

## 2 The scale of the problem



Women lie in bed at the Sisters Missionary of Charity Hospital in Port-au-Prince, Haiti, 22 March 2005. (Shaul Schwarz/Getty Images)

While it is impossible to determine the overall costs of corruption in the health sector worldwide, it is evident that it amounts to tens of billions of dollars. Indeed one US estimate of annual earnings from the sale of counterfeit drugs alone puts the annual cost at more than US \$30 billion, which is just the tip of the iceberg of health care corruption.

In this chapter, the World Bank's efforts to track expenditure in health give an indication of costs by tracking how much money dispersed by higher levels of government fails to reach its intended recipients. New data from Central and Eastern Europe finds a strong correlation between perceptions of corruption and an individual's health. A study in the Philippines highlights how local-level corruption undermines health service delivery. The case study on Costa Rica looks higher up in the chain of responsibility for health budgets, and follows the money trail in one of the country's

biggest ever corruption scandals. An example from Mexico shows that corruption can affect not only the volume of resources for health care, but also health policy. The UK's National Health Service claims high returns on its investment in anti-corruption and counter-fraud mechanisms.

The real costs, however, cannot be measured in dollar terms alone. The impact of corruption must also be measured in terms of those people who suffer because they cannot afford brown envelope payments to health care workers (see Chapter 4) and those who are forced to pay far more than they should for hospital services and pharmaceuticals due to rampant corruption (see Chapters 3 and 5). Corruption has a direct negative impact on access and quality of patient care and is one reason why, so often, increased spending on health does not correlate with improved health outcomes.

## Case study: Grand corruption in Costa Rica

*Emilia González (TI Costa Rica)*

Costa Rica has one of the best funded health systems in Latin America. Established in 1941, the Caja Costarricense de Seguro Social (CCSS) has been responsible for providing universal health care coverage since 1961. The health care network comprises five health regions, each with hospitals, clinics, health centres and mobile health units. Costa Rica's health indicators are comparable to those of developed countries and better than any Latin American country with the exception of Cuba. Workers pay 5.5 per cent of their salary in health insurance and employers contribute a further 9.25 per cent.

Given the high cost and the high regard in which the CCSS is held, its fall from grace was therefore steep when reports of maladministration and corruption started to seep into the public domain in 2001. Two congressional party commissions were tasked with looking into the matter. Allegations involved corruption at many different levels, most commonly in the purchase of medical services, often at inflated prices; the procurement of medicines and equipment; the provision of private training courses and medical research; the construction of hospitals; and the management of the CCSS pensions system.

The climax of the scandals came in October 2004 when the public prosecutor accused CCSS head Eliseo Vargas, members of the board of directors, several CCSS managers and former president Rafael Angel Calderón of corruption in the running of the agency. They had allegedly skimmed millions off a US \$39 million Finnish government loan (see Finland country report, page 156).

The loan to modernise hospitals was conditional on Costa Rica using at least half of it to buy Finnish products. The contract was won by Finnish consortium Instrumentarium Corporation Medko Medical and a commission of US \$8.8 million (20 per cent of the value of the loan) was paid to Corporación Fischel, the consortium's Costa Rican representative. It was this commission that found its way into the bank accounts of CCSS directors and senior government officials. The CCSS spent the loan – plus an extra US \$7.5 million of its own funds – on equipment that was not needed.

The money trail was uncovered in October 2003 by journalists who found that the head of CCSS, Eliseo Vargas, was living in a house worth US \$750,000, which had been paid for by Corporación Fischel (see *Global Corruption Report 2005*).<sup>1</sup> Suspecting that the house was payment for a favour, the reporters looked for a possible motive. They found that two years earlier, as head of the ruling party faction in congress, Vargas had pushed through approval of the tied loan from Finland. Vargas now argues that he was assisted – and encouraged – to do so by then president Calderón. The journalists later uncovered a series of bank accounts in Panama, Costa Rica, the United States and the Bahamas through which ‘commissions’ had been paid to politicians and CCSS officials. Vargas and the financial director of Fischel resigned when the news hit the headlines in April 2004.

The Finnish loan was not the first to be called into question. In 1997, a US \$40 million loan by the Spanish government and Banco Bilbao Vizcaya, also to modernise hospitals, was spent on equipment, much of which has never been used. A group of notable experts named by the government to look into the functioning of CCSS requested that the authorities responsible for executing the loan be investigated for paying above-market rates for the equipment and for failing to prepare the hospitals for the equipment to be installed.

Incidents of opaque procurement processes at CCSS are unfortunately not restricted to the use of the two loans. Complaints of systematic corruption have been made in a series of reports and statements by a special legislative commission, the ombudsman, a group of notable experts and users of the health system. CCSS internal audit reports also point to irregularities.

A majority party congressional investigation report published in April 2001 provided evidence of disorganised purchasing – the results of a decentralisation strategy that was supposed to make procurement processes more efficient.<sup>2</sup> The result was a chaotic network of channels through which millions of colones flowed, swelling the accounts of private pharmaceutical companies at the cost of the CCSS, and ultimately the taxpayer. In addition to the monetary costs involved, there were also the associated health costs resulting from delays in getting medicine to the sick and the use of poorer-quality medicines

The various reports into the CCSS note that a common practice at some hospitals was to purchase excessive quantities of medicines not included on the official list of medicines (defined by the WHO as those necessary to counter the principal causes of morbidity). These were purchased under a budget line reserved for medicines needed for uncommon illnesses or exceptional cases, which are not subject to the usual CCSS controls. Another concern is the readiness with which some CCSS doctors accepted trips paid for by pharmaceutical companies. This was the subject of a Supreme Court ruling in January 2004 stating that acceptance of gifts from providers could lead to a loss of confidence in the doctor and therefore could be cited as grounds for lawful dismissal.<sup>3</sup>

Many examples of overpayment for medical services contracted out to private service providers emerged from the investigations. It is difficult, however, to distinguish between poor management and corruption, where doctors – often with one foot in the public

system and the other in private practice – might have unnecessarily contracted out expensive treatments. For example, the CCSS paid a private foundation close to US \$1 million in 2000 for 9,600 minor surgical procedures, 37,000 eye and nose consultations and 322 vitrectomies at a cost per intervention of between 40 per cent and 140 per cent above the cost of CCSS providing the treatment at one of its own clinics. A special congressional commission published a report in May 2001 into the procurement of private medical services and the misuse of CCSS resources through offering excessively cheap teaching facilities to private university students.<sup>4</sup>

The CCSS response to these multiple accusations of maladministration and corruption has been to hire consultants and researchers to come up with new strategic plans and new mission and values statements. Complaints mechanisms have been introduced, and the client has been placed at the forefront of the institution's plans.

But the correctives do not go to the root of the problem. With the exception of the investigation into misuse of the Finnish loan, senior CCSS staff have not been asked to take responsibility for wrongdoing. Few are named in the numerous reports and documents written on the cases, and no administrative, criminal or civil action has been taken to sanction those responsible.

Close ties between the board and directors of the CCSS – many party members hold board-level positions at the CCSS – may have stood in the way of judicial and audit bodies, contributing to a situation where the CCSS functions with virtual impunity, unaccountable to users. There are indications that the close relationship between political parties and the CCSS may have led to conflicts of interest that influenced decision-making. The 1999 budget shows, for example, that more than US \$160 million of CCSS funds was invested in state bonds at a time of dire need for investment to improve health care facilities.

Scandals have erupted before without responsibility being assigned to the officials involved, while civil society watched on impassively. This time, public pressure and media attention is not abating. There is hope that high- and middle-ranking CCSS staff will be held to account and deep reforms will be made to the management, organisation and structure of CCSS, including the introduction of greater accountability and transparency mechanisms to reduce future opportunities for corruption.

## Notes

1. The team of investigative journalists from *La Nación* (Costa Rica) were awarded Transparency International's Journalism for Transparency prize in 2005.
2. Costa Rican Legislative Assembly, 'Informe de Mayoría: Comisión Especial que proceda a analizar la calidad de los servicios, compra de servicios privados, utilización de los recursos de la CCSS para la enseñanza universitaria privada, medicamentos y pensiones' (Majority Report: Special Commission to proceed to analyse the services, purchase of private services, use of CCSS resources for private university teaching, medicines and pensions), File number 13-980, San José, Costa Rica, 26 April 2001.
3. Ruling by the second tribunal of the Supreme Court, Exp: 95-000493-02-LA Res: 2004-00212.
4. A second congressional report co-sponsored by current president Abel Pacheco, a congressman at the time, presented a contrasting view of the CCSS, concluding that: 'There is no legal,

technical, scientific nor strategic reason whatsoever for us to have reservations about the contracting modalities used by CCSS since the end of the 1990s.' See Costa Rican Legislative Assembly, 'Informe de Mayoría: Comisión Especial que proceda a analizar la calidad de los servicios, compra de servicios privados, utilización de los recursos de la CCSS para la enseñanza universitaria privada, medicamentos y pensiones'.

## Measuring corruption in the health sector: what we can learn from public expenditure tracking and service delivery surveys in developing countries

*Magnus Lindelow, Inna Kushnarova and Kai Kaiser<sup>1</sup>*

Most government officials and development practitioners acknowledge that high levels of health spending do not necessarily translate into improved health status. This observation is also borne out by empirical evidence – studies have found that once other factors are controlled for, increased government spending on health is not associated with a reduction in child mortality in cross-country data, at least not in contexts with weak governance.<sup>2</sup> In part, the challenge in transforming resources into improved health outcomes is technical in nature; it concerns the allocation of resources across interventions and programmes, as well as the technical skills of providers responsible for delivering the interventions. The focus of this chapter, however, is on how corruption – defined here as ‘the abuse of public office for private gain’ – can drive a wedge between what is put into the health system, on the one hand, and what it delivers, on the other.

Some of the evidence on the nature and consequences of corruption in the sector comes from perception-based surveys.<sup>3</sup> While these surveys have generated useful insights, the data suffer from many of the same weaknesses that plague perception-based measures of corruption in general. An alternative approach is to try to develop more direct measures of fiscal leakages, including corruption. This has been the aim of a number of recent Public Expenditure Tracking Surveys (PETS), which aim to answer the question: ‘Does public money spent on health and education actually reach frontline health facilities and schools?’ They seek to achieve this by tracking the flow of public resources through various layers of the administrative hierarchy to individual service providers, and by developing quantitative estimates of fiscal leakage – that is, the failure of resources intended for frontline service provider (clinics and hospitals) facilities to reach their intended destination.

The World Bank and other organisations have conducted PETS, almost exclusively in the social sectors, in over two dozen countries, beginning with Uganda’s education sector in 1995 where it was found that 77 per cent of non-wage funds failed to reach schools. This chapter reviews what has been learnt from tracking surveys in the health sector so far. It shows that while many PETS have generated valuable insights, practical and methodological challenges have often made it difficult to develop firm and comprehensive estimates of leakage.

Moreover, once an estimate of leakage has been arrived at, there are challenges interpreting the data, specifically in how to establish the relationship between leakage and corruption. There are two main reasons for this difficulty. First, it is possible that resources were legitimately diverted from their intended purpose towards other ends. All budget systems allow for some flexibility in the resource allocation process: budgets can be changed, allocation rules can be modified or ignored, and so on. This provides government with the flexibility to adjust plans in response to unexpected events and needs, and means that discrepancies between expenditure outcomes and original allocations (leakage) may be both legitimate and desirable.

Second, facilities or lower levels of government may receive less than intended due to problems in the budget execution or resource distribution process. For example, capacity weaknesses and red tape can result in low levels of budget execution, and a broken down vehicle can disrupt the distribution of drugs. A discrepancy between expenditure allocation and outturn may hence be the consequence of delays in the disbursement or distribution of funds rather than evidence of corrupt acts.

With these caveats in mind, what have tracking surveys revealed about leakage in the health sector? As can be seen from the summary in Table 2.1, the focus of the surveys has varied across countries. Some surveys such as those in Ghana, Tanzania and Rwanda – have generated leakage estimates for overall expenditures. For example, the Ghana PETS found that 80 per cent of non-salary funds did not reach health facilities, with most of the leakage arising between central government and the district. Considering that approximately 65 per cent of total health spending (total spending estimated to be about US \$2.24 per capita in 1998) is non-salary recurrent, and assuming that the total of the 35 per cent salary expenditures reached the health facilities, approximately half of the overall amount allocated to clinics and hospitals did not actually reach them. Similar problems were found in Tanzania and Rwanda.

Tracking overall expenditures is often difficult, however. Health facilities typically do not receive a single monthly budget allocation that they proceed to spend and account for. Rather, they receive resources through multiple channels and sources.<sup>4</sup> The upshot of these institutional arrangements is a myriad of complex resource flows, each governed by separate administrative and recording procedures. In each case, there are risks of leakage. Expenditures on drugs and other supplies can leak through the procurement process, or through supplies being stolen, lost or disposed of (such as expired drugs or vaccines) as part of the distribution process. Administrative and logistical procedures tend to be different for other non-salary expenditures, but similar issues arise. Salary budgets can be siphoned off at different levels of government either by simply withholding salary payments, by creating fictitious health workers ('ghosts') and collecting the salaries on their behalf, or by paid staff simply not showing up for work.

Given this complexity, tracking surveys have often been forced to be selective about what resources to track. For example, the survey in Honduras collected individual-level data on 14,454 health professionals, and found that 9.3 per cent did not actually work in the location where they were officially assigned. About a quarter of these individuals

Table 2.1: Overview of findings from Public Expenditure Tracking Surveys in the health sector

<i>Country</i>	<i>Year</i>	<i>Sample</i>	<i>Leakage</i>	<i>Other findings</i>
Ghana <sup>a</sup>	2000	200 facilities; 40 districts	Leakage of non-salary recurrent expenditures is estimated at 80%.	Found greater leakage between centre and district than between district and facility. Service users bear much higher cost than intended primarily due to the non-salary expenditure leakage.
Honduras <sup>b</sup>	2000	805 staff; 35 facilities	2.4% of all workers on the payroll at health facilities considered 'ghosts'.	Absenteeism estimated at 27%. In addition, study found that 5.2% of workers were not actually in the assigned post but had moved to other locations.
Mozambique <sup>c</sup>	2002	90 facilities; 167 staff; 679 users	Some evidence of leakage of drugs in transfer from provinces to districts, within the primary health care system, but no firm estimate.	Documented delays and bottlenecks in budget execution and supply management; inequalities in allocation of resources across districts and facilities; incomplete registering of user-fee revenues by facilities (reported revenue as per cent of expected revenue was 67.6% for consultations and 79.6% for medicines); absenteeism estimated at 19%.
Nigeria <sup>d</sup>	2002	252 facilities; 30 loc. gov.; 700 staff	No firm estimate of leakage (focus was on governance issues in health sector, in particular on flow of resources, provider behaviour and incentives, and the role of local governments and community participation).	42% of staff experience salary delays despite sufficient budget; detailed description of governance and service delivery arrangements, including facility characteristics; evidence of delays in salary payments.
Papua New Guinea <sup>e</sup>	2002	117 facilities	No firm estimate of leakage (main focus on the education sector, but some data on health facilities were collected).	Evidence of poor access to care and limited availability of drugs; absenteeism estimated at 19%.

Table 2.1: *continued*

<i>Country</i>	<i>Year</i>	<i>Sample</i>	<i>Leakage</i>	<i>Other findings</i>
Peru <sup>f</sup>	2001	120 municipalities	Leakage in 'Glass of Milk' food supplementation programme estimated at 71% (includes 'leakage' of benefits at household level).	Quantified leakage at different levels of government (greater at the higher levels); evidence that poorer municipalities affected the most; diversion of funds to cover operational costs.
Rwanda <sup>g</sup>	2000	351 facilities; 40 districts	Some evidence of leakage between regions and districts, but no firm estimate.	Evidence of delays in budget execution and low execution rates (80% of non-wage funds released at year end); user-fee revenues and drug sales shown to be principal sources of funding.
Senegal <sup>h</sup>	2002	100 facilities; 10 districts; 37 loc. gov.	Some evidence of leakage at regional and communal level in allocation of non-salary resources from the central level to service providers through the decentralisation fund but no firm estimate.	Delays in the decentralisation fund transfers; evidence on extent of discretion by local governments in allocation of resources.
Tanzania <sup>i</sup>	1999	36 facilities; 3 districts	Leakage of non-salary funds estimated at 41% (budget and accounting mechanisms were studied for health and education at district and facility level).	Donor contributions shown to favour better-off districts; leakage attributed to poor record-keeping and lack of audits.
Tanzania <sup>j</sup>	2001	20 facilities; 5 districts	No firm estimate of leakage in primary education and health facilities studied.	Substantial delays at all levels, especially non-wage expenditures; lack of supplies in facilities; some evidence of underreporting of facility revenues.
Uganda <sup>k</sup>	1996	100 facilities; 19 districts	No firm evidence of leakage in flow of resources to primary health care providers but heavy reliance on in-kind flows and poor record-keeping hampered data collection. Qualitative evidence suggests that leakage is limited.	Qualitative evidence suggested that main leakage takes place at facility level, rather than in transfer of resources to facilities.

Uganda <sup>1</sup>	2000 155 facilities	Leakage of specific drugs and supplies estimated at 70% in government, private non-profit facilities studies.	Detailed descriptive data on facility characteristics and performance; overview of accountability arrangements; comparison of government and non-government providers.
---------------------	---------------------	---	--

## Notes

- a Xiao Ye and Sudharshan Canagarajah, 'Efficiency of Public Expenditure Distribution and Beyond: A Report on Ghana's 2000 PETS in the Sectors of Primary Health and Education', World Bank Africa Region Working Paper Series No. 31, 2002.
- b World Bank, 'Honduras: Public Expenditure Management for Poverty Reduction and Fiscal Sustainability', Report No. 22070, World Bank Poverty Reduction and Economic Sector Management Unit, Latin America and the Caribbean Region, 2001.
- c Magnus Lindelow, Patrick Ward et al., 'Primary Health Care in Mozambique: Service Delivery in a Complex Hierarchy', World Bank Africa Region Human Development Working Paper Series No. 69, 2003.
- d Monica Das Gupta, Varun Gauri et al., 'Decentralized Delivery of Primary Health Services in Nigeria: Survey Evidence from the States of Lagos and Kogi', World Bank Africa Region Human Development Working Paper 70, 2004.
- e World Bank, 'Papua New Guinea: Public Expenditure and Service Delivery', unpublished manuscript, 2004.
- f World Bank and Inter-American Development Bank, 'Peru: Restoring Fiscal Discipline for Poverty Reduction: Public Expenditure Review', Report No. 24286-PE, 2002.
- g Hippolyte Fofack, Robert Ngong et al., 'Public Expenditure Performance in Rwanda: Evidence from a Public Expenditure Tracking Study in the Health and Education Sectors', Africa Region Working Paper Series No. 45, 2003.
- h World Bank, 'Expenditure Tracking Survey in Senegal: The Health Sector', unpublished manuscript, 2003.
- i PricewaterhouseCoopers, 'Tanzania Public Expenditure Review: Health and Educational Financial Tracking Study', Final Report, vols I-II (Dar es Salaam, 1999).
- j Research on Poverty Alleviation and Economic and Social Research Foundation, 'Pro-poor Expenditure Tracking', unpublished manuscript, 2001.
- k Emmanuel Ablo and Ritva Reinikka, 'Do Budgets Really Matter? Evidence from Public Spending on Education and Health in Uganda', Policy Research Working Paper 1926, World Bank, 1998.
- l Magnus Lindelow, Ritva Reinikka et al., 'Health Care on the Frontline: Survey Evidence on Public and Private Providers in Uganda', World Bank Africa Region Human Development Working Paper 38, 2003.

were 'ghost' employees, while the remainder were retired or had been transferred without records being updated. The survey also found evidence of dual job-holdings, absenteeism and other human resource management problems.

While most health PETS have managed to generate leakage estimates for overall or specific resource flows to health care providers, the reliability of findings has often been undermined by the quality of administrative records (budgets, expenditure accounts, receipts, drug records, payrolls, and so on). These records are often poorly kept, reflecting a lack of capacity, weak procedures and possibly efforts by staff to 'play' the system. As a result, survey enumerators have to contend with records that are both incomplete and riddled with errors. In Mozambique, provincial health departments

could provide complete district-level data for only 40 per cent of their districts. Similarly, complete records were found in less than half of the district health offices surveyed in Ghana, and although the data collected in Rwanda were consistent with high levels of leakage – there were substantial discrepancies between funds recorded as dispersed by higher levels of government and the funds recorded as received by lower levels – these discrepancies may in part be due to poor book-keeping, and no firm leakage estimate could be developed.

### **Beyond leakage: insights into public expenditure management**

Where, due to the paucity of administrative records or the absence of clear allocation rules, it has not been possible to reach firm conclusions concerning leakage, valuable insights may still be gleaned from PETS. An important contribution has been to provide hard evidence on the extent and source of delays and bottlenecks in budget execution and supply management systems. For example, the Nigeria study found that although funds had been released to local government, 42 per cent of the facility workers had not received their salaries for more than six months in the year prior to the survey. Similarly, in the Mozambique survey, 30 per cent of staff said that salaries are always or almost always late, and 15 per cent of staff reported that salaries are sometimes not paid in full. Whatever the source of the problem, delays in payments are likely to have adverse consequences for staff morale, and may contribute to problems of absenteeism, informal charging and other problems.

Problems of the same nature have been documented in the case of non-salary budgets, and in the distribution of drugs and other essential supplies. The Senegal PETS found that it takes an average of 10 months for the resources from the Decentralisation Fund – the main source of government financing for health facilities – to actually reach the providers. In Mozambique, nearly 30 per cent of district health offices received their first budget transfer of the year more than three and a half months late. Delays in budget transfers often conspire with other factors to result in low levels of budget execution. For example, in Mozambique, districts executed an average of only 80 per cent of their budgets, and in some districts execution rates were as low as 35 per cent.

More generally, tracking surveys have contributed to a better understanding of the public expenditure management process, allocation rules, financial management and accounting practices, and accountability arrangements; in particular, at lower levels of government where routine monitoring and reporting systems tend to be weak. For example, the Ghana, Mozambique and Rwanda PETS found evidence that existing user fee rules and regulations are not followed: patients are charged more than they should be, exemptions are not granted, revenues are not used as intended, and so on. In part, these problems probably reflect the problems in the budget and supply systems, that is, user fees become a lifeline for facilities that do not receive adequate funds and resources from government – but opportunistic overcharging by health workers may also be a factor.

## The consequences of leakage and other public expenditure management problems

Do problems of leakage, delays and reallocation of resources matter? Many surveys have focused on primary health care services, which often account for a relatively small share of health spending. However, even though dollar values may be small, leakage of resources or delays in budget transfers or drug supplies may seriously undermine the capacity of facilities to deliver services. The costs in terms of poor health, suffering and loss of life may be considerable.

In Ghana, most clinics received fewer resources than intended – some received no cash at all – and had to rely on internally generated funds for their operations. As a result, users were forced to bear higher costs than intended, in part through high charges for drugs. The Nigeria survey found that most facilities were missing essential equipment, medications, vaccines and supplies: 95 per cent did not have microscopes, 59 per cent did not have sterile gloves, 98 per cent did not have a malaria smear, and 95 per cent did not have urine test strips. In Mozambique, over 60 per cent of facilities had been out of stock of one or more essential medicines during the six months preceding the survey, with an average stock-out time of six weeks. The Uganda survey (2000) also found evidence of stock-outs of vaccines and drugs, combined with overuse of antibiotics and other drugs. These problems may have multiple causes, but are clearly a cause for concern.

Tracking surveys thus can help diagnose leakages, delays and other budget execution problems that can seriously undermine service delivery and contribute to an improved understanding of how resources are allocated and used at lower levels of government – issues that often fall outside the purview of routine reporting systems. But PETS also have important limitations. For one thing, most tracking surveys have mainly been implemented in integrated health systems, where public resources are channelled to public providers, and have proven most effective in contexts with clearly identifiable service providers and explicit resource allocation rules. Tracking surveys may be less useful in other contexts, such as where third-party payers (insurers) play an important role, or where private provision and contracting is more widespread. Even within public integrated systems, different tools are needed to diagnose some forms of corruption. This raises questions about how PETS relate to other integrity and accountability tools.<sup>5</sup> It is clear that effective efforts to diagnose and combat corruption will depend on a wide range of internal mechanisms (such as clear rules and procedures, effective accounting and record keeping, internal and external audits) and external ones (transparency, mechanisms for client voice, and so on). PETS may have an important role to play, but this role needs to be determined with an eye on their cost, and with a view to complement rather than replace other parts of the public financial management system.

Ultimately, however, successfully channelling resources to providers is only half the battle. Once there, resources must be used efficiently and as intended in order to have an impact. Tracking surveys have increasingly sought to provide evidence on facility performance, but detailed studies – including facility surveys, case studies and

qualitative work – of absenteeism, informal charging and pilfering of drugs and other supplies also have an important role to play.

For example, a recent multi-country study based on multiple, unannounced facility visits reports absenteeism rates ranging from 23 per cent to 40 per cent in the health sector, and finds absenteeism to be related to both the location and the characteristic of the health facility.<sup>6</sup> Evidence from provider and household surveys have shown that informal or unofficial charges add an unintended financial burden on patients in many countries.<sup>7</sup> Finally, there have been attempts to collect facility-level data on theft of drugs and other supplies by health workers through small-scale surveys or case studies.<sup>8</sup> Such studies have revealed serious service delivery problems in many countries, and highlighted the importance not only of getting resources to facilities, but also of ensuring that health workers are provided with incentives and opportunities to perform. But the studies have also helped counter the image of health workers and government administrators as inherently corrupt agents – an unfortunate by-product of single-minded efforts to diagnose corruption in service delivery. Detailed case studies and qualitative work has shown that the majority of health workers are dedicated professionals trying to cope in difficult and frustrating environments with low pay, poor management and support systems, and weak accountability mechanisms.<sup>9</sup> This is an important perspective to keep in mind in any efforts to strengthen the tools for diagnosing corruption in the health sector.

## Notes

1. Magnus Lindelow is an economist at the World Bank in East Asia Pacific Human Development, Inna Kushnarova is a consultant with the World Bank, and Kai Kaiser is an economist with the World Bank's Public Sector Group in Poverty Reduction and Economic Management.
2. Deon Filmer and Lant Pritchett, 'Child Mortality and Public Spending on Health: How Much Does Money Matter?', Policy Research Working Papers, World Bank, 1997; Vinaya Swaroop and Andrew Sunil Rajkumar Swaroop, 'Public Spending and Outcomes: Does Governance Matter?', World Bank, Policy Research Working Paper Series, 2002. For a general discussion of the 'weak links' in the chain between public expenditure and outcomes in health and other public services, see *World Development Report 2004: Making Service Work for Poor People* (Oxford: Oxford University Press and World Bank, 2003).
3. See, for example, Anne Cockcroft, Lorenzo Monasta et al., 'Bangladesh Baseline Service Delivery Survey: Final Report', CIET International, 1999, and 'Filipino Report Card on Pro-Poor Services', World Bank Environment and Social Development Sector Unit East Asia and Pacific Region, May 2001. Evidence of corruption from perception-based service delivery surveys has been linked to child and infant mortality by Sanjeev Gupta, Hamid R. Davoodi and Erwin R. Tiongson, 'Corruption and the Provision of Health Care and Education Services' in George T. Abed and Sanjeev Gupta, *Governance, Corruption, and Economic Performance* (Washington, DC: IMF, 2002).
4. For example, facilities in Ghana, Rwanda and Mozambique receive practically no cash through the budget process. Salaries are paid directly to staff and other resources are procured at higher level and distributed in kind.
5. Increasingly, both bilateral and multilateral development agencies are channelling aid as general budget or sector support. Shifts in aid modalities, combined with debt reduction initiatives, have led to a growing concern with the transparency and integrity of public financial management in developing countries. In this context, PETS have emerged as an important diagnostic tool. Recently, PETS have also been proposed as a tool for promoting

accountability in public spending. For a discussion of PETS as a tool for tracking poverty-reducing public spending under the Enhanced HIPC Initiative, see *Tracking of Poverty-Reducing Public Spending in Heavily Indebted Poor Countries* (Washington, DC: IMF, 2001). A general discussion is provided in the World Bank's *Public Financial Management: Performance Measurement Framework* (Washington, DC: World Bank, 2005). The jury is still out on whether PETS are a useful and cost-effective tool for preventing corruption.

6. Nazmul Chaudhury, Jeffrey Hammer et al., 'Provider Absence in Schools and Health Centers', *Journal of Economic Perspectives*, (forthcoming).
7. James Killingsworth, Najmul Hossain et al., 'Unofficial Fees in Bangladesh: Price, Equity and Institutional Issues', *Health Policy Plan* 14(2): 152–63, 1999; Maureen Lewis, *Who is Paying for Health Care in Eastern Europe and Central Asia?* (Washington, DC: World Bank, 2000); Tim Ensor and Sophie Witter, 'Health Economics in Low Income Countries: Adapting to the Reality of the Unofficial Economy', *Health Policy* 57(1): 1–13, 2001; Paolo Belli, George Gotsadze, and Helen Shahriari, 'Out-of-Pocket and Informal Payments in Health Sector: Evidence from Georgia', *Health Policy* 70(1): 109–23, 2004; Tim Ensor, 'Informal Payments for Health Care in Transition Economies', *Social Science and Medicine* 58(2): 237–46, 2004.
8. Barbara McPake, Delius Asiimwe et al., 'Informal Economic Activities of Public Health Workers in Uganda: Implications for Quality and Accessibility of Care', *Social Science and Medicine* 49(4): 849–65, 1999; Rafael Di Tella and William D. Savedoff, *Diagnosis Corruption: Fraud in Latin America's Public Hospitals* (Washington, DC: Inter-American Development Bank, 2001).
9. Paulo Ferrinho, Wim Van Lerberghe and Aurélio da Cruz Gomes Ferrinho, 'Public and Private Practice: A Balancing Act for Health Staff', *Bulletin of the World Health Organization* 77(3): 209, 1999; Wim Van Lerberghe, Claudia Conceição, Wim Van Damme and Paulo Ferrinho, 'When Staff is Underpaid: Dealing with the Individual Coping Strategies of Health Personnel', *Bulletin of the World Health Organization* 80(7): 581–4, 2002.

## Local-level corruption hits health service delivery in the Philippines

Omar Azfar and Tugrul Gurgur<sup>1</sup>

In the past two decades there has been a widespread devolution of authority to local governments around the world. As local governments increase their share of authority and responsibility vis-à-vis central government, their effectiveness in terms of quality, quantity and the accessibility of public services has become critical. Consequently, the effect of local-level corruption on service delivery has critical relevance for development economists and policy-makers.

The Philippines is an ideal place to study the impact of corruption on service delivery. Five years after the democratic revolution in the Philippines, the Local Governments Act of 1991 devolved both political authority and administrative control of many health and education services to the provincial and municipal level. According to some public survey results and anecdotal evidence, much of the corruption in the Philippines does appear to be at the local level. The large number of municipalities, the significant devolution of authority, and the high and varying levels of corruption make the Philippines an ideal place to study the impact of corruption on service delivery.

Data collected in 2000 from 80 municipalities in the Philippines was used to assess the impact of corruption in local governments on health and education outcomes. The results showed clearly that corruption undermines the delivery of health services. We

found a significant partial correlation between 13 dependent variables that measure various aspects of health and education services and corruption perceptions, after controlling for capacity (based on measures of human and physical capital), adult education levels, urban residence, living standards (as proxied by assets), inequality, existence of private sector competition, voting and media exposure, accountability measures and local autonomy.

Corruption levels were measured using corruption perceptions of households and public officials (administrators, health and education services, school principals and health workers). The respondents were asked questions about specific acts of corruption (such as bribery, the sale of jobs and theft of supplies) as well as their general perceptions about the corruption level at each municipal government, public school and public health clinic. Most kinds of corruption were found to be more prevalent in the municipal administrator's office than in other offices, perhaps due to the administrator's office exerting more authority and thus having more opportunity to extract rents. A total of 19 per cent of municipal administrators said there were cases of bribery in their offices in the year preceding the survey (1999), while 32 per cent said there were instances of theft of funds. By contrast, the figures for municipal health officers were 2.5 per cent and 16.5 per cent, respectively.

To measure the quality, quantity, and accessibility of health services, we used seven variables: six of them from a household survey (immunisation of children, delay in vaccination of children, patient waiting times, accessibility of health clinics for treatment, choosing public health clinics for immunisation, and satisfaction with public health clinics) and one from the Ministry of Health (municipal average of immunisation rate of children).

The results showed clearly that corruption undermines the delivery of health services in the Philippines. In each case regression results indicated a significant and negative effect of corruption on the quality of health services. For example, a standard deviation (about 10 per cent) increase in corruption reduces the immunisation rate by around 10–20 per cent, increases waiting time in public health clinics as much as 30 per cent, decreases user satisfaction by 30 per cent, and reduces the odds of completing vaccination by four times and choosing public health facilities by a factor of three.

The results also suggest that corruption does not affect the rural areas the same way it affects the urban areas. In the urban areas demand for public health care is more 'corruption-elastic' (that is, households' use of public health facilities declines more rapidly in response to higher corruption incidence). Households in rural areas, on the other hand, suffer with more waiting at public health clinics, late immunisation of infants, and less satisfaction with public health services as compared to households in urban areas facing the same level of corruption. The presence of alternative health facilities in urban areas, either in the form of private health care providers or other public health facilities, may be the reason for such differences.

We also ran regressions to understand the effect of corruption in rich, middle-income and poor municipalities. Even after controlling for other factors we found that when corruption is endemic, poor and middle-income municipalities report more waiting at public clinics and a higher frequency of being denied vaccines than rich municipalities.

Corruption in public clinics is also more likely to deter households living in poor municipalities and forces them to opt for self-medication.

Robustness checks that control for outliers, sample selection problems and reverse causality concerns (for instance, that some common variable is affecting both corruption and service delivery, or that poor service delivery is causing corruption) confirmed our findings.

Taken together our results suggest that corruption undermines the delivery of services in the Philippines. This complements cross-country findings on the subject, and adds to the expanding list of ways corruption undermines welfare.

#### Note

1. Omar Azfar (omar@iris.econ.umd.edu) is a research associate at the IRIS Center of the University of Maryland College Park, and Tugrul Gurgur (tgurgur@umd.edu) is a graduate student at the Economics department of the University of Maryland College Park. The article summarises research conducted by the IRIS Center of the University of Maryland on behalf of the World Bank and the Netherlands Trust Fund. The full report was published as: Omar Azfar and Tugrul Gurgur, 'Does Corruption Affect Health and Education Outcomes in the Philippines?', Working Paper (College Park: IRIS Center, University of Maryland College Park, 2004), available at [www.iris.umd.edu](http://www.iris.umd.edu). The authors thank Satu Kahkonen, Anthony Lanyi, Patrick Meagher and Diana Rutherford for their contributions to this report.

## Corruption is bad for your health: findings from Central and Eastern Europe

Richard Rose<sup>1</sup>

Modern medicine offers many treatments that can alleviate pain or restore people to good health. Moreover, in prosperous OECD countries there is the assurance that, if you do get ill, you will be treated by a state-funded health service or through a private health insurance programme. But health care costs money, and in many developing countries the most the state can finance are the rudiments of public health facilities, such as clean water and sewers. In the developing world, individuals needing health care must sometimes turn to traditional remedies or borrow money to pay for private health care. Where corruption is rife, people have the worst of both worlds: paying twice for treatment, once through taxes and once in a brown envelope.

Communist governments in Central and Eastern Europe once promised health care to everyone in need. However, the result was favouritism and corruption in the allocation of medical and hospital treatment. Those who were in the party *nomenklatura* had access to good treatment; those who could pull strings through informal networks (*blat*) also benefited; and people who could offer payments on the side were more likely to get good treatment than those who could not. The corruption that was an integral part of the 'shadow' economies of communist countries has left a legacy of corruption throughout the region, particularly in the health sector.

As part of this legacy, the imposition of a 'corruption tax' for treatment that ought to be free is likely to have negative consequences for the health of citizens. At worst, it may lead to the denial of treatment or even people not seeking treatment because they do not have the money to make payments under the table. Corruption in health inevitably punishes the elderly, who are most likely to need health care, and the poor.

The seventh New Europe Barometer (NEB) of the Centre for the Study of Public Policy has tested the extent to which corruption is bad for a society's health.<sup>2</sup> Between 1 October 2004 and 23 January 2005, it organised nationwide random sample surveys of the adult populations in eight new EU member states (the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia); two applicant countries (Bulgaria and Romania); plus Belarus and Russia. National research institutes interviewed 13,499 people face to face, asking questions about their perception of corruption, health care and such influences on health as age, education and social class.

When people assess their physical health, the largest group of 39 per cent, not surprisingly, says it is average; 34 per cent say their health is good; and 10 per cent describe it as excellent. By contrast, only 14 per cent say their health is bad and 3 per cent report it is very bad.<sup>3</sup> In Romania, Slovenia and Slovakia, more than half say their health is good or excellent. Even in Belarus, where one-quarter says their health is bad, the largest group has average health.

However, almost three-quarters of those surveyed have a negative view of their country's health services (Table 2.2). Altogether, 24 per cent describe the system as very bad, and almost half characterise it as not so good, as against 27 per cent who consider it fairly good, or very good. The evaluation of health care varies greatly within the region. In the Czech Republic, an absolute majority gives the health system a positive endorsement and the same is true in Belarus. By contrast, in Russia and Bulgaria fewer than one in twelve is positive. Bulgarians and Russians differ only as to whether their health service is not so good or very bad.

At the same time, there is a widespread perception that the body politic is infected with corruption. When asked how many officials are corrupt, 29 per cent say that practically all officials are corrupt and an additional 44 per cent see a majority of officials as corrupt (Table 2.3). Again, there are big differences between countries. In Romania, a majority perceive practically all officials as corrupt, and in Russia 43 per cent do. By contrast, nearly half of all Estonians and Slovenes polled think corruption affects less than half of public officials.

Where corruption appears widespread, people also see major deficiencies in health care (Figure 2.1). Five out of six people who see nearly all officials as corrupt think their health system is either very bad or not so good; and almost four-fifths who think a majority of officials are corrupt see the health service in negative terms. Among those who think that less than half the public officials are corrupt, three in five still have a negative view of the health service. Even among the small percentage of citizens in the region who see very few officials as corrupt, just under half have a positive view of their health system.

Table 2.2: Health service seen as not very good

Q. How would you evaluate the current system for health care in this country?

	Very good	Fairly good	Not so good	Very bad
Czech Republic	3	51	39	7
Slovenia	4	42	42	11
Belarus	2	49	38	11
Romania	2	14	66	18
Hungary	1	38	46	15
<b>All NEB countries</b>	<b>1</b>	<b>26</b>	<b>49</b>	<b>24</b>
Estonia	1	24	49	26
Lithuania	1	22	56	21
Slovakia	1	21	52	26
Latvia	1	20	47	32
Poland	1	16	48	35
Bulgaria	1	7	55	38
Russia	1	7	53	40

Source: Centre for the Study of Public Policy, *New Europe Barometer VII*. Total number of respondents: 13,499. Fieldwork conducted between 1 October 2004 and 23 January 2005.

Table 2.3: Corruption perceived as widespread

Q. How widespread do you think that bribe-taking and corruption are in this country?

*Very few public officials are corrupt; less than half are corrupt; most public officials are engaged in corruption; almost all public officials are engaged in corruption.*

	Almost all	Majority	Less than half	Very few
	(% replying)			
Romania	51	34	14	1
Bulgaria	43	45	10	2
Russia	43	46	8	3
<b>All NEB countries</b>	<b>29</b>	<b>44</b>	<b>22</b>	<b>5</b>
Lithuania	32	50	15	3
Slovakia	30	50	18	2
Hungary	27	36	35	1
Belarus	26	44	21	8
Latvia	24	49	22	6
Poland	22	52	24	2
Czech Republic	21	49	26	5
Slovenia	17	36	33	14
Estonia	12	39	36	13

Source: Centre for the Study of Public Policy, *New Europe Barometer VII*. Total number of respondents: 13,499. Fieldwork conducted between 1 October 2004 and 23 January 2005.

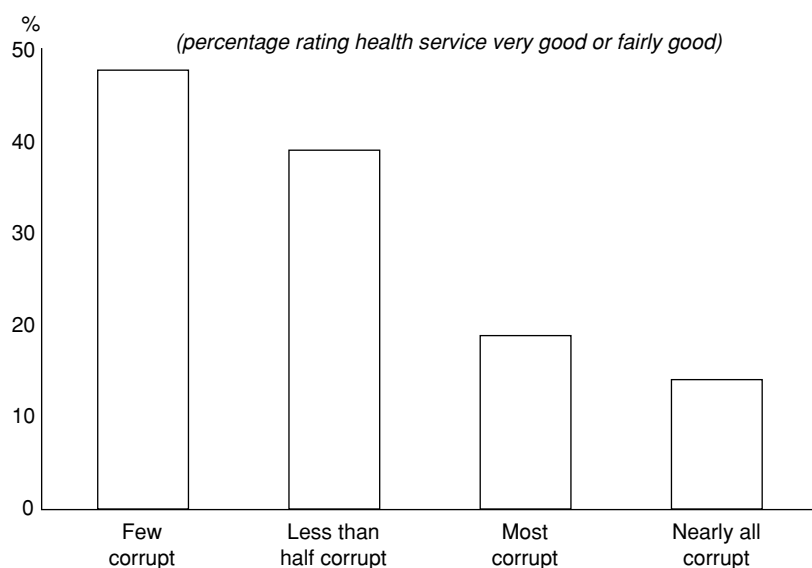


Figure 2.1: As corruption rises, health service gets worse

Source: Answers to questions in Tables 2.2 and 2.3 gamma correlation:  $-0.36$ . Centre for the Study of Public Policy, *New Europe Barometer VII*. Total number of respondents: 13,499. Fieldwork conducted between 1 October 2004 and 23 January 2005.

People with below-average health are most likely to be dissatisfied with their country's health system; 78 per cent describe it as not so good or very bad. But being in bad health is not the chief reason why a health service is viewed negatively. More than three-quarters of those who rate their health as average also think that health care is not very good or very bad; and even among those in good or excellent health, two-thirds view the health care available in negative terms.

An individual's health not only reflects the state of the country but also the characteristics specific to that person, such as age and education. The extent to which bad government has a negative effect on individual health, in addition to individual characteristics, can be determined by multiple regression analysis. It identifies conditions that have a statistically significant influence on health, net of the effects of other influences.

Both individual characteristics (age, social status and education) and perceptions of public services significantly – and independently – influence the health of individuals in Central and Eastern Europe and the former Soviet Union. Together, they can account for 26.8 per cent of the variance in self-assessed health. As expected, age is by far the single most important influence: being 60 or over has an even more negative effect on health than the positive effect of being under 30.

Three other socio-economic characteristics give a significant boost to individual health. The higher a person's social status and education, the better his or her health, however old they are. The more durable consumer goods there are in the house – a

proxy for income in countries where subsidies and shadow earnings complicate the evaluation of conventional wages – the better a person’s health. The statistic that shows men are more likely to be healthy than women is a by-product of the higher rate of male mortality at younger ages, which results in men who do survive into old age on average being healthier.

The perception of corruption has both a direct and an indirect influence on health. After controlling for social characteristics, people who perceive government as more corrupt are more likely to be in worse health. Corruption also has an indirect effect because it correlates with a negative assessment of the health service, and a bad health service is bad for individual health. For individual health, at least, the individual perception of corruption is more significant than the overall national rating.<sup>4</sup>

Notwithstanding the widespread perception of inadequate and even corrupt public services, the welfare values of Central and East Europeans continue to support paying taxes for better services. However, the more corrupt a system actually is, the less benefit that individuals will gain from paying higher taxes. In order to improve health in the region, national governments not only have to spend more money on health care, but also have to spend that money honestly.

## Notes

1. Richard Rose is professor at the Centre for the Study of Public Policy, University of Aberdeen, Scotland.
2. The New Europe Barometer survey is financed by a grant from the British Economic & Social Research Council for the analysis of diverging paths of post-communist countries. The health data was collected with the support of a MacArthur Foundation grant to Professor Sir Michael Marmot, Department of Epidemiology and Public Health, University College, London.
3. All percentages are based on pooling the 12 NEB national surveys and weighting each equally, so that each contributes one-twelfth of the total answers reported.
4. The TI Corruption Perceptions Index (CPI) does not register statistical significance due to the fact that the CPI rates the country as a whole; thus the regression analysis assigns the same CPI score to each individual respondent in a country. However, there is never 100 per cent agreement within a country as to the degree to which officials are corrupt. The NEB collects data from individuals and thus can take into account differences in individual perception within a country.

## ‘Citizens’ audit’ in Mexico reveals paper trail of corruption

*Helena Hofbauer*<sup>1</sup>

At the end of 2002, as it was discussing the 2003 budget, Mexico’s Congress announced it would provide 600 million pesos (US\$ 56.5 million) of additional funding for programmes that promoted women’s health. The president of the Budget Committee sent instructions to that effect to the Ministry of Health. Included was a statement that 30 million pesos (US\$ 2.8 million) were to be reallocated to a private organisation, Provida, as part of the women’s health initiative. Originally, the amount had been allocated to HIV/AIDS public health campaigns.

Six Mexican civil society organisations (CSOs) – Consorcio para el Diálogo Parlamentario y la Equidad; Equidad de Género, Ciudadanía, Trabajo y Familia; Fundar, Centro de Análisis e Investigación; Grupo de Información en Reproducción Elegida; Letra S, Sida, Cultura y Vida Cotidiana; and Salud Integral para la Mujer – launched an investigation into why the budget had been altered. The six embarked on a time-consuming piece of detective work lasting 18 months during which they documented evident irregularities. Much of the CSOs' efforts were possible because Mexico implemented a new Transparency and Access to Public Information Law in June 2002.

The organisations uncovered a funding request that Provida presented to the Ministry of Health on 3 December 2002 for 30 million pesos, as well as confirmation from both the ministries of finance and of health that 30 million pesos were given to Provida's national committee. They also uncovered the signed agreement between the grants administrator and Provida, a financial and social impact report presented by Provida on the expenditure of the resources and a 6,525-page financial file containing invoices detailing how the 30 million pesos were spent.

With this knowledge, the CSOs began their own audit trail of how Provida spent 30 million pesos of taxpayers' money in 2003. They found evidence of misuse and corruption. More than 80 per cent of the funds were used to hire the services of a public relations firm for work such as a campaign against provision of emergency contraception for women. Money was also spent on an agency importing overpriced medical equipment, as well as to pay for the rent of a ballroom. The two companies and the owner of the ballroom shared Provida's address, telephone numbers and its administrative director. The CSOs also found that Provida had purchased luxury pens, clothing and groceries with some of the funds. Documents showed serious fiscal inconsistencies. Receipts dated October 2003 related to products acquired in July 2003.

In addition the CSOs made a number of observations about procedural violations that had taken place. First, the president of the Budget Committee is not allowed to speak for the plenary, or to issue instructions to a minister; second, Congress cannot allocate money to private organisations, particularly if it is taken away from public programmes; third, the Ministry of Health can only disburse resources to NGOs through an open, public process, after soliciting proposals; and fourth, Provida's radical stance contradicts significant parts of Mexico's public health policy in that it actively opposes the prevention of HIV/AIDS via the use of condoms, and systematically rejects the right to abortion that was granted to raped women.

Armed with this damning evidence, the CSOs unveiled their 'citizens' audit' at a press conference in June 2004 at which they launched a campaign demanding transparency and accountability, supported by 700 NGOs across Mexico. The campaign demanded that the Ministry of Health publicly explain its reasons for financing a private organisation that advocated health policies contradicting those of the government; that the government carry out an official audit of the 30 million pesos and clarify the responsibilities of the government officials involved and Provida's legal representative; that the 30 million pesos be returned to the state budget; and that legislation be drafted and implemented to prevent similar transgressions with government money.

The campaign became the focus of national attention, occupying the headlines of Mexico's news media for a month. As a result of the mounting public pressure, Congress

unanimously voted in July 2004 to call on the Minister of Health to explain the use of the 30 million pesos and speed up an ongoing official audit. Shortly after, the ministry demanded the return of the 30 million pesos and cancelled its contract with Provida, suspending the distribution of additional funds to the organisation for 2004.

In September 2004, the Internal Comptroller, who is responsible for initiating audits within the executive branch of government, issued the results of the official audit, which corroborated the irregularities the CSOs had identified. At the end of March 2005, the earliest permissible date, the Auditor General (of the legislative branch) also issued its results on the case. But the Auditor General's report went further, noting that 90 per cent of the money Provida received from the government had been inappropriately used. As a result, the Senate asked for a judicial process to be started against Provida and its legal representatives.<sup>2</sup>

In April 2005 the Internal Comptroller removed the three officials at the head of the health ministry unit who had handed out the resources without a public process; and banned Provida's legal representative, Jorge Serrano Limón, from occupying public office and fined him 13 million pesos. The 30 million pesos have not been returned, the fine has not been paid and the judicial process is still under way.

Nonetheless, the CSOs have effectively promoted the cause for greater transparency in important ways.

They demonstrated the important role CSOs can play in making government more accountable by using a country's legal framework. In particular, they showed the value of the Transparency and Access to Information Law to enable processes that would not have been possible three years ago.

This was the first time CSOs followed a misallocation of resources and its corrupt expenditure throughout the entire budget process. It was possible to identify what had happened, to audit the exercise of resources and to reach into the oversight stage of the process in order to seek redress. The misuse of resources and the corruption highlighted by CSOs was confirmed by official institutions, and action followed.

A legal precedent was established, since the Law of Responsibilities of Public Officials (in operation since 1982, with several reforms) was applied for the first time to an individual (Serrano Limón), who had made unlawful use of public resources.

Inconsistencies between public health policies and Provida's activities were highlighted, and the care centres that should have been built and run with the 30 million pesos have since been carefully supervised in order to ensure lawful practices.

The administrative unit in the Ministry of Health responsible for distributing resources among CSOs reviewed its policies and for the first time published its procedures in the public domain.

## Notes

1. Helena Hofbauer is Executive Director of Fundar, Mexico City.
2. [www.senado.gob.mx/sgsp/gaceta/?sesion=2005/04/26/1&documento=60](http://www.senado.gob.mx/sgsp/gaceta/?sesion=2005/04/26/1&documento=60)

## Fighting fraud and corruption in Britain's National Health Service

*Jim Gee*<sup>1</sup>

Fraud and corruption represent a pincer movement on organisations affected by them. They deny them the resources they need while undermining the confidence of the public. For too long, the defence against such attacks has been poorly organised and unprofessional. In recent years in the United Kingdom, and especially in its National Health Service (NHS) – the third largest organisation in the world, with 1.2 million staff and an annual budget of £70 billion (US \$125 billion) – this picture has changed considerably.

The Counter Fraud Service (CFS) was created in 1998 with overall responsibility to protect the NHS and its resources from fraud and corruption. Our starting point is to accurately measure and track losses to fraud and corruption in each area of the NHS budget to an accuracy of within 1 per cent and to have that independently audited. This helps to identify the nature and extent of the problem, which is essential to finding the appropriate solution. Thus we know that losses to patient fraud have been reduced from £171 million (US \$305 million) in 1999 to £78 million (US \$139 million) in 2004 (a reduction of 54 per cent), and losses to fraud by medical professionals have fallen by about 43–54 per cent over the same period. We are currently measuring losses to payroll fraud involving ‘ghost employees’, or where people obtain employment by using bogus qualifications and false employment histories. These figures should be available in late 2005.

The CFS has the responsibility not only for ‘operational’ work to counter corruption (detection, investigation and the seeking of sanctions and redress). It also works to develop a real anti-fraud and corruption culture, to create a strong deterrent effect, and to revise policy and systems to prevent the problem recurring. By integrating these two aspects, we have ensured that we generate not only activity, but also tangible outcomes in terms of reduced losses to fraud and corruption. As a legal requirement, the CFS is staffed by professionally trained and accredited counter-fraud specialists, members of a new profession numbering around 8,500 across the public and private sectors since its formation by the government in 2001.

The CFS has encountered and dealt with many different aspects of corruption. Examples in recent years include:

- We are suing a number of generic drug companies for £152 million (US \$271 million) because we believe they formed a cartel to raise prices for the drugs warfarin, penicillin and ranitidine.
- A chief executive of an NHS Trust who falsified his qualifications to obtain the post resigned to avoid dismissal; a criminal prosecution is under way.
- Medical professionals who claimed and pocketed payments for treatments they did not provide are usually prosecuted criminally, with civil legal action to recover losses. Finally, they are suspended or removed from professional bodies.

These and other examples where we have detected and stopped corruption total more than £170 million (US \$303 million) since 1999, but this is only part of total financial benefits to the NHS of £675 million (US \$1.2 billion), which also includes recovery of monies lost to fraud and reductions in measured losses due to CFS intervention. This amounts to a 13:1 return on its budgetary investment, and the equivalent of what it would cost to build 10 new hospitals.

To achieve this, the CFS has worked to mobilise the honest majority, undertaking more than 1,400 presentations and awareness sessions reaching hundreds of thousands of staff and millions of patients. It also seeks to deter the dishonest minority by publicising the actions taken, with around 400 media articles each year. Detection rates have risen by several hundred per cent, with a 96 per cent success rate in prosecution, alongside extensive use of civil law to freeze and recover assets.

There have been four keys to this success. These are:

- accurate identification of the nature and scale of the problem
- comprehensive action to tackle the problem (not limited to traditional policing)
- professional agency staff with the right skills to reduce losses to corruption permanently
- successful mobilisation of the honest majority and the deterrent effect this has had on the dishonest minority.

The CFS approach is widely recognised as best practice in the UK public sector and increasingly across Europe, with information being shared via the new European Healthcare Fraud and Corruption Network.

It is time that work to counter fraud and corruption moves from its pre-professional period and becomes fully professionalised. No one expects an untrained lawyer to provide good legal advice or an unqualified surgeon to operate on a relative. It is equally unacceptable to take a non-professional approach to the protection of public bodies against fraud and corruption.

#### Note

1. Jim Gee is chief executive of the National Health Service Counter Fraud Service and director of Counter Fraud Services in the UK Department of Health.