights into corruption patterns which can form the basis future analytical work in this area

have also been used. These include forensic investigations, economically modeled estimates based on commission rates, performance of quality, and expenditure tracking surveys. All these options were assessed for their suitability for the first assessment of corruption in the health system in Pakistan. However, after a preliminary review of anecdotal

²⁸ Nishtar S. Corruption in the health sector in Pakistan. Heartfile and Partnership for Transparency Fund; 2007.

evidence and some key informative impressions when a number of processes stood out as having a high incidence of corruption, it became clear that an assessment in each domain was outside the of scope of the present study. It was therefore decided to conduct a descriptive, qualitative study, envisaging that such a study would be relevant to mapping corruptive practices that are deeply entrenched in the system and could serve as an entry point to comprehensive corruption assessment and subsequently, hopefully, an anti-corruption reform. Table 2 outlines the possible analytical options that would have given a more precise estimate of the magnitude of corruption in several corruption related domains compared with data in the present study; it also refers to the possible evaluation tools and the reasons for not utilizing those for the present assessment; in addition it also outlines areas where analytical work is needed in the future.

Notwithstanding these limitations, it must be appreciated that qualitative survey methods adopted for this study have yielded important insights into corruption patterns which can form the basis future analytical work.

Table 2. Limitations of the present study in analytical terms and a suggested way for ward for corruption assessment

Area of corruption	Assessment tool	Why it wasn't employed for the present assessment	Way forward in analytical terms
State capture; operational decision making in the human resource domain; other regulatory domains outlined in Table 2; collusion in contracting and procurements; malpractices by health care providers	Forensic investigations	Outside of the scope of the present study	Corruption does not leave a paper trail and hence except for cases to determine patterns for the purpose of extrapolating lessons for developing solutions, it is not being recommended in general
Quality and transparency of governance	Standardized assessments of quality and performance of key elements of governance	Indicators for quality, performance and transparency in governance have not been developed in the Pakistani context	Agreement over a set of indicators and their means of monitoring should be a priority
Commissions and bribes in contracting and procurements	Economically modeled estimates based on existing commission rates	Cost and time implications Inaccessibility to data needed	A priority as a next step in corruption analysis to determine the magnitude of the resources lost and misdirected
	Public expenditure tracking surveys	Need electronic tracking systems	Public expenditure tracking electronic systems should be established and where they exist, data should be analyzed and reported periodically
Price regulation	Price information comparison surveys	Cost and time implications Inaccessibility to data	Need to be institutionalized through collaboration with independent consumer protection groups
Informal payments in service delivery	Exit interviews	Need structured surveys	Exit interviews should be conducted on a representative sample
Staff absenteeism and ghost workers in service delivery	Data from staff and wage payments	Need electronic tracking systems	Staff and wage tracking electronic systems should be established and where they exist, data should be analyzed and reported periodically
Quackery in service delivery	Health census	Cost, time and labor intensive	The survey capacity of the Federal Bureau of Statistics should be leveraged to conduct a health census
Theft	Data from electronic supply inventories	Need electronic tracking systems	Electronic tracking electronic systems should be established and where they exist, data should be analyzed and reported periodically
Unscrupulous marketing and spurious drugs	Market surveys	Cost, time and labor intensive	Independent third party marketing surveys should be a regular feature

2.2.3 Methodology

The methods used to collect data were in-depth interviews, focus-group discussions and review of documentation. Participant's observations were sometimes used to validate interview data. Semi-structured in depth interviews varied from quick interviews to a number of sessions over many hours with the same person and were open ended with broad topic areas to guide the conversation. In-depth interviews were done with managers at various levels both within the public and the private sectors. A total of 50 interviews were conducted; the professional profile of the interviewees ranged from class 4 employees of the government,²⁹ and equivalent private sector employees to CEOs and former cabinet members. All the interviews were conducted by the Principle Investigator (PI) familiar with the research purpose and responsible for the analysis and writing. Gender, culture, language and social consideration were taken in when planning interviews. The PI also conducted focus group discussions with a homogenous group of five to ten people on a particularly focused issue. A total of seven focus group discussions were held. These were also used to supplement and validate other questionnaire information. In-depth interviews were recorded by taking notes by the PI and the accompanying research assistant(s) and were not tape recorded. Because of the sensitive nature of the subject no names of persons interviewed have been retained in files.

Extensive use of documentation was made for this study. Most of these documents are in the public domain; however a few of the documents were internal to agencies. This also included an analysis of material culture such as the graffiti and written data from organizational and official records. Again, because of the sensitive nature of the subject, the precise name of the document and the name of the person providing the document have not been included in this report. All copies of internal reports were destroyed at the end of this study. Finally the PI made some use of participant observation. This included attending public and private meetings at various levels.

**Many of the conclusions
reached in this report were
triangulated based on
coherency and agreement
between the various types of
information gathered.**

Many of the conclusions reached in this report were triangulated. The Principle Investigator looked for coherency and agreement between the various types of information gathered

²⁹ Lowest category of support staff in the public system

from people interviewed for the study. The strength of triangulation is that it provides an internal validation of the evidence presented. Confidence in the evidence is gained by the observation of patterns, repetition of statements from numerous sources, and agreement of various sorts of information – written and spoken.

However, an important caveat here is that while qualitative methods provide a unique window to study the issues raised in this report, they have many limitations; these include their inability to put a precise number value on the level of funds misused and the costs that incurred in accessing care and the level to which public service quality was compromised. A more tangible and quantitative understanding of these subjects will require additional studies; for some of these studies, methods and tools exist but for others, these need to be developed. Table 1 provides initial guidance in that direction.

A more tangible and quantitative understanding of these subjects will require additional studies

2.2.4. Classification of corruption coined by the study

Several classifications of corruption have been used in international literature: these include white and blue collar corruption; petty vs. judicial vs. state capture and corruption of greed vs. corruption of need. This publication adopts a practical classification of corruption based on the various health systems domains and reports the findings of this study under four categories: strategic directions, operational decision making, regulation and marketing. In each category, the role of the public sector and the corresponding role of the private sector in perpetuating corrupt practices have been alluded to in **Table 3**.

Table 3: The modes of corruption in the health sector and the role of the public and private sectors in institutionalizing practices

Areas of corruption	Corrupt phenomenon in the public sector (... and stakeholder)	Corrupt phenomenon in the private sector (... and stakeholder)
Strategic vision, direction and planning	State Capture (<i>politicians and decision makers</i>)	Undue influence to shape state policies, laws and regulations (<i>corporate elite, well connected individuals, lobby groups</i>)
Operational Decision making		
Human resource hiring and placements	Preferential treatment to well connected individuals, nepotism, cronyism (<i>decision makers</i>)	Undue influence to shape decision making (<i>elite, well connected individuals</i>)
Contracting and procurements	Collusion in contracting and procurements (<i>decision makers</i>) Record falsification, padding bills, over invoicing, clever book keeping, overpayment for supplies and over invoicing. (<i>administrative staff</i>)	Undue influence to shape decision making through bribes and kickbacks (<i>contractors, manufactures, suppliers and wholesalers</i>)
Regulation		
Publicly financed and provided services		
Quality standards and ethics	Absenteeism, ghost workers, shaving off hours, low quality standards and unethical practices in healthcare delivery (<i>Staff</i>)	Practices in the private sector for a cost at the expense of public sector time which incurs no cost, low quality standards, unethical practices and using public leverage for private practice especially in the case of specialists (<i>staff qualified to practice</i>)
Service prices	Unauthorized payments (<i>service delivery and administrative staff</i>)	Quackery (<i>staff not qualified to practice</i>) Offering petty bribes to access services and for administrative clearance (<i>patients, vendors, suppliers</i>)
Supplies and stocks	Theft of supplies, pilferage and dispensing to ghost patients (<i>store and procurement officers</i>)	Buy back in the market (<i>retailers and wholesalers</i>)
Healthcare services in the private sector		
Permissions to establish facilities	A regulatory framework for the private sector does not exist Pharmacies: preferential treatment (<i>Decision makers and self regulators</i>)	Mushrooming of health facilities without regard to quality and standards (<i>health providers and owners</i>) Undue influence to shape decision making through bribes and kickbacks (<i>aspiring owners</i>)
Licensing quality standards	A regulatory framework for the private sector does not exist	Practices in the private sector for a cost at the expense of public sector time which incurs no cost, low quality standards, unethical practices and using public leverage for private practice especially in the case of specialist (<i>staff qualified to practice</i>) Quackery (<i>staff not qualified to practice</i>)
Output based control of service prices	A regulatory framework for the private sector does not exist	Unchecked fees without regard to access issues (<i>health providers</i>)
Accreditation	A framework for the private sector does not exist	Malpractices and low standards of quality

Continued(Table 3)

Areas of corruption	Corrupt phenomenon in the public sector (... and stakeholder)	Corrupt phenomenon in the private sector (... and stakeholder)
Medical education		
Permissions to establish facilities and numbers entering medical schools	Preferential treatment (<i>Decision makers and self regulators</i>)	Undue influence to shape decision making through bribes and kickbacks (<i>aspiring owners</i>)
Licensing quality standards	Deliberate inattention to oversight (<i>regulatory agencies</i>)	Undue influence to shape decision making through bribes and kickbacks (<i>owners</i>)
Human resource		
Hiring	Nepotism, cronyism, preferential treatment	Undue influence and bribes
Placements	Nepotism, cronyism, preferential treatment	Undue influence and bribes
Oversight	Deliberate inattention to oversight	Commissions and incentive sharing
Licensing	Regulatory capture that is self serving	Private sector promotes regulatory capture through peer regulation
Pharmaceuticals		
Registration	Unnecessary registrations, 'selling' registration files to competitors, violating IPR regulations	Commissions, bribes and incentives
Pricing	Overestimations in prices calculations and granting higher favorable prices	Bribes and incentives
Production	In attention to oversight	Low standard of drugs and spurious, adulterated
Wholesaling	Selling back pre-marked consignments wholesalers in the market	Buying back consignments, hoardings, creating shortages, offering bribes and undue influence
Retailing	Inattention to oversight and fake licenses	Possessing illegal and fake licenses to sell, absence of warranty of purchase of all products, dealing with the black market, inadequate storage practices at outlets and the absence of unqualified staff. Offering bribes and incentives to regulators
Marketing		

The classification of the modes of corruption follows a classification of governance coined by the PI, which is in the publication pipeline.³⁰ This classification enables linking in with governance attributes that have been variously classified as indicators, domains and principles by various international agencies albeit while describing patterns under domains so as to facilitate the development of mitigating strategies. The attributes include WHO stewardship domains, World Bank indicators and UNDP's principles. World Health Organization outlines six stewardship domains;³¹ these include Generation of intelligence, Formulating strategic policy direction and ensuing tools for implementation: powers, incentives and sanctions, Building coalition / building partnership, ensuring a fit between policy objectives and organizational structure and culture and Ensuring accountability. The World Bank organizes governance indicators into six clusters corresponding to the six basic aspects of governance;³² these include: Process by which those in authority are selected and replaced (Voice and Accountability, Political Instability and Violence); Ability of the government to formulate and implement sound policies (Government Effectiveness, Regulatory Burden) and Respect of citizens and the state for institutions which govern their interaction (Rule of Law, Graft [measures and perception of corruption]). In addition UNDP outlines five principles of governance which include legitimacy and voice (participation and consensus), direction (strategic vision), performance (responsive and efficiency and effectiveness), accountability (accountability and transparency), fairness (equity, inclusiveness and rule of law).^{33,34,35}

The classification of the modes of corruption follows a classification of governance coined by the Principle Investigator

30 Nishtar S. Health Reform in Pakistan – Gateway Paper 3. Heartfile and Pakistan's Health Policy Forum; Islamabad, 2007. In press

31 Travis P, Egger D, Davies P and Mechbal A. *Towards better stewardship: concepts and critical issues*. Geneva, World Health Organization, 2002.
http://www3.who.int/whosis/discussion_papers/pdf/paper48.pdf

32 Developed from Governance Matters, Policy Research Working Paper No. 2196, Kaufmann et al, World Bank, 1999)

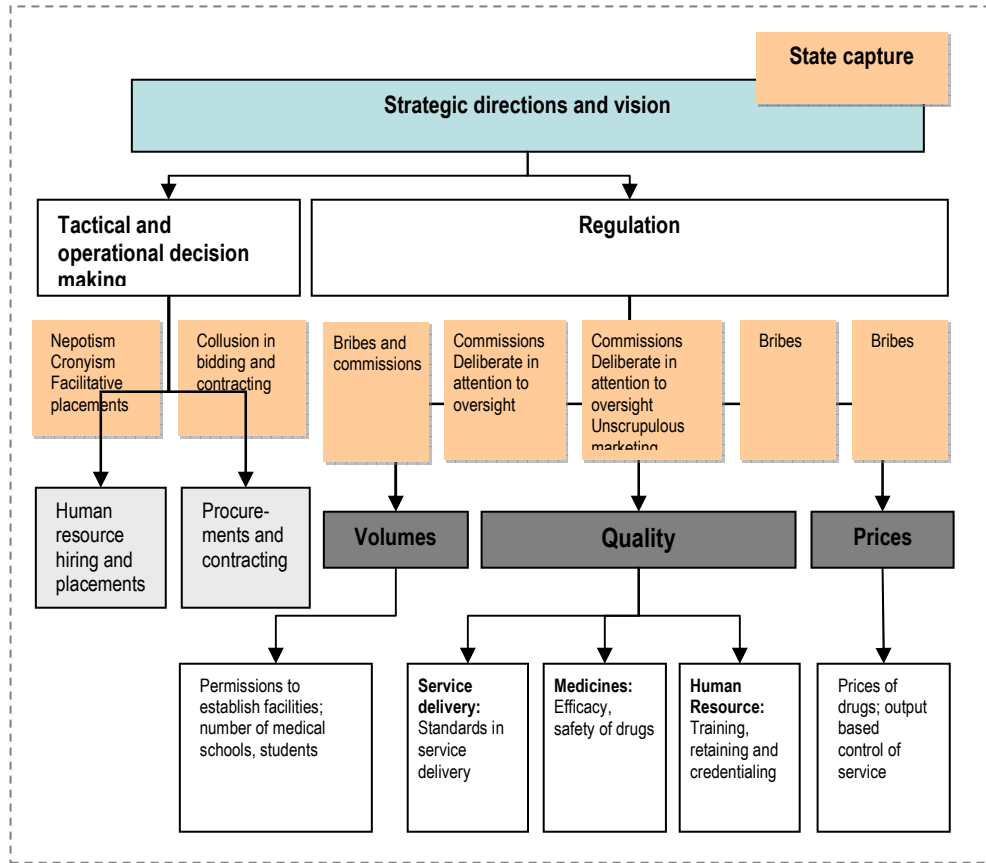
33 Development Programme. *Governance for Sustainable Human Development: a UNDP Policy Document*. New York, UNDP, 1997. <http://magnet.undp.org/policy/chapter1.htm>

34 Graham J, Amos B and Plumptre T. *Principles for Good Governance in the 21st Century*. Policy Brief No.15. Ottawa, Institute on Governance, August 2003.

<http://unpan1.un.org/intradoc/groups/public/documents/other/unpan011842.pdf>

35 United Nations Development Programme. *Governance for Sustainable Human Development: a UNDP Policy Document*. New York, UNDP; 1997. <http://magnet.undp.org/policy/chapter1.htm>

Figure 2. Patterns of corruption in the health system



2.2.5. The domains of corruption as identified in this study

2.2.5.a Strategic vision and directions and state capture

The words stewardship and governance are often interchangeably used. Stewardship in the context of the health sector means oversight and guidance, on behalf of the state and its citizens, of the working and development of the nation's health actions.³⁶ Based on this definition, stewardship normally falls to the Ministry of Health and includes health policy development, regulation and the gathering, sharing and use of information at the national policy making level. However according to the Constitution, and Pakistan's Rules of

³⁶ Published definition – primary source undetermined

Business,³⁷ health is a provincial subject and therefore 'oversight and guidance' within the respective provincial domains is also the responsibility of provincial governments. The Ministry of Health has an additional constitutional stewardship role in the health sector in the areas of national economic coordination with reference to foreign assistance as well as research and capacity building. Governance covers how authority over health resources and services is exercised. It includes the mechanisms, processes, relationships and institutions through which citizens and groups articulate their interests, exercise their rights and obligations and mediate their differences.³⁸

The core functions of the stewards of health is to determine strategic policy directions based on evidence, set norms and standards, regulation, quality assurance and initiating multi-sectoral action for health. Stewardship and governance are closely interlinked and the two most important attributes that determine their quality are capacity and transparency within the system. Weaknesses of capacity within the state system are well recognized; these have manifested themselves in an inability to strategically plan based on locally suited and relevant priorities and makes the space for policies to be donor driven. In addition it also manifests itself through policies that lack an outcomes orientation.³⁹ Limited capacity has also led to the configuration of the structure of the Ministry of Health and the departments of health in such a way that they do not perform their core essential functions and remain focused on peripheral administrative issues. In addition it also deters them from developing capacity that is contemporaneously relevant – as for example capacity to regulate the private sector and appropriate capacity to harness the potential of their outreach to deliver public goods that are a state mandate.

On the other hand, the other attribute of setting strategic direction in policy and planning which has to do with ensuring transparency in the system also merits careful attention. The World Bank uses corruption as one of its indicators and UNDP outlines it as one of its principles. However corruption is cross cutting to governance as has been illustrated in the operational classification of governance (Table 3). In the area of determining strategic policy directions, it is important to make a distinction between administrative corruption and state capture. While administrative corruption takes many forms ranging from regulatory corruption to corruption in procurements and contracting and malpractices in the administrative control and oversight process within the realm of service delivery and human resource, state capture refers to the manifestation of a broader system phenomenon where the laws of the land and policies are made to favor a few; and where the private sector, lobby groups and those with vested interest and influence shape state policies, laws and regulations for their own benefit. State capture is detrimental to the equity objective. In addition, lack of transparency also impacts the health system through clouding of business

37 Government of Pakistan. The Constitution of the Islamic Republic of Pakistan (as modified up to March 1987). Fourth Schedule – Concurrent Legislative Lists, pg. 259. Islamabad, Pakistan: Ministry of law and Parliamentary Affairs, Justice Division; 1987.

38 Published definition – primary source undetermined

39 Nishtar S. The Gateway Paper, Health Systems in Pakistan; a Way Forward. Islamabad Pakistan: Heartfile; 2007. Page 15 and 17

environment and lowering investor confidence which in turn impacts the economy and ultimately the funds that the social sector gets.

State capture is a broader phenomenon in policy and decision making and is not specific to health or the social sector in isolation and whereas this remains a potential threat, its existence is hard to prove. It has been frequently cited that the tendency to invest in civil works, physical infrastructure and equipment purchases is motivated by vested interest; however this may not always be the case. There could be several other reasons for the preference to invest in these areas; for example, decision makers in the health sector with weak technical capacity may think that this is the best use of resources in health and political decision makers in their quest for interventions that show quick results, may have a tendency to invest in such projects for political reasons to serve the visibility objective. The recent allocation of investments for the construction of medical towers is envisaged by some groups to be due to the opportunity these create to pilfer funds; however, the afore-stated considerations warrant careful attention in coming to such conclusion.

State capture is a broader phenomenon in policy and decision making and is not specific to health or the social sector in isolation and whereas this remains a potential threat, its existence is hard to prove.

However on the other hand, instances have been well reported where regulations in the pharmaceutical domain have been changed to favor commercial entities without regard to access and affordability implications. As such practices do not leave tangible evidence, it may be difficult and perhaps pointless in retrospect to map such occurrences. However they do have implications in terms of underscoring the need to build systematic safeguards such as by ensuring safeguards against the issuance of impromptu Statutory Regulatory Orders, by mandating the open posting of decisions in this arena and involving consumer protection groups in decision making in areas that can have implications for access and affordability.

2.2.5.b Decision making of relevance to health related human resource

A number of malpractices are frequently reported with reference to human resource management in public sector settings; these differ based on the category of staff involved and the organizational settings. Examples are cited from the domain of recruitments, placements and monitoring.

Recruitments: with reference to recruitments, preferential treatment to well connected individuals, unfair hiring practices and nepotism have been well described. This is less frequent, albeit prevalent when several levels of systems and procedures are in place for merit based recruitment, particularly in higher level professional jobs such as specialist doctors. A critical factor in ensuring some level of conformity with stipulated rules and regulations is peer oversight, as a result of which blatant forms of unfair hiring practices generally do not occur. Notwithstanding, subtle forms of preferential treatment to well-connected individuals does exist.

For example, the open posting of an advertisement for a key clinical job can be influenced by a well placed individual to ensure that timing is suitable for the 'chosen' well connected individual. Similarly, the exact specifications and requirements of a job can be played around with to suit a particular individual. Pakistan's premier regulatory authority PMDC is known to have engaged in such practices in the past.⁴⁰

For higher jobs where peer oversight doesn't exist such as in the case of administrative non-clinical appointments, cronyism and conflict of interest in public sector appointments is well described. However, in staff hiring for lower positions where competitive qualifications do not pose as an impediment to selection criteria, and where informed peer oversight is minimal, the misuse of public authority to influence hiring is well-described.

Even when hiring is purportedly through open competitive processes, sanctioned letters are awarded directly from politically appointed representatives even while comparative statements exist to guide rational decisions on merit. Similarly, tampering with comparative statements has also been reported.

Placements: staff placements in key roles are critical in enabling corrupt practices to prevail in several governance related domains referred to herein. These are particularly relevant to contracting and procurement in hospitals and the public health programs where the placement of a person can be the difference between corruption and transparency. Since such practices are widely institutionalized, the placement of an appropriate person on a key decision making seat is actively pursued by the interested lobby of stakeholders who 'benefit'. If an honest person is appointed to such a position he is deliberately sidelined to make way for the one who will be 'facilitative'. Hospitals medical superintendents/administrators and their equivalents are notorious for the use of their discretionary powers for adhoc appointments which they are entitled to exercise in the event of a seat being vacant and which they abuse in order to enable a 'facilitative person' assume a position on a chocolate seat. The latter is a name given to an administrative post, which has a certain level of authority over decision making in procurements and contracting and is critical in enabling corrupt practices to prevail in the system.

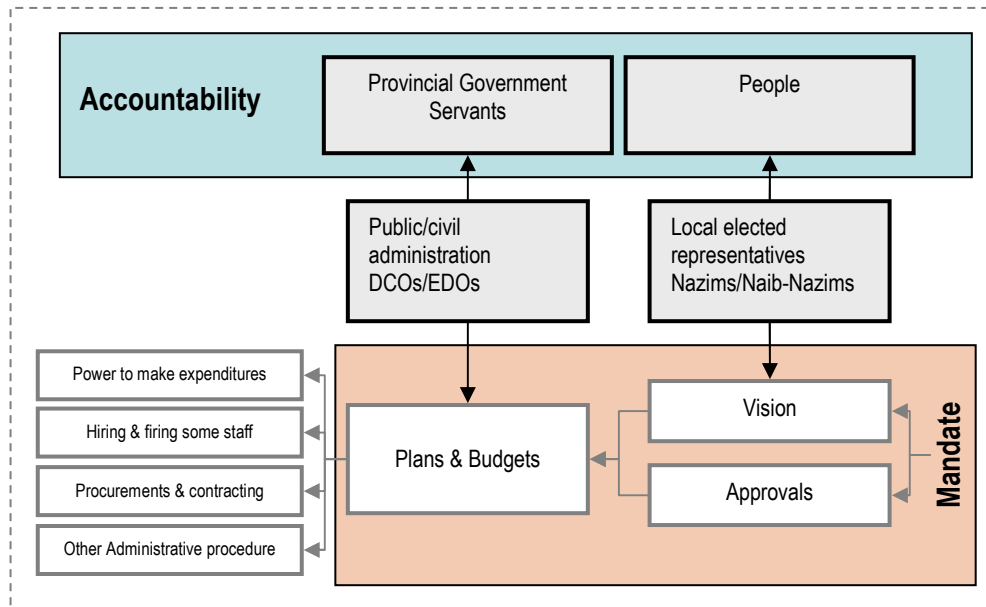
40 <http://www.dawn.com/weekly/cowas/20060108.htm>
<http://www.dawn.com/2006/09/05/letted.htm>
<http://www.dawn.com/2006/08/21/ed.htm#2>
<http://www.newslines.com.pk/Newsmar2004/newsspmar2004.htm>
<http://www.thenews.com.pk/print1.asp?id=77322>

The devolution of administrative power within the technical bureaucracy and political system has impacted the sharing and/or incentive splitting within this context in a 'novel' manner. The district administration traditionally had a more institutionalized control on these channels as is shown in **Figure 3**. However, the District political administration was quick to learn the potential for gain by having access to such controls and therefore there are frequent reports of controversy and souring of relationships between the district political administration and the district civil administration over procurement authority and contracting decisions and therefore access to incentives. The civil administration fears that their share has now substantially diminished. According to one informant, "they (political administration) eat the pastry and we (civil administration) just lick the paper cup" (after devolution of powers).⁴¹

The devolution of administrative power within the technical bureaucracy and political system has impacted the sharing and/or incentive splitting within this context in a 'novel' manner!

41 Ordinance Number VI of 2001: Government of Pakistan. Local Government Ordinance, 2001

Figure 3. Mandates, prerogatives and accountabilities of the district political and civil administration



Misconduct of doctors in public hospitals and other public settings is very well described, particularly, with reference to breaches of ethics in terms of not drawing a line between private practice and public jobs.

Lack of attention to oversight and accountability: another form of corrupt practice at a human resource level stems from deliberate lack of oversight and inattention to mechanisms that compel accountability by senior public officials. This is most pronounced in the case of managerial reluctance to confront physicians in public hospitals. Misconduct of doctors in public hospitals and other public settings is very well described, particularly, with

reference to breaches of ethics in terms of not drawing a line between private practice and public jobs. Most of the doctors draw as part of their salaries what is called a non-practicing allowance while they have flourishing private practices. In addition others forms of deliberate inattention to oversight in the case of human resource misconduct both on the public administrative arena and in the delivery of publicly financed services and regulation of the private sector have been well described and are addressed in various section of this report.

2.2.5.c Decision making in procurements and contracting

Corruption is perhaps most institutionalized in the health sector in the domain of contracting and procurements. However its magnitude depends upon what is procured, the size of procurements and the periodicity of procurement. It is also dependent on the level of checks and balances that the procuring agency has in place and the opportunities for bypassing and exploiting the system and procedures.

In the procurement process for equipment and drugs and in the process of contracting and outsourcing as in the case of service delivery contracts in basic health facilities, ancillary contracts in hospitals and contracts given for developing high budget behavioral change communication campaigns common corrupt practices include collusion among bidders, kickbacks from suppliers and contractors to influence the selection process, and bribes to public officials monitoring the winning contractor's performance. This process can also involve over invoicing and overpayment by government agencies so that the margin can be shared back. In the case of medicines and equipment, corrupt procurement officers can also purchase sub-standard drugs in place of quality medicines and equipment and pocket the difference in price.

Corruption in procurement of equipment: a huge margin exists for building in kickbacks through over invoicing, padding bills and clever book keeping in the procurement of equipment. In hospitals with minimal levels of oversight blatant forms of procurement frauds have been documented.

In a Federally Administered Tribal Area hospital in NWFP where the level of oversight is minimal, an enquiry commission found gross discrepancies with respect to specifications on comparative statements vis-à-vis physical verification of radiological equipment which additionally was of severely compromised quality. For example, a 'Cardiac Color Doppler', which was purchased at three times the price of the state of the art Cardiac Color Doppler machine available in the market, had no color mode and had been fixed with an abdominal probe. In the same hospital, the 'echo machine' bought for a hefty price consisted of an out dated computer monitor whereas a water de-ionizer purchased far above the market price consisted of 10 kg water canisters.

This may be an example of the most blatant forms of procurement fraud in hospitals with the most minimal level of checks and balances and therefore this example cannot be widely generalized; notwithstanding, similar frauds have been reported in other settings even

where the level of oversight was much better but where procurement officials find a way around them.

On the other hand, in settings where institutional mechanisms of oversight exist, the likelihood of such blatant forms of corruption is less. Notwithstanding, the time established forms of corruption involving collusion in the contracting process and the sharing of kickbacks amongst those involved in the process continues to prevail. In addition, several other forms of corruption have also emerged over time; for example, in high budget equipment procurements, doctors tend to ask for items with very narrow specifications. Given that only a few manufactures comply with such specifications, it is often perceived by the administration that sometimes these are preconceived in concert with the commercial sector with prearranged incentives. In this form of corruption state resources are pilfered and there is danger that the procured item may not be the ideal for the system and hence of compromised quality. The opportunity for this form of corruption is highest in technologically sophisticated high cost equipment. Even if the kickbacks are not in the form of outright payments or bribes, 'paybacks' in the form of sponsorships for conferences are well described and although these are perfectly legal, the manner in which they influence decision making as it relates to the technical advice vis-à-vis the use of state funds raises many conflicts of interest issues. Other more inappropriate forms of paybacks have also been described such as sponsoring family weddings and the provision of items for personal use.

In hospitals with compromised levels of oversight, blatant forms of procurement frauds have been documented.

Corruption in pharmaceutical procurements: corruption in the pharmaceutical sector involves both the regulators and the private sector and may involve any step along the drug supply chain, starting from registration and licensing to the setting of prices, marketing of drugs and sale and procurements. Corruption in drug supply and registration has a direct bearing on the performance of the health system and can reduce access to essential medicines, particularly for vulnerable groups. The regulatory aspects of corruption in the domains of registration, pricing, quality control have been discussed in the relevant sections whereas unethical marketing practices have been discussed in another dedicated section. This section will focus on irregularities in procurements of medicines.

Corruption in pharmaceutical procurement can be well institutionalized and prevail despite the existence of several oversight mechanisms; these have been given different names – medicine coordination cells and committees, that provide approved lists of generic drugs from which selection is made and 'blinded' inspection and supply committees, which serve

their respective roles. It would appear difficult for corruption to take place in the presence of so many 'systems' in place. Notwithstanding, these practices widely prevail. In the case of hospitals in far flung areas where institutional processes are not as strong, the chances of corruption are even higher because decision making at different levels is in the hands of the same person.

Commission related incentives generated from the procurement of drugs and equipment (as previously stated) and the process of contracting through which these are procured are deeply institutionalized within the system. It is well established that kick backs are distributed as commissions according to fixed percentages amongst those that are involved in the process. Clear cut formulae exist for commission sharing according to which a percentage of the cost of procured items is allocated according to pre determined but unwritten packages amongst audit, finance, store and other related administrative staff. So well organized is this system that in addition to establishing percentages for distribution of funds, the fund generated is also used for emergency purposes such as paying off unexpected auditors and 'buying off' difficult auditing staff.

The level of commission ranges from 10-20% depending on a number of factors. It is also dependent on whether procurements are made from multinational companies or local pharmaceutical companies. It has been reported that wholesalers of some multinational companies offer up to 3% in commission, which is a part of the 10% profit they earn and implies that the multinationals do not engage in offering commissions directly. However local pharmaceutical companies offer up to 30% in commission, which is indicative of their profit margins as well as the level of 'investments' they make to tip the decision making process in their favor. It comes as no surprise therefore that local companies have 80% of the market share in government procurements.

Commission related incentives generated from the procurement of drugs and equipment and the process of contracting through which these are procured are deeply institutionalized within the system.

The commission based system which applies to procurements is very well organized and is deeply institutionalized within the system to the extent that a parallel mafia operates but in a much more coordinated manner than the one managing public accounts. Commissions

are usually channeled into a 'fund' which is managed and disbursed according to unwritten but clearly stipulated rules and procedures. These funds are given different names in various facilities. One respondent explained that the most popular connotation for these funds is 'kitty fund', which in addition to commissions also gets contributions in many different ways. Details have been described in the section on publicly financed service delivery, Page

However it must be noted that the hospital and procurement staff also bypass the procedures of procurement through competitive bidding by making bulk procurements in piecemeal consignments, each of which is below the financial ceiling authorized to the administrator for purchase of medicines and supplies. Bulk procurements made in this way repeatedly, also enables the administrative staff to earn more commissions which are then channeled through kitty funds. Page –

2.2.5.d Regulation

Regulatory strategies in this study have been described under two main headings:

i) Regulation and management of services in publicly owned and financed systems; and ii) Regulation initiated by the government to correct market failures. The former focuses primarily on regulation of services whereas relevant to the latter is quantity, quality, price, inputs and process regulation. In the case of regulation of services in the public domain, the regulatory strategy adopted is one that involves administrative and bureaucratic control whereas in the case of correcting market failures a range of regulatory strategies can be adopted. These range from i) administrative and bureaucratic controls and implementing legislation in order to monitor infringements and enforcing sanctions using command and control mechanisms – a style of regulation which may be coercive; ii) market harnessing methods that are third-party based using contracts and self regulation; iii) market harnessing methods by expanding the use of consumer voice and exit, through information and disclosure and by creating routes for seeking redress (rights and liabilities). Each of these can be plagued with malpractices, mal-governance and corruption; examples of patterns are highlighted in each domain. However it must be noted, as has been described in the later sections, that the stakeholder to be regulated is often party to corrupt practices. Therefore this section focuses both on the regulatory aspects of the corruption, (which in most instances involves the public sector or peer groups in the case of self regulation) as well as the party to be regulated (the private sector or public sector employees in the case of publicly owned and financed systems) on the other.

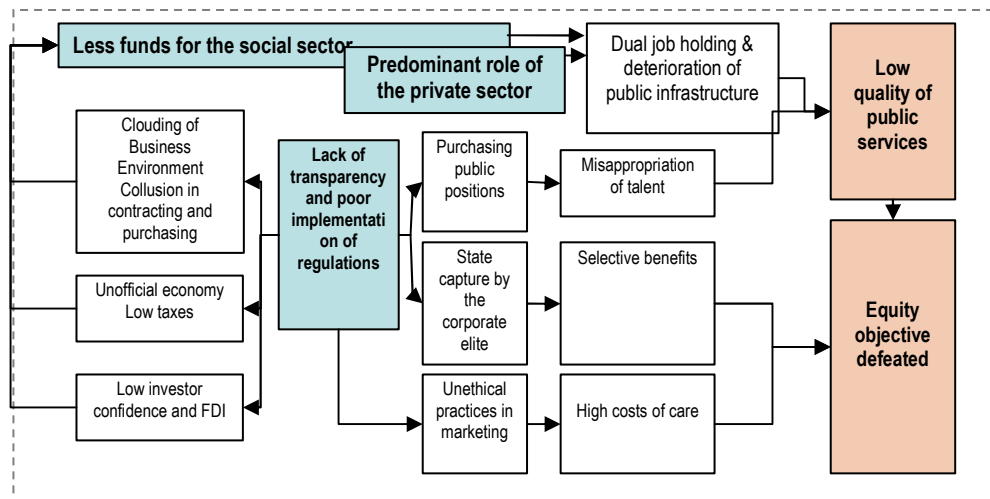
2.2.5.d.i Regulation of publicly financed and provided services and the role of public providers

This form of regulation is synonymous with having an oversight role to ensure the provision of services both qualitatively and quantitatively in the state health system. In most publicly financed and provided systems, the providers are government employees but usually have dual practices. Such health systems have the social welfare mark, albeit with significantly compromised quality and outreach of public services as a result of a number of factors. These include the consistently common triad of insufficient funding for the social sector, a

regulatory environment which enables the private sector to operate in the delivery of social services and lack of transparency in governance. These three determinants act together to compromise the quality of public services and defeats the equity objective through a number of ways, which have been illustrated in Figure 4. When providers have better incentives to work in private systems, the issue of dual job holding and absenteeism arises and public infrastructure is undermined. Lack of transparency causes misappropriation of talent, collusion in the contracting and the procurement processes and therefore pilferages from the system.⁴²

The triad of insufficient funding for the social sector, a unregulated environment for the private sector and lack of transparency in governance work together to defeat the equity objective in a number of different ways.

Figure 4. The three governance-related determinants of weaknesses of mixed health systems



42 Nishtar S. Politics of health systems: WHO's new frontier. Lancet 2007 Sep 15;370(9591):935-6.

The following sections describe the patterns of corruption in publicly financed systems where oversight of field operations is necessary and in other cases where services are delivered out of facilities (BHUs and hospitals and various levels)

2.2.5.d.i.i Publicly financed systems where oversight of field operations is critical:

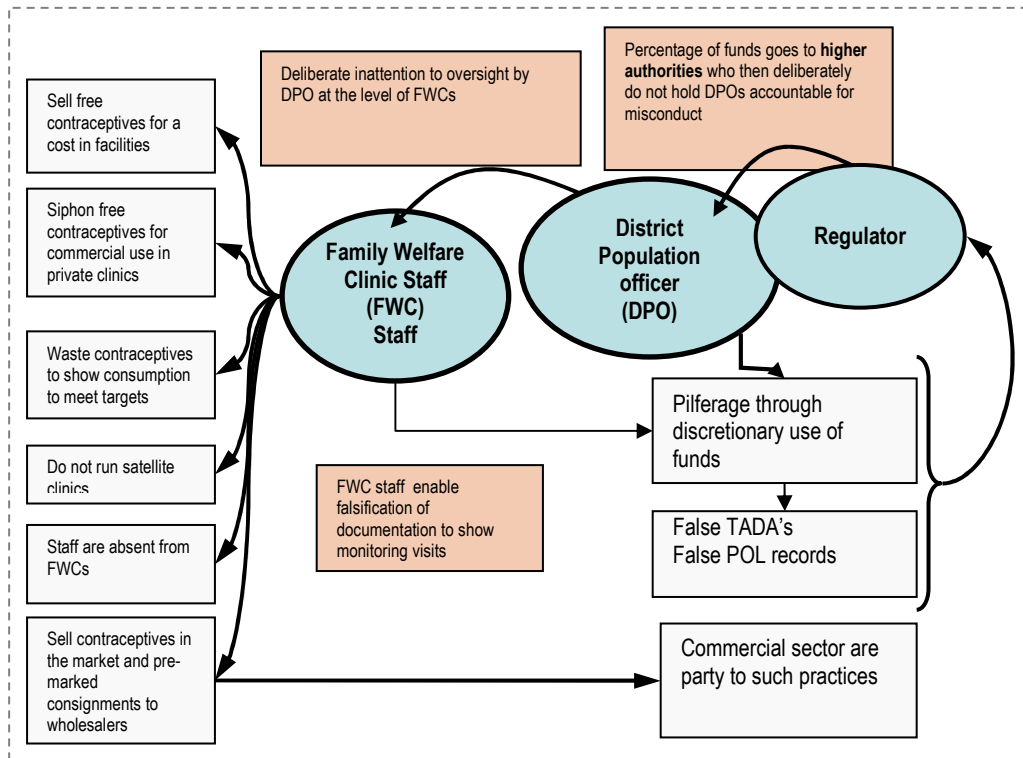
The Population Program in Pakistan is an example of a publicly financed program where oversight of field operations is critical; it is also one of the few programs in the country which is adequately funded in the social sector. The service delivery structure of the program includes 2,500 Family Welfare Clinics (FWC) all over the country; these are located both in the rural as well as the urban areas. Each receives a regular supply of contraceptives; of these, those that are meant for implantation/injection at the facilities (Intra-uterine devices and injectables) are meant to be given for free whereas the other takeaway contraceptives (pills and condoms) are meant for dissemination at nominal costs to avoid pilfering and to enable the generation of revenue, which is meant to be used as an incentive for staff. Financial resource constraints are never cited as an impediment to program impact in professional circles in this program. However, despite that the program is failing to meet its objectives and recent reports show that the once on-the-rise Contraceptive Prevalence Rate is stalling.⁴³ Figure 4 shows that a range of complex and interdependent institutionalized corrupt practices act as co-determinants of these failures, because of their impact on pilfering fiscal resources from the system, undermining service delivery qualitatively and quantitatively in addition to incurring access cost for services that are otherwise meant to be free. These corrupt practices involve FWC clinical staff and the regulators at various levels. However, it must be noted that there can be no generalizations; during the course of interviews and observations, there were many examples of facilities, which ran efficiently and transparently and District Population Officer's (DPO) that diligently performed a dedicated regulatory function. This notwithstanding, the pattern that is being outlined here is well described and reported anecdotally. DPO's deliberate inattention to staff misconduct at FWCs is perceived to be related to the 'collaboration' of FWC staff, which can enable them to falsify records showing fabricated monitoring visits on ledgers; this in turn enables the DPO to draw travel and subsistence allowances and forge POL receipts; this 'income' gets supplemented by inappropriate use of other discretionary funds at the disposal of the DPO. The pool of funds then gets distributed sometimes according to pre-determined percentages and unwritten protocols and at other times on a more impromptu basis, to the DPO as well as to the higher authorities above the DPO who have a vested interest in keeping the 'right' DPO in the 'right' place. This leads to leakages of funds from the public system, which then gets pocketed by individuals at several levels.

On the other hand, lack of regulatory oversight manifests itself in a number of ways at the health service delivery level; the FWC staff is frequently absent from the FWC and do not set up satellite clinics which they are supposed to do twice a week. Lack of oversight also enables them to sell contraceptives meant for free distribution for commercial use in private clinics; in addition, FWC staff is known to waste/destroy contraceptives to show

⁴³ Government of Pakistan. Pakistan Demographic and Household Survey 2006-07 (preliminary report). Islamabad Pakistan: National Institute of Population Studies, 2007.

consumption to meet targets and pre-marked contraceptives, which cannot be sold to the market are sold back to the distributors for a lower cost. As a result of these practices, service delivery is compromised but there is also a cost levied on what is meant to be a free service. In this process state resources are pilfered and mis-targeted. It is also important to know that a range of commercial for profit entities support these practices especially in falsifying POL records and buying back pre-marked contraceptives as in the case of wholesalers.

Figure 5. The Family Planning Program of Pakistan – an example of a publicly financed system where oversight of field operations is critical



The afore-stated pattern is based on anecdotal evidence but can be supported by evidence from other sources. The recent Demographic Health Survey (DHS) data on contraceptive mix does not, for instance, match service statistics which emerge from the FWCs. Furthermore institutional statistics on contraceptive consumption in FWCs do not match the annual reported patient turnover of three per day in FWCs and according to some consumption statistics it can be inferred that every woman in the catchment area has an IUD, which clearly cannot be the case.⁴⁴

⁴⁴ Government of Pakistan. Pakistan Demographic and Household Survey 2006-07 (preliminary report). Islamabad Pakistan: National Institute of Population Studies, 2007.

Similar patterns of deliberate inattention to oversight can also be seen in other areas of publicly financed health systems where oversight of field operations is necessary. A few examples are cited:

Sanitary inspectors are meant to regulate food outlets (e.g. bakeries, meat shops and food vendors) and manage production facilities (factories and hotels) for quality. As part of their work they provide advice on sanitary ethics, conduct inspections for compliance, issue notices and prosecute in the case of non-compliance. Because of their low salaries, which are incompatible with decent living, inspectors are forced to engage in bribes – a phenomena the food manufactures and retailers have a vested interest in promoting as it serves their purpose of continuing to engage in unethical practices. In addition to isolated bribes a monthly system of remuneration also exists to keep the inspectors from checking them.

It is not just the food and sanitary inspectors but also a range of other regulatory institutional entities that subsist on this pattern; many of these have overlapping functions which leads to duplication of efforts and wastage of state resources. In Islamabad, for example, some functionaries within the District Health Office, the Directorate of Municipal Administration, the Directorate of Health Services, the Labor and Excise Department and the Price Magistrate are all known to operate in this way. In addition to the system of bribes the way in which the judicial system processes and prosecutes cases is a major deterrent to accountability and justice. A sanitary inspector reported that after prosecuting a meat shop for unsanitary hygiene practices and meat storage, it took him three years of regular weekly visits to the court for them to come up with judgment against the wrong-doer as a result of which a penalty of Pak. Rs. 200 was imposed. This was hardly a deterrent and did not deter the retailer from changing his practices, which continue on the same pattern to this day.

A similar pattern can be seen in the Malaria Control Program of the Government of Pakistan, which employs CDC inspectors (communicable disease inspectors) to carry out the key field intervention of the program – spray of insecticides. The CDC inspector is under the DHO office. Corruption in this system involves procurement embezzlement of insecticides, where procuring agency over report purchases and pockets the difference in price. The field staff who are accomplices to the falsification of the documents subsequently engage in a range of corrupt practices because of the regulator's deliberate intention to oversight. These practices involve commercial sale of insecticides meant for free spraying and use of spray equipment for private use.

Similarly, in the vaccination program, vaccinators engage in petty thefts in the field at various levels, by charging money for vaccination cards and syringes that are disseminated to them free and by selling part of the vaccine stock to private hospitals. The recent Open-Vial Policy is being particularly abused in this connection. BCG and measles vaccines are made available in vials that contain 20 and 10 dozes respectively. However, according to the new Open-Vial Policy, the field vaccinator has the prerogative to open the vial even for one child in order to maximize vaccination coverage. This discretionary power is often abused and enables vaccinators to benefit in two ways; on the one hand, it enables

them to meet targets while on the other, it also facilitates them in making additional money by selling vaccination vials in the market, particularly to private nursing homes and hospitals. The field staff mandated with an oversight role often lets such things go unnoticed because of the same oversight/incentive patterns referred to above and demonstrated in Figure

Patterns of deliberate inattention to oversight can be commonly seen in publicly financed health systems where oversight of field operations is necessary.

Examples can also be cited from other public health programs that necessitate field activities. For example in the TB DOTS program of the Ministry of Health, the DOTS monitoring visits can be forged to draw false travel allowances. Abuse of power to draw travel allowances is widely reported at all levels. In the health sector in particular collusion with the pharmaceutical industry enables decision makers to get trips sponsored while they still get to charge these to government and pocket the difference.

2.2.5.d.i.ii Publicly financed systems where services are delivered out of facilities (BHUs and hospitals and various levels)

Publicly financed service delivery mechanisms of the Ministry of Health and the Federal level and the department of health in provinces (BHUs, RHCs and hospitals at secondary and tertiary level) are plagued with similar malpractices as the ones described in the example above. Corruption in service delivery has its root in the existence of an active and unregulated private sector in health and the imbalance it creates in terms of the differences in remuneration and incentives – public vis-à-vis the private sector. Low salaries manifest themselves in the form of informal payments, absenteeism, theft and other individual coping strategies and a range of unethical health provider behaviors, which are exacerbated by absence of regulatory controls and quality assurance mechanisms in the country. These are also symptomatic of bad management and are a reflection of absence of accountability. These malpractices include staff absenteeism, dual job holding, unethical behaviors in service delivery and patient care, theft of supplies and procurement and contracting frauds. Of these the latter two have been described under operational decision making.

Staff absenteeism and dual job holding: staff absenteeism and dual job holding is one of the most serious issues within public health facilities in Pakistan; whereas dual job holding

is ubiquitous, staff absenteeism is relatively more common in rural and remote urban settings where a certain level of oversight cannot be maintained such as in BHUs and RHCs. Absenteeism undermines service delivery and leads to closed/under utilized public health facilities, which in turn undermines the equity objective of publicly financed health care. It also undermines the quality of health care across the board by relying on ill-trained providers for care and under investing in the quality of future providers. In a minority of cases, absenteeism is unavoidable; for example, rural health workers often need to travel to larger

**Informal payments,
absenteeism, theft and
unethical health provider
behaviors are symptomatic
of bad management and are
a reflection of absence of
accountability.**

towns to receive their payments, fetch supplies or drugs and are sometimes delayed by poor infrastructure or weather. However in most cases absences are frequently motivated by responsibilities at a second job. Other than absenteeism there are also other staffing issues that can undermine productivity at public health facilities. For example, lower productivity can occur through shaving off hours, late arrival and early departure, and frequent and long breaks – a pattern commonly seen in hospitals. Ghost workers are common to areas with limited oversight however the practice is also prevalent in areas where layers of oversight exist but where institutionalized corrupt practices enable others to benefit from absences by sharing their salaries (Figure 5). Often ghost workers do not exist within the public system, whereas in other cases, they get placed as personal staff to reporting officers and others higher up in the hierarchal chain. Hospital gardeners, air-conditioner cleaners and other class four employees are abused by their seniors and are made to work at home.

Unauthorized payments: informal payment is defined as a payment to individual and/or institutional providers, in kind or in cash, that is made outside official payment channels or are purchases meant to be covered by health care systems. This encompasses ‘envelope’ payments to physicians and ‘contributions’ to hospitals as well as the value of medical supplies purchased by patients and drugs obtained from private pharmacies but intended to be part of government-financed health services.” More specifically they are under-the-table payments to doctors, nurses and other medical staff for jumping the queue, receiving better

or more care, obtaining drugs, or just simply for any care at all.⁴⁵ The findings of the study corroborate the evidence, which has been referred to earlier in terms of informal payments being common in Pakistan.

Various patterns of informal payments are known to exist; as opposed to the commonly described pattern in other developing countries, which usually involve a petty bribe for accessing healthcare, unauthorized payments in Pakistan usually involve many other forms. The commonest involves record falsifying by administrative staff to enable cushioning of incentives by underreporting entries. This pattern can largely be attributed to lack of automated systems given that manual records are more readily exploitable through dual ledgers.

A 1400 bedded tertiary care hospital in a cosmopolitan provincial capital city of Pakistan with a daily out patient turnover of three thousand previously had a manual method of record keeping, which was widely exploited by the staff. Record falsification enabled cushioning of incentives by underreporting entries as well as by many other sinister means such as by granting false alibis to convicted criminals. Therefore, attempts to computerize outpatient records were deeply resisted by the clerical staff, to the extent that the system was sabotaged. However, despite that the hospital administration was strong willed to implement the program and once it was installed the results were very encouraging in terms of increased revenue and enhanced efficiency.

Lack of automated processes also opens avenues for petty corruption and unauthorized payments in many other areas; an example of this is the opportunity that this creates for medical supplies to be ordered by hospital staff that are intended to be part of government health services.

These practices are prevalent in operation theaters where tracking of supplies delivered by family to the requisite staff inside the theater is virtually impossible. In one particular incident in a newly constructed tertiary care hospital the theatre administration was maintaining two receipt books and two cash registers to facilitate this process.

In this form of unauthorized payment, the patient gets to pay for a commodity that is meant to be covered by the hospital through government revenues; the hospital staff sells the supplies back in the market while using pre-marked hospital supplies.

Health care provider's behaviors: various dimensions of unethical practices on the part of health care providers have been alluded to in several sections of this report. This section refers to unethical practices in patient care. This category includes a number of characteristic patterns related to the behavior of doctors generally and specialist doctors in particular. Foremost is the use of public job leverage to boost private practices and private health facilities.

45. Lewis M. Informal Health Payments in Central and Eastern Europe and the Former Soviet Union: Issues, Trends and Policy Implications. In *Funding Health Care: Option for Europe*. Figure and Moussiales (eds). Buckingham: Open University Press, 2002.

The commonest form of unethical payment involves record falsifying by administrative staff to enable cushioning of incentives by underreporting entries in hospital outpatient records.

A number of unethical practices such as refusing to see patients in hospitals and referring them to private clinics are well established and are almost regarded as a conventional norm. In most leading premier public sector hospitals a specialist's clinic prescription is the ticket to a hospital bed – a phenomena resident staff is familiar with.

These practices exist despite the existence of a law on private practice and while some of the doctors also draw what is labeled as a non-practicing allowance on their salary slips.

Unethical practices in prescribing and choosing diagnostic options for patients are also well described. Most of these stem from incentive structures that are either created by unethical marketing practices of the pharmaceutical sector or the incentives that the market enables the provider to generate by subscribing to certain choices in prescribing medicine and choosing diagnostic procedures. The former has been alluded to on the section of unethical marketing. With reference to the latter it has been a frequent observation that public sector employed specialists set up organized diagnostic services frequently across the street from hospitals. There are anecdotal reports of incidences where the management of public facilities deliberately impedes certain tests since these are offered at private facilities across the street.

A publicly owned MRI machine, the only one in a provincial capital, was known to be out of order for a year. A similar private sector owned machine within the radius of one mile, serviced by the same vendor operated by the same radiologist continued to provide services. Given that the radiologist in the public sector also owned the private facility, it can be assumed that lack of attention to maintenance was deliberate.

It has also been reported that commission based incentives generated from prearranged diagnostic facilities enables private providers to supplement their income.

A laboratory in a cosmopolitan provincial capital offers 10-30% in payback to the doctor referring patients for tests to the private laboratory, depending on the rupee value of the test recommended. The staff stated that it is imperative to be competitive in a market where such practices are commonplace.

These practices are not confined to specialist doctors but are also ingrained at all levels of the health delivery system. Similar incentives are also given by chemists and retailers to doctors in order to prescribe certain choices. The pharmaceutical sector is often party to such arrangements.

Malpractices of non-qualified health care providers who pass themselves as qualified and provide services that they are not qualified to provide, for a cost, dominate healthcare delivery in the peri-urban and rural areas in the country; technicians, paramedics and females health worker quacks are known to provide services they are not legally meant to and often impersonate doctors. Unfortunately there are gaps in regulating such practices and no attempts have been made to date, to mainstream their role into the delivery of care by accrediting them to provide some services, which on the one hand can be safe for them to deliver and on the other hand, can serve as enough of an incentive for them to stay away from the delivery of other services.

Commission based incentives generated from prearranged diagnostic facilities and retailers enables health providers to supplement their income.

Theft of supplies: in hospitals, varying quantities of drugs and medical supplies are often stolen from central stores enroute to the final distribution channel in individual facilities and are diverted for resale for personal gain in private practices or in the black market. The selling back of drugs and supplies that are procured through public money back into the market is also well established. There have been instances reported of entire consignments diverted to the black market despite their being pre-marked for government use. A thriving market in a non-settled area of Pakistan enables the selling back of complete trucks of medication into the black market, where wholesalers and retailers transact business.

This is a result of a variety of institutionalized practices which involves record falsification, dispensing drugs to 'ghost patients', graft and padding of bills, clever book keeping, overpayment for supplies, over-invoicing and over payments or simply pocketing the patient's payment. The administration perceives the use of pre marked packages for government use a deterrent against these practices. However staff gets around these issues in a variety of innovative ways such as selling them back to wholesalers.

Other forms of abuse and theft as a result of inefficient management and monitoring capacity are also well described; e.g. supplies do not meet expected standards, or they are only partially delivered or not delivered at all, or sell low quality, expired, counterfeit and harmful drugs at cheaper prices.

In addition to bulk theft, petty theft of medicines and supplies occurs within the dissemination channels in hospitals; this occurs en route from central stores to the ward. Since it is up to the nursing staff's discretion to dispense it to patients, the absence of supply and consumption inventories in most hospitals allows manual handling of goods with commercial value open to exploitation.

Theft is particularly common in cases of items that have a commercial value that are provided free to the hospital.

In the radiology department of a secondary care hospital, a seamless system of pilfering x-ray films exists; publicly employed radiology technicians, use stolen x-ray films in their private practices and subsequently deposit the films back for proof of use, as the latter is a requirement to ensure that value added items are indeed used in the government run hospital.

Pre marked drug packages intended for government use are sometimes sold back to wholesalers as they cannot be sold to retailers.

Management of illicit Resource: the afore-stated malpractices in publicly financed systems lead to pilfering of resources from the state system to benefit a range of stakeholders. The section on malpractices in procurements (page ..) has alluded to the existence of a parallel system or mafia which manages the pooling and sharing of these resources in a 'coordinated' manner. The section has also described the existence of 'funds' through which these illicit resources are channeled and referred to one of the connotations used for such a fund – kitty fund. The kitty fund and its namesakes also have several other sources of contributions in addition to procurement related pilferages described earlier (Figure 6).

In hospitals resources generated from forged medicolegal cases and percentage of salaries of staff 'allowed' to be absent from duty are also added to this. In addition to established percentages according to which funds are distributed from the kitty fund to a number of pre-determined stakeholders, the kitty fund is also used for emergency purposes such as paying off an unexpected auditor or visitor. One participant even commented that there is an established but unwritten 'kitty-code' analogous to the Government of Pakistan's esta-

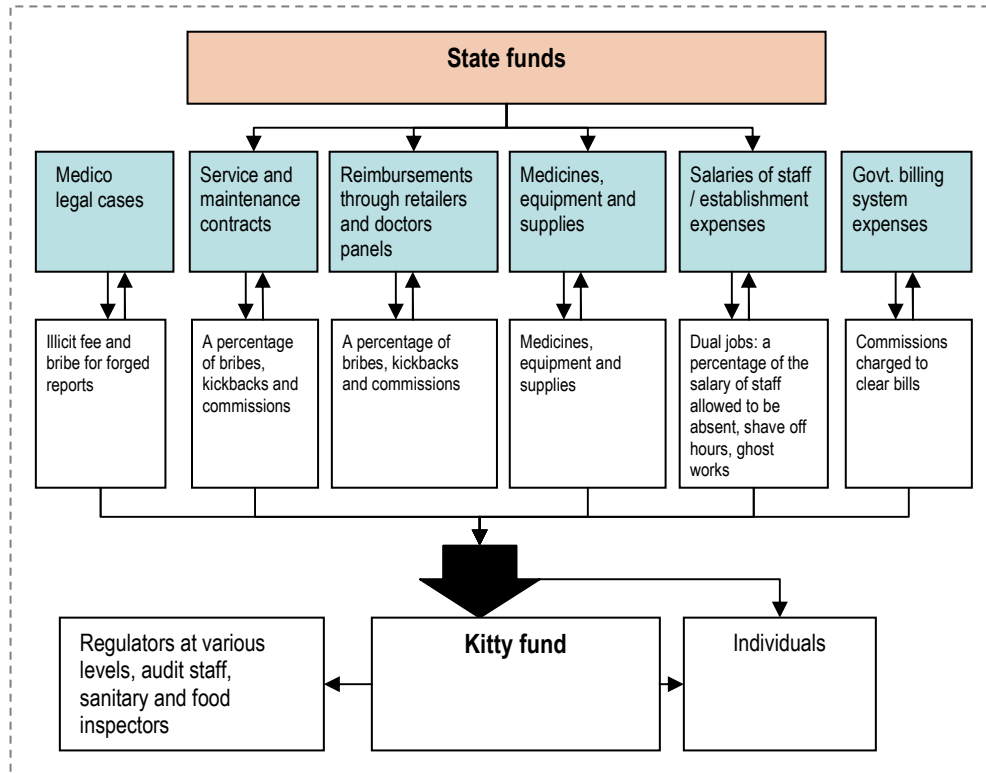
code⁴⁶ It is interesting to note that the same accounts officer manages both the public as well as the kitty fund.

A parallel system or mafia, manages the pooling and sharing of pilfered resources in a 'coordinated' manner and ensures their dissemination to stakeholders according to agreed percentages as commissions

Kitty funds also receive contributions from a number of other sources depending on the health financing mechanism in a facility. Procurement embezzlement in local purchase is one of these sources; local purchase is a system of procurements in hospitals that enable purchases on a day to day basis in the case of certain pressing needs. Commissions in this case are sometimes fixed for the whole year with the supply agency and in other cases are based on the actual volume of medicines and other supplies purchased. Local purchase is also used as a tool by administrative authorities to abuse the procurement channel for personal items. In addition to in-kind gains, part of the pilfered resources also get pocketed by individuals in cash and it is difficult to draw separating lines between what does and does not get channeled into kitty funds. The discrepancies in items requested vis-à-vis supply are usually not traceable in systems because of manual/dual record keeping. This forms the basis of strong recommendations later on in this document to institutionalize electronic supply inventories

⁴⁶ Esta Code or the **Civil Establishment code of Pakistan** is a compendium of laws, rules and regulations and instructions relating to the terms and conditions of federal civil servants of Pakistan

Figure 6: Sources of contribution to the 'kitty fund'



Another source of contribution to the kitty fund is through reimbursements. A number of parastatal agencies operate in Pakistan. These provide health cover to a large number of employees by reimbursing predetermined health providers 'on their panel' for services rendered and retail outlets for medication provided as per the prescription; Pakistan has 30 parastatal agencies,⁴⁷ which provide health cover to an estimated 25 million employees and their dependants. In this model parastatal agencies and other corporations usually have contracts with retail stores, to whom they give supply orders against which regular payments are made. This system is abused at various levels – by doctors charging a fee for writing fake prescriptions, issuing parchis for a price to fake patients or by retailers charging a commission for processing them by buying the prescription from the patients at the percentage of its cost. It is conventional to buy the prescription at 20% of its cost and distribute the rest amongst those involved in awarding contracts. Again these funds usually channel to a range of beneficiaries through kitty funds or get pocketed individually.

Another source of corruption which makes a contribution to the kitty fund in this chain can be through the process of the government billing system as commissions and percentages

47 WAPDA, PTCL, SNGPL, SSGPL, Pakistan Railways, Fauji Foundation, Insurance companies, ESSI, NHA, PIA, OGDCL etc.

are sometimes charged by officers in the finance and accounts departments to clear bills that are presented by suppliers. However the occurrence of this is dependant on the integrity of the officer in charge because in the absence of his 'patronage' these malpractices become very difficult. The commissions levied may or may not get diverted through kitty funds.

In summary, it is difficult to prove the existence of a kitty fund and map its sources of contribution or the dissemination channels, as such funds do not leave a paper trail. In any case there is enough anecdotal evidence of their existence to look at structured ways of breaking this vicious institutional cycle. The recommendations articulated in this report aim to address these through a two-pronged approach: enabling the factoring in of adequate incentives for administration with some level of accountability and coercive action, on the one hand whereas on the other, the leveraging technology as a deterrent against the exploitation of manual record keeping and tracking systems.

2.2.5.d.ii Regulation to correct market failure

The government uses a range of regulatory strategies to correct market failures; most of these involve administrative and bureaucratic control excised directly from the government Ministry of Health and the departments of health. Recently there have been attempts to create regulatory authorities; a health regulatory authority has been created in NWFP presumably on the premise that the normative and regulatory arms of the government should be separated. However it is yet to initialize systematic action within the several regulatory domains it should be mandated with. Similarly work was previously initialized to create a Drug Regulatory Authority, which unfortunately does not appear to be making significant headway.

The only market harnessing method that has been employed for sometime in Pakistan is self regulation in the area of licensing, recognizing and accreditation of health professionals by various professional associations. These include the Pakistan Medical and Dental Council (PMDC), Pakistan Nursing Council (PNC) and the Pakistan Pharmacists Council (PPC). More recently the government has used contracting as a means of regulating the delivery of services at the primary health care level.

In this report, the current patterns of corrupt practices in regulation are described under the domains of service delivery by the private sector, regulation of health related human resource and regulation of pharmaceuticals.

2.2.5.d.ii.i Regulation of service delivery in the private sector

The private health sector – defined as providers and suppliers of health inputs outside the government sector – includes both for-profit providers and NGOs. The sector constitutes a diverse group of doctors, nurses, pharmacists, traditional healers, drug vendors, as well as laboratory technicians, shopkeepers and unqualified practitioners. The services they provide include hospitals, nursing homes, maternity clinics, clinics run by doctors, nurses, midwives, paramedical workers, diagnostic facilities and the sale of drugs from pharmacies and

unqualified sellers. However, in some cases, the distinction between public and private sectors is not very clear as many public sector practitioners also practice privately – legally or illegally. The sector is fragmented and is characterized by a mixed ownership pattern, many types of providers and different systems of medicine. Despite its mammoth size, the private sector has remained poorly regulated in Pakistan. As a result, most facilities have been established to provide a living or profits to the owner and facilities seem to make a high return on investments given that there is no incentive or disincentive for ensuring or not ensuring optimal quality of service.

This, coupled with limited accountability of the professional community manifests itself in a number of malpractices: with notable exceptions, hospitals, nursing homes and clinics in Pakistan do not follow facility design standards and the high cost of building a hospital almost always leads to a tradeoff between quality and costs resulting in inadequate clinical and support services in the case of most hospitals and nursing homes. Exceptions notwithstanding, private clinics are often set up in unhygienic environments and employ rudimentary medical technology; additionally, the ownership patterns characterized by sole proprietorships or partnerships (amongst doctors) usually do not have enough leverage to establish multidisciplinary facilities with optimal technological backup. Once facilities have been established, no formal mechanism exists to ensure continued quality of care through yearly or biennial inspections by local health authorities. As a result issues related to provider-driven over-consumption of health services, over-prescription, and over-use of diagnostics are well known in relation to professional practices.⁴⁸

In order to address these practices, a multi pronged approach is needed; central to it is the creation of an independent regulatory mechanism that focuses on quality of care and mechanisms for regulation of service delivery by the private sector. However this would be a challenge in itself given that the current regulatory models in the public sector have consistently proven to be facilitating for corrupt practices to flourish, as evidenced by examples cited under publicly financed health systems.

Furthermore, it must also be recognized that the current models of restructuring the mode of public service delivery usually warrant a role for the private sector. Here enhancing vigilance either in the existing system through tightening bureaucratic control will have limited impact to the existing incentive structures. On the other hand it is plausible to use market harness methods for improving service delivery at this level, for example through the use of contractual relationships with non-state and private sector actors, which can replace the integrated model of public financing and provision of services, which warrant a command and control form of regulation.

48 Private sector health care, in: Nishtar S. The Gateway Paper, Health Systems in Pakistan; a Way Forward. Islamabad Pakistan: Heartfile; 2007. Page 83

Corruption in the contracting process for health service delivery at a primary healthcare level or for outsourcing support and maintenance services in hospitals can involve the same patterns of collusion as for procurement contracting.

Corruption in the contracting process for health service delivery at a primary healthcare level (as in the case of BHUs) or for outsourcing support and maintenance services in hospitals (e.g. cafeteria and laundry) can involve the same patterns of collusion as for procurement contracting. Recently, as part of several NGO collaborative initiatives, the government of Punjab initially and subsequently other provincial governments under the President of Pakistan's directive have decided in principal to contract out clinical services and facility management of Basic Health Units and Rural Health Centers to the private sector.⁴⁹ Although in principle this is in line with the need to reconfigure the mode of health service delivery in the country, an important caveat here is that this may open a potential avenue for nepotism and preferential treatment. Lack of transparency in contracting arrangements, price negotiations and failure to safeguard the interests of the poor and failure to uphold the implementation of guidelines on ethical and administrative matters can compound access and affordability issues rather than obviate them. Therefore, there is a need to establish guidelines on ethical and administrative matters and develop sample contracts and terms for price negotiations and mechanisms to safeguard public health interest. It is also important to strengthen community oversight of these contractual relationships through organizational community levers and civil society groups such as in the case of the Community Citizen Boards, wherever they are functioning.

2.2.5.d.ii.ii Regulation of health related human resource

Pakistan has delegated regulation of health related human resource and medical staff to professional organizations. Doctors and dentist are under the regulatory control of the Pakistan Medical and Dental Council (PMDC), human resource issues relevant to nurses are governed by the Pakistan Nursing Council (PNC) and regulatory authority of relevance to paramedics and pharmacists is delegated to Pakistan Pharmacists Council (PPC) whereas

49 Nishtar S. Rahim Yar Khan Revisited. The NEWS International: August 6, 2006. accessible at <http://heartfile.org/viewpoint.htm> (last accessed November 19, 07)

practitioners of traditional medicine come under the preview of the National Council of Tibb and Homeopathy. These organizations provide oversight and exercise control over a number of different attributes through peer/self regulation. In addition to professional licensing and recognition of training, they also grant permissions to establish training facilities of relevance to the related discipline and set standards and norms of individual and institutional behavior, ensure compliance with standards and stipulate the number of students entering medical schools; in certain cases they also exercise control over salary levels, remuneration and other benefits. In theory this form of self regulation holds merit because staff that is well qualified to assess performance is involved in monitoring. However, this also opens many avenues for exploitability and malpractice at various levels.

‘Regulatory capture’ which can result in it being self-serving and defending individual members.

Firstly, self regulation can fall prey to ‘regulatory capture’ which can result in it being self-serving and defending individual members. In Pakistan we see that the PMDC does not for instance, adequately publicized malpractice cases in order to protect the profession, does not take due action against doctors who are party to promote hospitality-based-incentive-intense-marketing practices and has largely been silent on disciplinary action on infringements on the code of ethics; the most recent example of this is their relative silence on the illegal kidney transplantation saga. PMDC also fails to provide proactive monitoring of activities of professionals including their failure to curb quack medicine. In addition, their silence on the issue of dual practice of public physicians is also of concern, which has often led to failed coercive action by governments and to the exodus of the best doctors in the public sector, as was the case in NWFP in the year 2002.

Another form of regulatory capture, related nepotism and cronyism is reflected in the manner in which PMDC has led to the growth of private medical schools and handing over of public hospitals to private medical schools without due regard to quality. Moreover, the level of controls that regulatory authorities have over discretionary decision making in the absence of participatory and independent governance opens an avenue for exploiting a public office for private gain by granting permissions to open school, upscale the number of students entering a school and recognized institutes. This pattern of self regulation can be improved and made more transparent by fostering transparent and true independent representation in governance, by fostering an open information and disclosure policy and through expanding the role of consumer voice and by creating a mechanism of redress.

2.2.5.d.ii.iii Regulation of medicines and pharmaceuticals:

Corrupt practices in the regulation of medicines chain can involve registration, price setting, production, wholesaling, and retailing, licensing pharmacies, marketing and procurements.

The public and the private sector are usually both party to promoting such practices. The latter two – marketing and procurements – have been discussed in separate sections. Corruptive practices of relevance to the other areas mentioned can be considered within the rubric of product and quality regulation, price regulation and Intellectual Property Rights (IPR) and patent regulation. Here it must be recognized that there are many gaps in the stated areas, which have to do with weaknesses of the law, capacity constraints to implement the law and other issues with implementation in these areas; these are not within the scope of the present discussion and have been alluded to separately. Here the focus will be on corruptive practices only.

In the area of product and quality regulation, approval and registration of drugs and granting of manufacturing and marketing licenses, opens an avenue of corruption through bribes. Corruption in the sector has its roots in the commercial interests of the non-bonafide pharmaceutical companies, who find compliance with regulations affecting drug licensing, accreditation and approvals costly and try and bribe and influence regulators to get their product registered, speed up the approval process, get favorable prices or to have their drugs included on the essential drug list in order to increase their market share.

Pakistan has 411 local and 30 multinational companies, which produce 125 categories of medicines. Although most of these bonafide companies comply with the standards of quality, there are many backstreet production facilities, which are known to generate counterfeit, misbranded, spurious and adulterated drugs in the market. Pakistan is amongst the 13 countries where manufacturing of fake medicines has consistently displayed an ascending trend. The saga of suo moto action against spurious drugs by the Supreme Court of Pakistan in 2006 brought some of these issues into the limelight – allegations of 50% of the drugs being fake were banal, notwithstanding, the market for spurious drugs is large in the country – lending impetus to some level of strengthening of regulatory controls through inspections.

Here it must be recognized that regulation to deal with spurious drugs manufacture as well as related regulatory measures to ensure mandatory GMP compliance, overseeing the conduct of clinical trials, ensuring the incorporation of Good Clinical Practices (GCP) protocols and strict accordance to ethics are essential components of quality regulation. These ensure compliance with the stipulations of the quality assurance mechanism established under the Drug Act of 1976. Compliance with these standards is usually ensured through the process of inspections; and it is here that the most critical gap lies because the process of inspections is fraught with institutionalized corruption through a systematically structured system of bribes, many of which are given on a monthly basis. The stakeholder to be regulated creates incentives for inspectors to overlook corrupt practices and impede accountability. Incentives are shared in the regulatory chain as has been shown for the example cited in Fig 6.

At a retail level, regulatory corruption enables chemist's shops and retailers to operate with illegal and fake licenses to sell in the absence of warranty of purchase of all products. Gaps in the sale purchase record of all products, inadequate storage practices at outlets and the absence of unqualified personnel at outlets has also been described as a result of lack of

transparent regulation. Because of the higher profit margins, retailers also buy drugs from the black market; Pakistan has a vibrant black market for drugs because of its proximity with the landlocked Afghanistan, which creates an opportunity for medicines supposedly enroute to Afghanistan under transit trade agreements to be sold into the Pakistani territory, where a much larger market exists.

In addition the exponential growth of the pharmaceutical manufacturing sector in India and the cross border movement of drugs make low priced drugs available in the black market in Pakistan. Many a times these are indistinguishable from licensed drugs and enable retailers to earn a higher profit margin.

Malpractices in other regulatory aspects of the medicines chain also lend impetus to the availability of spurious drugs such as lack of attention to oversight over resale of local/imported and second hand machinery and regulatory stipulations relating to raw material sale and purchase in the market.

Retailers and wholesalers also act together to create shortages of drugs in the market. Shortages of drugs have various causes, some of which are genuine and some are true supply and demand related; a discussion of these is outside of the scope of the present document, but these have been reported elsewhere by the author.⁵⁰ However it is also well known that wholesalers create artificial shortages so as to get a price increase or to maximize profit margins. The latter is evidenced by the shortage of I/V grade dextrose which is created in the market every summer with the advent of the diarrhea season

Similarly the process of price regulation can be fraught with procedural inaccuracies in granting prices so as to benefit the commercial sector in lieu of incentives for the regulator/regulating agency. Setting prices of medicines on the basis of the price of raw material creates an avenue for collusion in the form of over invoicing of imported raw material price. Furthermore the wide discrepancy between the retail prices of some drugs in the market and the prices of the same quoted to the government, which cannot be accounted for by bulk purchase subsidy, raises concerns about the profit margins on existing prices.

A 30 tablet (10 mg) pack of anti-hypertensive medication is available for Pak. Rs. 118 in the market as opposed to it being made available to the government in bulk procurement at Rs. 13.5 per for the same size and strength. From this pattern it can be inferred that either the profit margin of these drugs is very large or substandard medications are being supplied to the government in pre-marked packages. Part of the profit margin that companies make are channeled for unethical marketing practices whereas over payments feed commissions, which fuel individual pockets and the kitty fund referred to earlier.

The third area of regulation relates to IPR and patent regulation. Pakistan is a signatory to the Agreement on TRIPS and has promulgated the Patents Ordinance 2000 to comply with

⁵⁰ Nishtar S. Pharmaceuticals--strategic considerations in health reforms in Pakistan. J Pak Med Assoc. 2006 Dec;56(12 Suppl 4):S100-11.

its requirements. Under TRIPS the duration of patent protection has been increased from 16 to 21 years and it is perceived that strong patent protection could mean higher prices of drugs. Stronger controls on prices and narrowing of opportunity for local manufacturers who compete for market share of generics that are already in their maturity phase could mean a worsening of the existing lack of transparency, against which safeguards must be built.

In view of the prevailing potential of exploitability in this system, the government has created a Drug Regulatory Authority to address lack of efficiency and transparency in regulation; however the success of this regulatory entity depends on a number of factors, which have been discussed in this, the section on mitigates.

The process of drug inspections is fraught with institutionalized corruption through a systematically structured system of bribes, many of which are given on a monthly basis.

2.2.5.e Unethical marketing:

In Pakistan, more than 440 pharmaceutical companies manufacture almost 30,000 brands of different medicines and some molecules have over 100 brands in the market. Such competition often leads to aggressive marketing strategies, which can involve unethical promotion of medicines or to conflicts of interest that influence a physician's judgment.

The doctor-industry relationship is ubiquitous in Pakistan as it is anywhere else in the world. This relationship falls on a spectrum; on one end of the spectrum, interactions range from the innocuous practice of doctors being given drug samples by manufacturing representatives, receiving food at their work place and receiving reimbursements for costs associated with professional meetings and continuing medical education to receiving payments for speaking or enrolling patients in a trial. Clearly such relationships between physicians and industry can have some positive effects on patient care but can also have serious negative effects; for example doctors with close ties to the industry maybe more inclined than their colleagues to prescribe a brand name drug despite the variability of a cheaper generic version. It may also stimulate the premature adoption of novel treatments which could lead to serious health problems and could reduce physicians adherence to evidence based practice guidelines in favor of company medications.

However, on the other end of the spectrum there are many other unethical patterns of marketing practices, which are certain to create a conflict of interest. Under the influence of unethical incentives offered by pharmaceutical firms, doctors are known to prescribe medicines without due consideration for appropriateness of need, socio-economic status of the patient or the quality of medicines; it is this hospitality-based incentive-intense marketing that adversely affects medical practice and treatment decisions of physicians.⁵¹

In recent years, marketing and hospitality has been redefined by pharmaceutical companies in countries such as Pakistan, where local regulations are exploitable and regulatory capacity is weak to implement the international code of marketing practices. Examples of such practices include providing items of personal use to doctor's residences such as expensive electrical appliances, paying for trips abroad along with their families, picking up the cost of weddings and cash incentives. Some pharmaceutical companies have also blatantly developed a system of commissions as cash and in kind incentives based on the number of prescribed drugs of particular brand; notable doctors are enrolled in such programs and reputable chemist's shops are partner to record keeping and channeling commissions.

The ultimate outcome of all these practices are either higher price for purchased medicine and/or compromised quality.

3. Framework for Action and Implementation – the action plan

Corruption within a sector is not a phenomenon in isolation; but a manifestation of a broader systems phenomenon involving a certain level of state capture; a comprehensive anti-corruption reform therefore has to address the determinants of state capture which are rooted in weak capacity of state institutions along with lack of control and accountability; vested economic interests and private interests of powerful politicians; close ties between economic interests and political institutions and a nascent civil society.

A serious anti-corruption policy depends upon a detailed understanding of the particular nature of the political, economic and social landscape of the country, the level of state capture or administrative corruption and the interaction between these two forms of corruption. It warrants actions at three levels – political will, collective action and leveraging technical knowledge and practical action.

A comprehensive anticorruption agenda in the health sector also requires mandates and prerogatives both within but more importantly outside the health sector and has to go beyond the traditional technocratic approach focused on administrative reform of the civil

51 Nishtar S. The Gateway Paper: Health Systems in Pakistan – a Way Forward. Islamabad, Pakistan: Heartfile, 2006.

services to address issues related to structural reform of political institutions and judicial and prosecutorial reforms; this entails investments in building institutional mechanisms of political oversight, rejuvenating the civil society and opening up the media, albeit with ethical safeguards. In addition it must also be recognized that economic reforms can be one of the most powerful anti-corruption strategies; by promoting competition and market entry, it can enable a vibrant sector of small and medium enterprise to weaken the concentration of economic interests promoting state capture and through liberalizing measures to reduce bureaucratic discretion in the economy.

A careful analysis of the current situation in Pakistan reveals a number of challenges in these areas. Structural reform of political institutions appears unlikely over the short term, as most political parties are either cult or clan-based or are embedded in extreme religious ideologies. Most of them are controlled either by influential circles or mafia like groups, which have considerable capacity to infiltrate and influence the establishment. The contemporaneous potential for exploitability, which is created by Pakistan's current geo-strategic vulnerability and the vested economic interests of political parties mean that structural reform of political institutions in Pakistan may not be a realistic expectation, at least in the short term. This is clearly a significant impediment to anti-corruption work in any area. Moreover, previous efforts to grant the media freedom of expression and the seemingly up beat role of judiciary now seems to have come to a halt in view of the current political crisis in the country. In addition, the National Reconciliation Ordinance has created a set back for the work of the National Accountability Bureau and the importance of the Ehtesab Ordinance and many new statutory regulations with reference to eth role of the media and civil liberties mean lesser opportunity for freedom of expression and participation, which are an essential pillar of anti-corruption work.^{52,53} Furthermore, the envisaged change of government subsequent to the election in 2008 mean that some of the policies aimed at streamlining financial management and mainstreaming transparency reform – their weaknesses and issues with implementation, notwithstanding – as in the procurement arena may not be sustained. These over arching realities will significantly hamper anti-corruption reform in the technical and administrative domains. Notwithstanding, the following considerations merit careful attention in terms of an anti-corruption reform of relevance to the social sector in general and health in particular.

Here it should be recognized that corrupt behaviors fall on a spectrum and although it may be difficult to categorize them, it is useful to draw a distinction between the two forms of corruption from the point of view of the feasibility of anti-corruption reform in Pakistan. On one end of the spectrum are corrupt practices, which fall in the operational/administrative domains; most of these represent individual coping strategies and are relatively, more readily amenable to reform. At the other end of the spectrum, corruption involves a level of state capture, which is rooted in weak capacity of state institutions along with lack of control

52 Government of Pakistan. National Accountability Bureau Ordinance. No XVIII of 1999. Ministry of Law and Parliamentary Affairs; Islamabad, 2000.

53 Government of Pakistan. National Reconciliation Ordinance. Ministry of Law and Parliamentary Affairs; Islamabad, 2007.

and accountability and vested economic interests of the powerful elite. The determinants of state capture are not amenable to reform within an isolated sector.

The first kind of corruption involves a variety of patterns in the operational, administrative and regulatory domains; these range from financial corruption in contracting and procurements where a huge margin exists for building in kickbacks to corruption in many regulatory domains; these include granting permissions, licenses and registrations and monitoring and inspections to ensure compliance with stipulated standards in the domains of quality, price and volume regulation. In these cases, commissions, bribes and deliberate inattention to oversight are endemic and clearly it is not just the public sector which is involved but also the private sector that fuels this practice. This form of corruption also includes the moral, procedural and financial forms of corruption in the delivery of services as in the case of the health, population and education sectors, where discretionary funds can be embezzled, inspectors may be deliberately inattentive to oversight and providers can get by through moonlighting in the private sector, pilfering state funds and charging costs for services that are meant to be provided by the state for free. There can be no condoning these practices, notwithstanding it must be appreciated that many of the above represent individual coping strategies and are economic responses to low incentives in the public system. When a public servant is not paid enough to pay for his utility bills and cover the cost of the children's education, but at the same time has the discretionary authority which enables him to raise money elsewhere, it is only plausible that he will exercise that power. These practices are exacerbated by poor oversight and accountability and ultimately get institutionalized in the system, enabling most of the stakeholders to benefit from them in one way or the other.

There is evidence to show that corruption at this level can be addressed to some extent if attention is paid to three aspects of reform, which strengthens the incentives-performance-accountability nexus. Lessons learnt from police reforms in the federal capital can be instructive in this regard and show that where systems of compensation adequate to sustain appropriate livelihood are set up, and where services generate incentives for performance, it is possible to implement ethical and administrative codes of conduct. The following measures would be needed in this connection:

1. Developing effective and transparent systems for public service. Foremost is the need for institutionalizing integrity in public service. Although integrity is envisaged to be an attitude, there are means of structurally inculcating it such as by developing systems of compensation adequate to sustain appropriate livelihood, systems for transparent hiring and promotion and mechanisms to provide appropriate oversight of discretionary decision-making. In addition regular and timely rotation of assignments can also reduce insularity and reduce corruption.
2. Establishing and implementing ethical and administrative codes of conduct that proscribe prohibitions or restrictions governing conflict of interest, promote transparency through disclosure and ensure that contacts between government officials and business service users are free from undue and improper influence. It is also important to promote ethical

and administrative codes of conduct taking due account of the existing relevant international standards.

3. Developing management tools that safeguard accountability of public service. In addition to effective legal frameworks, management tools include transparent auditing and procurement procedures and systems that promote fiscal transparency and information availability. It is also important to adopt relevant international standards and practices for regulation and supervision of financial institutions. A number of new regulatory institutions have been created to streamline public procurement in Pakistan such as PIPRA and a range of reforms have been institutionalized to streamline financial management and accounting systems. The guidance that these can offer to the health sector should be reviewed and leveraged. Policies should also be able to mitigate collusion in the procurement process.

4. Capitalizing technology for promoting transparency in management and tracking. The use of technology is being increasingly promoted in the health sector; however it must be recognized that its effective use is in the area of establishing systems that can enable and promote greater transparency. For example, electronic national health accounts promote greater transparency in health systems; electronic public expenditure tracking procedures and electronic equipment and supply inventories can track leakages from the system and a nation-wide database for matching staff and wage payments can maintain up-to-date personal records and therefore can assist in eliminating abuses such as paying ghost workers. In addition, drug procurement reforms centered on electronic bidding can promote greater transparency in the process of drug registration and pricing. In addition, establishing and maintaining information systems on prices, quality, volumes, performance of suppliers, etc, that are simple and easy to use can enable the tracking of leakages and discrepancies.

5. Promoting market harnessing methods in regulation using contracting and self regulation; these mitigate reliance on discretionary command and control mechanisms. Some level of success in this approach has been shown in the domain of taxation reforms and needs to be further build upon in other areas, particularly the social sector where governments can leverage markets to deliver services in new models of service delivery. The National Commission for Government Reform can be a good entry point for such reforms, albeit if the government has sustained policy support.

6. Strengthening of local regulations in line with the international code of marketing practices and their enforcement as minimum requirements for the pharmaceutical industry and the medical community to comply with. Other measures should be promoted to check mushrooming of spurious drugs – an area which was significantly in the limelight a year ago with the suo moto action by the Supreme Court of Pakistan. Strict penalties should be implemented for violations of the law which make it possible for spurious drugs to gain access to the market such as fake licenses to sell, duplicate documents, absence of warranty of purchase of all products, gaps in the sale purchase record of all products, inadequate storage practices at outlets, and the absence of unqualified personnel at outlets.

7. Mainstreaming alternative modes of service delivery and financing at a service delivery level. In autonomous hospitals this can be done by strengthening governance and bringing efficient management that is given true administrative and fiscal controls. Service delivery reforms at the basic health care level can increase accountability through management devolution/contracting out and by giving greater fiscal and administrative autonomy. In such arrangements institutional incentives such as the ability to hire and fire the staff and authority to reward performance and discipline, transfer and terminate employees who engage in abuses and the ability to audit can also help counter corruption. With reference to the practice of quackery, coercive regulation is unlikely to be effective and therefore decisions to curb these practices have to be pragmatic and feasible such as by developing approaches to mainstream their role into the delivery of care by accrediting them to provide some services. However, an anticorruption agenda at a health systems level is complex and warrants health system reconfiguration; this goes beyond incentives and has to do with health systems' reforms in a broader sense.

8. Capitalizing the public private nexus to make governance more inclusive and participatory as well as independent and transparent. Governance structures that have private sector participation can help reduce opportunities for corrupt practices. This becomes all the more important as the government moves towards creating regulatory authorities in the new service delivery frameworks that entail a role for the private sector and focus on quality assurance.⁵⁴

However in creating such statutory autonomous bodies a number of questions need to be addressed: how 'autonomous' is 'autonomous'? How 'representative' is the 'governance of autonomous'? What are the 'prerogatives' of 'autonomous governance'? Where are the accountabilities? What kind of 'controls' would state institutions have on this regulatory agency? Who will ensure 'transparency' and according to what 'criteria'? Then again, even if the right ingredients at a governance and representation level are ensured, the regulatory agency ultimately has to operate through the existing implementation arm, which is where the existing field force of inspectors, quality assurance teams and many inefficiencies and procedural malpractices factor-in. In order to mitigate these structural issues, a number of considerations will merit careful attention at the outset. On the one hand, the regulatory agency will have to be appropriately mandated in a role beyond being a clearing house and its governance and management arrangements will have to be made meticulously transparent with broad-based representation so as to obviate commandeering by vested interest groups. On the other hand, the regulatory agency will also have to be appropriately funded so that it can hire staff with appropriate capacity and/or incentive existing staff structures and create an efficient incentives-performance-accountability nexus.

The other kind of corruption – much harder to fight is rooted in state capture, which is a broader phenomenon in policy and decision making, where the laws and regulations of the land are made to favor a select few – usually cronies of powerful with access to the corridors of power. In this form of corruption, decision makers use state resources and leverage for patronage either for personal or institutional gains. In addition to straightforward

54 Nishtar S. Scaffold for the National Health Policy 2007. Heartfile: Islamabad, 2007.

commissions on large transactions, this form of corruption also manifests itself as preferential treatment to well connected individuals. This form of corruption also overlaps with regulatory capture which results in regulation to be self serving.

Here an anticorruption agenda needs to go beyond the traditional technocratic approach focused on administrative reform to a more overarching set of measures to address many issues related to structural reform; this creates a number of policy and institutional imperatives. In the first place, it necessitates reform of political institutions and building mechanisms of oversight. Secondly there is need for judicial and prosecutorial reforms; within this context, the current emphasis to ensure an independent judiciary is well placed, however it must also be ensured that the judiciary is transparent in view of the evidence presented in Transparency International's World Corruption Report of 2007, which focused on corruption in the judicial system. In the third place, there is a greater need to expand the use of consumer voice by creating avenues for seeking redress, rejuvenate the civil society and ensure that the media remains open. In addition it must also be recognized that economic reforms can be one of the most powerful anti-corruption strategies; by promoting competition and market entry, it can enable a vibrant sector of small and medium enterprise to weaken the concentration of economic interests promoting state capture.

In order to implement these approaches, Pakistan needs neither new statutes nor another set of institutional mechanisms. A number of federal and provincial laws exist, including the *Ehtesab* Ordinance 1996. What is greatly required is strengthening of the institutional framework as well as the implementation and application of the existing laws and procedures. Pakistan has faced issues of corruption since its inception and has been attempting to deal with them through various legislative actions. Federally, the Public Servants (Inquiries) Act, 1850, followed by the Prevention of Corruption Act, 1947 and then the Pakistan Penal Code, 1860 (Sections 161-165), all included detailed provisions concerning corruption, bribery and other such offenses by public servants. Provincially legislation complemented federal laws, such as the Sind Prevention of Bribery and Corruption Act, 1950, the West Pakistan Anti-Corruption Establishment Ordinance, 1961, the Punjab Anti-corruption Establishment Rules, 1985. As well as anti-corruption action against public servants, measures were also sought to be applied to holders of public offices, such as members of legislative assemblies, through the Holders of Representative Offices (Punishment for Misconduct) Order, 1977 and Parliament and Provincial Assemblies (Disqualification for Membership) Order, 1977. Subsequently the *Ehtesab* Ordinance was promulgated in 1996. Although this did not present anything new it did contribute in targeting the top ranking bureaucrats and politicians. It was envisaged that this new format may have provided a fresh move forward to address corruption issues with greater force. In term of existing laws, it must be appreciated that the legal framework for dealing with corruption already existed even before the *Ehtesahib* Ordinance, both in substantive and institutional terms. What is greatly required is strengthening of the institutional framework as well as the implementation and application of the existing laws and procedures. However it must be ensured that new laws do not dampen the spirit of existing anti-corruption efforts; in particular the National Reconciliation Ordinance has been a set back to anticorruption work in Pakistan, at least in spirit.

Pakistan also does not need new institutional mechanisms to counter corruption. Several institutional such as the National Accountability Bureau, established through the Ehtesab Ordinance 1996 and the Federal Investigation Agency (FIA) established under the Federal Investigation Agency Act, 1974, exist and must be strengthened further and where needed depoliticized; it is also important that these should not be used as instruments of political exploitation. In addition the Wafaqi Mohtasib (Ombudsman), appointed under the Establishment of the Office of Wafaqi Mohtasib (Ombudsman) Order, 1983, exists and is mandated to identify, investigate, and rectify any injustice done to an individual through maladministration⁵⁵; however it is currently not mandated to deal with corruption. In view of its related role, there is a need to broaden its scope and create closer synergies created between exiting institutional arrangements.

A concerted focus on these arrangements would also enable redressing mis-governance, mismanagement and inefficiencies in addition to corruption as these are deeply inter-woven and failure to address them will continue to mis-target resources and compromise public investments, regardless of the level of economic growth and the increase in fiscal space.

4. Institutionalization and Dissemination

This study has outlined the patterns of corruption in the health sector of Pakistan, which can be extrapolated to other areas as well. However it also underscores the need for further analytical steps as a priority. Firstly, there is a need to put a precise number value on the level of funds misused through additional studies; the methods available for such studies have been alluded to in Table 2; however of these the one that seems most plausible in terms of time and feasibility is economically modeled estimates based on existing commission rates; this can give an estimate of the funds lost through the system. Secondly, the findings of the study should guide the development of indicators relevant to Pakistan. Corruption is a multi-directional concept and a single indicator cannot provide all encompassing measures. Therefore there is a need to exploit the complementarities between indicators and rely on evidence emerging from different indicators rather than relying on one source. However indicators need to be 'action worthy' or in other words able to measure things that are under the control of the policy makers. Such an approach will enable the system to move from opinion surveys (from which data on corruption is generally gathered in Pakistan) and cross country rankings to systematic comparative measurements, which can yield data for advocacy as well as enable the tracking of implementation of anti-corruption policies. For example, tracking adhoc appointments in hospitals can be a proxy measure of the discretionary powers that hospital administrators use to place key individuals in decision makers roles that can enable collusion in contracting and procurements – an area of major fund siphonage.

The project has also taken a number of steps to disseminate findings and to help institutionalize anticorruption measures; key points are summarized below:

⁵⁵ Hassan, T. Corruption and accountability in Pakistan. web-address

Study findings were presented at a National Meeting organized by the National Accountability Bureau on December 8, 2007; the meeting was chaired by the Prime Minister of Pakistan. NAB is a statutory national institutional entity of high visibility which is mandated with anti-corruption work in Pakistan; it was created in 1999 through the promulgation of the *Ehtesab* (accountability Ordinance) 1999. To date, NAB has recovered billions of Rupees and prosecuted many corrupt officials in the past including many renowned politicians and high ranking officials. NAB is yet to begin anti-corruption work in the health sector and the possibility of building further on the work of this project is very strong.

Department of Health of NWFP will release the action plan once the new elected government is in place to garner their commitment subsequent to which some key anticorruption interventions in the electronic systems domain will be developed and institutionalized as a priority

The Health Policy Forum will oversee this process and provide technical support to it over a long term basis; Health Policy forum of Heartfile, advises DoH NWFP on several matters and is currently also drafting the provincial health policy

This study will form the opening chapter of Gateway Paper 111 on health reform – a powerful technical and political tool to place anti-corruption work high on the agenda



Heartfile



Memorandum of Understanding

This Memorandum of Understanding **is between**

Heartfile

The Health Sector Reform Unit, Department of Health, Govt. of NWFP; and
GTZ

on December, 06

on the subject of

Developing collaboration on the program entitled “*Assessing governance for eliminating Corruption in the health sector in Pakistan*” which has received support from the *Partnership for Transparency Fund Support to Civil Society Initiatives for Governance* initiative of *Transparency International*.

The objective of this project is to:

Assess corruption in health facility settings in NWFP in collaboration with the GTZ supported NWFP Health Reform Unit of the Department of Health of NWFP;

Intervene through anticorruption interventions *as may be feasible* during the project duration;

Develop an agreed Action Plan for the NWFP Government Department of Health on an anticorruption strategy within their jurisdiction of authority;
and

Develop and institutionalize anti-corruption assessment and intervention tools.

Both Heartfile and the Health Sector Reform Unit, Department of Health, Govt. of NWFP commit to collaborating in achieving these objectives.

The **roles and responsibilities** of the partners are articulated hereunder:

Heartfile will:

- Take a lead role and anchor the process and be primarily responsible for deliverables as articulated in the project document.
- Provide resource inputs to the assessment and intervention phase as permitted in the project contract agreement with Transparency International.
- Solicit inputs from members of the Health Policy Think Tank/Forum on the strategic Directions.
- Utilize its secretariat to logistically support this process
- Authorize use of Heartfile and Pakistan's Health Policy Forums logos on approved materials.

The Health Sector Reform Unit, Government of NWFP will:

- Facilitate the assessments and intervention in the site of intervention
- Solicit participation of all relevant stakeholders in meetings and provide, logistic support to this activity
- Take a lead role in coordinating meetings; co-host meetings and actively participate in the consultative process
- Obtain concurrence through a consultative processes from all stakeholders
- Authorize use of logo(s) on approved materials
- Institutionalize anti-corruption assessment and intervention tools.
- Institutionalize the Action plan on an anticorruption strategy within their jurisdiction of authority; and

Dr Sania Nishtar, commits to contributing her time voluntarily to lead the consultative process and develop the NWFP health Policy in national interest.

This MOU also expresses the intent of the partners to engage in mutually synergistic activities to advance the common cause of improving health outcomes within the province.

In *witness* whereof, this MOU is signed the day and year first above written



For Heartfile

For GTZ

For the HSRU
NWFP



Memorandum of Understanding

This Memorandum of Understanding is **between**

Heartfile

The Health Sector Reform Unit, Department of Health, Govt. of NWFP; and
GTZ

On

Developing a Health Policy for NWFP based on the Gateway Paper's approach to health systems.

This MOU **builds further** on GTZ and NWFP-Health Reform Unit's participation in the Heartfile-hosted Health Policy Think Tank/Forum, the strategic plan of the Health Policy Think Tank/Forum and its planning meetings held in the first quarter of the 2006, post publication of the Gateway paper and the subsequent discussions between Paul Rückert (Principal Advisor; GTZ), Bernd Appelt (Principal Advisor SHSR; GTZ), Muhammad Javed Khan (Technical Advisor; GTZ, SHSR, NWFP) and Sania Nishtar (President; Heartfile).

The **context** of this stems from the recent publication of the Gateway Paper – the first publication of Pakistan Health Policy Think Tank/Forum which *'articulates the raison d'être for health systems reforms within the country, proposes a direction for reforms and emphasize the need for evidence based approach to reforms'*. The strategy proposed by the Gateway Paper has been recognized as a model for developing a Health Policy in NWFP.

The development of the Health Policy in NWFP is part of the Post-Gateway Paper deliberations to develop a Federal and Provincial Health Policy in congruity, which in addition to its health systems orientation will also clarify federal, provincial and district level roles, responsibilities and prerogatives in health care delivery.

Within this context, the **objective** of this MOU is to develop a Health Policy for NWFP based on the Gateway Paper's approach to health systems.

The **roles and responsibilities** of the partners are articulated hereunder:

Heartfile and the Health Policy Think Tank will:

- Take a lead role and anchor the process of policy development and its consultative process in NWFP. This will involve conducting key informant interviews on the Gateway Paper approach to health systems reform as relevant to NWFP, resourcing, moderating and anchoring consultations/focus group discussions with various stakeholders in the health sector and performing an analytical role.
- Take a lead role in developing the policy framework; this will involve the articulation of a direction for a health systems reform in NWFP and its crystallization in the shape of a policy framework linking-in with the Gateway Paper approach to health systems
- Solicit inputs from members of the Health Policy Think Tank/Forum on the strategic Direction of the Policy framework
- Utilize its secretariat to logistically support this process
- Authorize use of Heartfile and Pakistan's Health Policy Forums logos on approved materials.

The Health Sector Reform Unit, Government of NWFP will:

- Take a lead role in coordinating meetings; co-host meetings and actively participate in the consultative process
- Establish committees comprising of broad based representation mutually agreed between stakeholders in each health systems domain and take proactive measures to mobilize stakeholders
- Solicit participation of all relevant stakeholders in meetings and provide, logistic support to this activity
- Obtain concurrence through a consultative processes from all stakeholders
- Anchor the process of institutionalizing the Health Policy once developed and garner institutional support for the new policy
- Authorize use of logo(s) on approved materials

German Technical Cooperation will:

- Co host meetings and proactively participate in all meetings
- Provide technical support to the consultative process
- Provide expert opinion and counsel all stakeholders whenever required
- Authorize use of logo(s) on approved materials
- Bear the cost of the publication of the deliverables
- Support the logistic costs incurred at the NWFP Health Reform Unit and Heartfile

Dr Sania Nishtar, commits to contributing her time voluntarily to lead the consultative process and develop the NWFP health Policy in national interest.

This MOU also expresses the intent of the partners to engage in mutually synergistic activities to advance the common cause of improving health outcomes within the province.

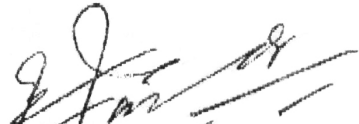
In *witness* whereof, this MOU is signed the day and year first above written



Sania Nishtar FRCP,
Ph.D.
Heartfile



Dr. Bernd Appelt
GTZ-SHSR NWFP



Dr. Hameed Affidi
Deputy Chief HSRU
Department of Health, NWFP

