

# Transparency and Corruption in the Health Sector: A Conceptual Framework and Ideas for Action in Latin American and the Caribbean

William D. Savedoff

Health Technical Note 03/2007

May 2007

**Sustainable Development Department**  
Social Programs Division  
Inter-American Development Bank  
Washington, D.C.

This paper was commissioned by the Inter-American Development Bank to serve as an input to the IDB Health Strategy Document. The author is senior partner at Social Insight, an international consulting firm with expertise in economic and social analysis of public policy. Many of the ideas presented in this paper are drawn from ongoing efforts to research corruption in the health sector, including an unpublished literature review by the author and Chapter One of Transparency International's Global Corruption Report 2006 which was co-authored with Karen Hussman. In particular, Hussman's contribution to depicting and analyzing the roles of different actors is gratefully acknowledged. Any errors in the document are the author's sole responsibility. Messages could be sent to [savedoff@socialinsight.org](mailto:savedoff@socialinsight.org).

This working paper is being published with the sole objective of contributing to the debate on a topic of importance to the region, and to elicit comments and suggestions from interested parties. This paper has not gone through the Department's peer review process or undergone consideration by SDS Management. As such, it does not reflect the official position of the Inter-American Development Bank.

## Foreword

Corruption makes health initiatives, health policy and international aid less effective in achieving their goals, undermining international efforts to combat deadly diseases and to increase better coverage and quality in the health systems. Combating corruption in health systems is an essential development goal, due the capability to increase efficiency and maximize the outcomes of the health resources spent by the countries

Corruption in the health services industry comes with a high price tag, representing worldwide billions of dollars lost to theft, bribery and extortion. Unethical and fraudulent behavior in the health sector compromises the fundamental human rights and create barriers to the achievement of essential medical care. It also leads to dangerous and life-threatening treatments being administered, and helps trigger drug-resistant strains of deadly diseases such as malaria and tuberculosis.

Corruption affects all health systems. Whether in the industrialized or developing world, whether via embezzlement from health budgets or bribes extorted at the point of health service delivery, the effect is enormous and the burden falls disproportionately on the world's poor.

This paper was organized to evaluate and propose what could be done about corruption in the health systems of Latin America and the Caribbean. The IDB has already taken initiatives that address corruption the health sector indirectly – via efforts to improve the transparency and efficiency of tax administration, procurement, and financial transactions.

However, combating corruption in Latin American and Caribbean health systems should be seen as an integral part of the imperative to improve the provision of health care services needed by their populations. In this sense, anti-corruption programs can add a further dimension to programs that already aim to increase accountability, transparency, and managerial competence in the health sector.

The paper defines corruption; reviews and classifies the forms of corruption found in Latin American and Caribbean health systems; presents a range of existing anti-corruption initiatives; and concludes with ideas that the IDB could use to develop new programs and activities in this area.

As part of the initiative to increase knowledge and concerns by the public authorities and the civil society in the Region, the IDB is also publishing in 2007 the Spanish translation of the Global Corruption Report 2006 with special focus on Corruption and Health. This report will soon be available in the Bank's bookstore.

André Cezar Medici  
Senior Social Development Specialist  
Inter American Development Bank

# Index

Introduction

1

Defining Corruption and Fraud in Health

2

How Corruption and Fraud are Manifested

3

What to Do About Corruption in Latin America and the Caribbean's Health Systems?

10

References

15

Annexes

17

# Introduction

Corruption has been a concern in Latin America and the Caribbean for a long time, but it is an issue that has traditionally been left in the hands of domestic politicians and journalists. Only in the last decade, has corruption begun to be addressed openly among international organizations as a problem that inhibits economic growth, undermines social development, and debilitates the provision of important public services. In 1996, a landmark declaration was signed by the nations of the Western Hemisphere, pledging to collaborate in reducing corruption for the common good. Subsequently, governments in the region have engaged in more open debates over corruption and initiated programs – sometimes with international support from the World Bank, the IDB, Transparency International or bilateral agencies – to learn about and reduce corruption.

To date, it appears that most anti-corruption initiatives with international support have addressed problems in security, trade, and the administration of justice. Yet, other sectors that involve the public are also subject to abuses that result in significant burdens to the population. The health system is one example of a sector that involves large sums of public money, service providers who are engaged in activities that require public trust, and ample opportunities for personal enrichment. If the rates of abuse in other countries are extrapolated to Latin America and the Caribbean, then it can be conservatively estimated that \$28 billion is probably being stolen or diverted each year from its intended use in providing health services.

The impact of such abuses in the health sector is not limited to the financial cost. When resources are stolen from public health systems, patients frequently suffer the consequences, whether through poor quality care and ineffective medications, or simply not getting the services they need. This health impact of corruption and fraud is large enough to appear in population-wide health indicators. A study using data from 71 countries demonstrated that countries with high indices of corruption systematically had higher

infant mortality, shares of low birth weight babies, and child mortality, even after statistically controlling for a variety of other factors (S. Gupta *et al.* 2003).

Addressing abuse in health systems is important, then, for several reasons. First, it limits the resources available to the health system. Second, it reduces the effectiveness of health services and public health activities. Third, it has an impact on population health status. Fourth, it has a corrosive impact on trust in public institutions and among society's members. Taking action against abuse is likely to yield many benefits to society, and should be taken into consideration when debating public policy toward health.

This paper was commissioned by the Inter-American Development Bank to see what can be done about corruption in the health systems of Latin America and the Caribbean. The IDB has already taken initiatives that address the health sector indirectly – via efforts to improve the transparency and efficiency of tax administration, procurement, and financial transactions. To date, however, it has only conducted research on corruption in the health sector, yet combating corruption in Latin American and Caribbean health systems should be seen as an integral part of the imperative to improve the provision of health care services needed by their populations. In this sense, anti-corruption programs simply add a further dimension to programs that already aim to increase accountability, transparency, and managerial competence in the health sector.

The next section of this paper defines corruption and fraud as they apply to the health sector. It is followed by a review that classifies the kinds of corruption that are most common in the health systems of Latin America and the Caribbean. The subsequent section discusses current initiatives aimed at controlling corruption that are relevant to health in Latin America and the Caribbean. The final section presents ideas for addressing this problem, whether promoted or implemented by international agencies, NGOs or governments.

# Defining Corruption and Fraud in Health

A commonly used definition of corruption is the abuse of public office for personal gain (P. Bardhan 1997), and this usage will be followed here. However, the focus on public officials does not mean that private behavior is excluded from this definition. Corruption should also be understood to encompass actions by non-public individuals or entities that abet a public official's abuse (e.g. through offering a bribe).

Nevertheless, many abuses in the health system do not fall under this definition. Many abuses involve private individuals or entities enriching themselves through misrepresentation; for example, through billing the government for services that were not rendered; doing surgery that was not medically indicated; or selling expired medications in altered packages. The term "fraud" is used, in this paper, to denote such abuses by private actors who benefit personally through misrepresentation. The term "abuse" will be used to encompass both corruption and fraud.

The scope of corruption in the health sector may be larger than in other sectors because many private actors in the health sector are considered to be bound by professional ethics that require them to serve the common good. In this regard, they implicitly serve as "public" servants and can be accused of abusing their "office". This is most evident for the medical profession which is held socially, and often legally, accountable to a standard that requires them to do "what is best for the patient" independent of the impact on their personal income. This view is also expressed in public discussions regarding the behavior of insurance companies, medical equipment manufacturers and pharmaceutical corporations – none of whom are explicitly bound by any professional ethic. Therefore, the special role of health care providers means that the scope of corruption may be construed to apply more widely

than just to those who are officially on the public payroll.

The line between abuse and honest mistakes is also frequently blurred in the health sector because of uncertainty – regarding the efficacy of treatments, interpretation of diagnostic tests, or the expected consequences of different courses of action. For example, if a provider regularly bills the government for providing the most expensive treatments, it may be difficult to ascertain whether patients really require more expensive treatments or the provider is allowing pecuniary interests to affect medical decisions. In the event that the treatments are not medically indicated (or not even provided), it may still be difficult to determine whether the decision represented an intentional effort to defraud the government, poor training, or a simple mistake.

One final observation is that the definition of what constitutes "corruption" may vary across cultures and societies. In fact, some maintain that corruption as defined above may be ethnocentric – originating with a "Western", or even specifically Anglo-Saxon, notion of separating public and personal interests that does not apply the same way in other places (M. Lewis 2001) (A. Sen 1999). A payment to a public employee that might be considered a bribe in one country might be considered proper reciprocation in another. Thus, the dividing line can be further blurred.

These definitions and considerations are not raised in the spirit of confusing the issue, but rather to qualify that, in what follows, there may be different interpretations of the evidence at certain margins. Nevertheless, most of the evidence available refers to actions that are of such an egregious nature as to defy explanation as being culturally acceptable, medically necessary, or unintentional.

# How Corruption and Fraud are Manifested

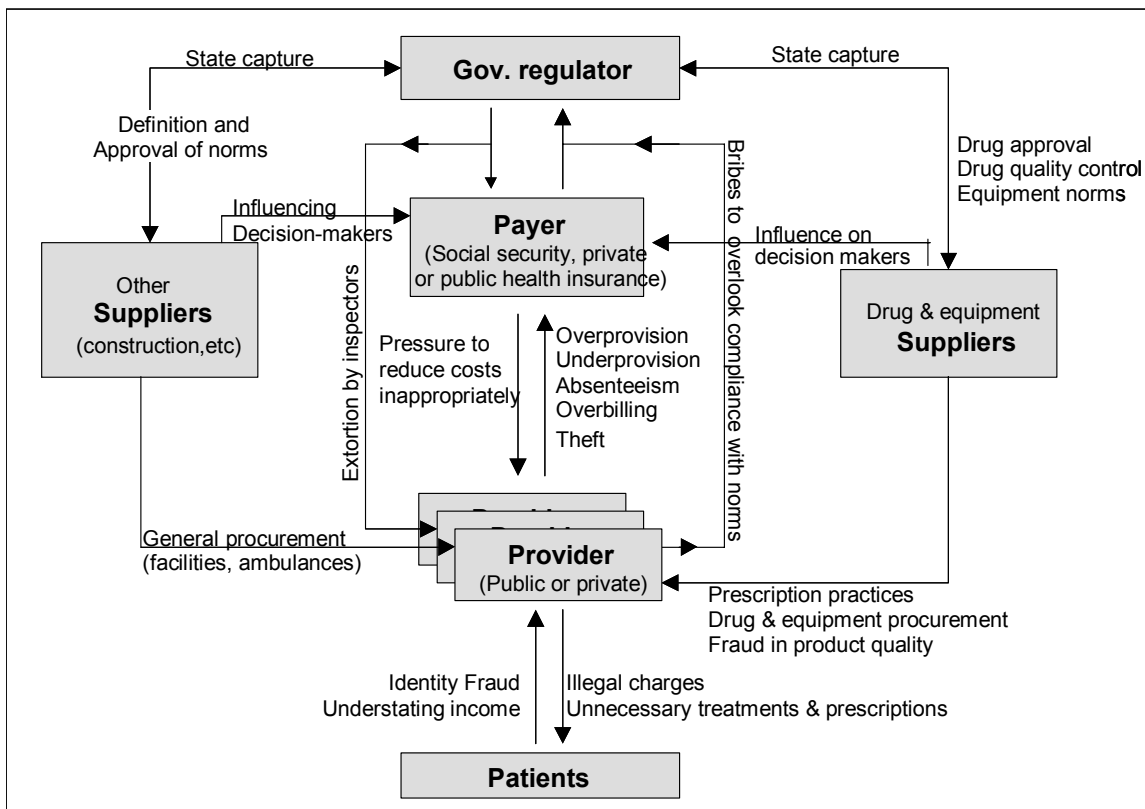
## CLASSIFYING BY ROLES AND RESPONSIBILITIES

Looking at relationships among different health system actors is the clearest way to classify abuses because all abuses involve transactions between two or more actors (See Figure 1 and Table 1). For example, an analysis can begin by looking at hospitals and determine what kinds of abuses may be occurring in its relationships to suppliers, insurers, regulators, patients and other hospitals, respectively. Alternatively, one can imagine looking at a Ministry of Health and its relationships to the Finance Ministry, other

branches of government, citizens, health care providers and insurance companies.

The roles and responsibilities embedded in these relationships are split between regulators, payers, health care providers, suppliers and consumers in ways that make good decision making difficult, even when everyone is thoroughly honest. When individuals are willing to take advantage of such a system, things become even more entangled. To see how this works, it is useful to consider, in turn, how each actor can use its position to defraud others.

Figure 1 How corruption and fraud is manifested in health systems



*Regulators (ministries of health, parliaments, supervisory commissions)*

The basic uncertainty in health care services creates a potential role for government to protect consumers through supervision and improved information. It is common for governments to assume the role of verifying that medications are safe and effective, that health care practitioners have completed approved courses or have proven skills, and that facilities are adequately staffed and equipped. However, the existence of regulations opens avenues for corrupt activities. Pharmaceutical companies can skew research studies, influence review boards or simply bribe regulators to approve or speed up the processing of their applications. Health care providers and facilities may be tempted to pay a regulator to overlook lapses in licensing requirements. As in any sector, government inspectors can be tempted to abuse their position to extract bribes even when providers are in compliance.

*Payers (social security organizations, health insurers)*

Other actors can defraud payers, but they can also engage in corrupt practices themselves. The public sector can act as a payer either through direct provision of care or as a public insurance agency. In the private sector, payers include commercial insurance firms and non-profit insurance organizations. Individuals can also be considered ‘payers’ when they pay fees directly to providers (see ‘consumers and patients’ below).

When the public sector provides services directly, it generally allocates resources through the normal public budgetary process. This creates opportunities for political interests to contravene decisions that are in the best interest of patients. For example, decisions may be made to favor regions governed by political allies, rather than following criteria of equity and efficiency.

When the public sector manages an insurance fund, as is common in countries with mandatory social insurance, corruption can occur when officials embezzle funds. The public insurer can also allocate resources for political gain and at the expense of patients or taxpayers.

Private insurers, whether for-profit or non-profit, can engage in abuse when they collaborate in public programs, or are subjects of regulation. They may defraud public sector programs that subsidize health care through fraudulent billing. They may reject insurance claims that they are committed to reimburse by law. And they may bribe insurance regulators to ignore illegal practices.

*Health care providers (hospitals, doctors, nurses, pharmacists)*

Health care providers have a wide range of opportunities to engage in abuse because they have such a strong influence over medical decisions, including prescribing medications, determining the length of a hospital stay, ordering tests and referring patients for additional consultations or services. In making these decisions, health care providers may act in ways that are not in their patients’ best interests, whether motivated by direct financial gain, increased prestige, greater power or improved working conditions. These risks are one of the reasons that health care professionals are generally bound by professional standards and ethical codes that are expressly aimed at deterring abuse.

Patients generally defer to health care professionals in determining what course of action should be taken to treat an illness. Consequently, health care providers are in the unique position of telling the ‘consumer’ what service ‘to buy’. When providers are paid ‘fee-for-service’ (i.e. a fee for each service that they provide), it is in their financial interest to provide more services, and more costly services, than might otherwise be indicated by the individual’s health condition. When providers are paid on a ‘capitated’ basis (i.e. a single fee to cover any services required by a patient enrolled in their care, regardless of how many are actually provided) then it is in their financial interest to provide fewer services than would otherwise be indicated by the individual’s health condition alone. When providers are paid a fixed salary, independent of the volume of services provided, there are no financial incentives to oversupply or undersupply services,

but there is a tendency to be less productive and provide less care.<sup>7</sup>

In the case of publicly employed health providers, a wide range of abuses can occur. They can abuse their public sector job by referring patients to their parallel private practice (or use public facilities and supplies to serve their private patients). They may defraud the public sector by accepting a full salary while absenting themselves to provide private consultations elsewhere. They may steal drugs and medical supplies for resale or use in other places, and solicit bribes from patients for services that are supposed to be free. Although these practices are generally illegal, they may be excused in many countries by people who see them as acceptable strategies for coping with low pay and poor working conditions.

Health care providers are also in a position to defraud payers in several ways. Most payment systems have to rely on the honesty of providers to state the kind and intensity of services that have been provided. Health providers may even create 'phantom' patients to claim additional payments. They can order tests to be conducted at private laboratories in which they have a financial stake, or prescribe expensive drugs in exchange for kickbacks or bribes from pharmaceutical companies.

In addition to health care providers, health facility officials may accept kickbacks to influence the procurement of drugs and supplies, infrastructure investments and medical equipment. In so doing, they may pay higher prices or overlook inadequate work.

#### *Patients*

Consumers or patients can also participate in abuse. In many systems, patients try to get free or

subsidized care by under-reporting their personal or family income. In other systems, patients misrepresent their enrollment in an insurance plan by using the insurance cards of friends or family members. This has been documented in Canada where the province of Ontario detected numerous people using forged cards to gain access to free public care (Norman Inkster 2002). Patients may also bribe doctors to obtain benefits for non-health issues, such as health certificates to obtain drivers licenses, to avoid serving in the military service or to obtain disability payments.

Paying bribes to get privileged access to public care is also a common form of corruption. In some countries, such bribes are socially acceptable and excused as a way to compensate poorly paid public sector health professionals, or as an understandable response by people who may be in dire need of care. When such bribes become 'institutionalized', however, it creates a situation in which wealthier people are likely to get better attention than those who are poorer and unable to pay bribes.

#### *Suppliers (producers of medical equipment, pharmaceutical companies)*

Medical equipment suppliers and pharmaceutical companies have privileged information about their own products and deliveries that create opportunities for abuse. Suppliers can skimp on the quality of equipment or repackage expired medications. They can short-change deliveries and bribe procurement officers to authorize higher prices. They can induce providers to use their products at inflated prices even when cheaper, equally effective alternatives are available. In the mid-1990s, Germany investigated 450 hospitals and more than 2,700 doctors for taking bribes from manufacturers of heart valves, life support equipment, cardiac pacemakers and hip joints (H. L. Karcher 1996). Suppliers can bribe public health authorities in any of their normal procurement processes, including kickbacks from companies that want to win lucrative hospital construction tenders (Transparency International 2005).

Finally, suppliers can bribe regulatory agencies to develop policies in their favor. For example,

---

<sup>7</sup> For a discussion of different payment mechanisms and their impact on provider behavior, see H. Barnum, J. Kutzin and H. Saxenian, 'Incentives and provider payment methods', *International Journal of Health Planning and Management* 10, 23-45, 1995 and also J.C. Robinson, 'Theory and Practice in the Design of Physician Payment Incentives', *The Milbank Quarterly* 2001 Nov 2;79.

pharmaceutical companies may influence governments to impede competition from generic drug manufacturers, or equipment producers may try to change regulations so that licensed facilities will be required to purchase their products.

### **USING HEALTH SYSTEM STRUCTURE TO IDENTIFY VULNERABILITIES**

Although health care providers, payers, consumers, regulators and suppliers are active in all health systems, the actual relationships, responsibilities and payment mechanisms will vary. Some countries have relatively well financed public health services that are directly provided by national or local governments (Sweden, Spain). In other high-income countries, the public sector pays for health services that are provided by private and public health care providers (Canada, Germany). In most low and middle-income countries, the health system is fragmented. It may include a public insurance scheme for formal sector workers; direct public provision of health care for the indigent; private insurers and providers contracted by wealthier households; and a large share of private practitioners who are paid directly by their patients, both rich and poor (Mexico, South Africa) (World Bank 2004; World Health Organization 2000; Inter-American Development Bank 1996).

Abuses in the health system aimed at personal gain are not exclusive to any particular country or health system. But the forms of abuse may differ depending on how funds are mobilized, managed and paid. For this reason, it is useful to classify health systems into two broad categories based on their institutional structure: systems in which the public sector finances and directly provides health care services, and systems that separate public financing from provision (see Table 2).

In the case of direct public provision of health care services, it appears that the most common forms of abuse involve kickbacks and graft in procurement; theft; illegally charging patients; diverting patients to private practice; reducing or compromising the quality of care; and absenteeism (see Table 3). By contrast, in systems that separate public financing from provision, the

most common forms of abuse appear to involve excessive or low quality medical treatment, depending on the payment mechanism used, and fraud in billing government or insurance agencies. This hypothesis – that forms of corruption vary across different health systems – has not been empirically proven. Nevertheless, it is a useful starting point for investigating what kinds of corruption are most prominent and problematic in a particular system.

#### *Systems with direct public provision*

In many countries, public health systems have been established to provide health care to the population at little or no cost at time of service. The most common structure for such systems involves a Ministry of Health, or its equivalent, which hires the necessary administrative, medical and support staff, builds facilities, and organizes the purchase and distribution of medications, equipment, and supplies. Many European countries follow this model. Integrated public health systems display a wide range of structural differences, whether through decentralization (as in Spain) or experimenting with autonomous health facilities (as in Sweden), but they share common approaches to allocating budgets and delivering services.

In developing countries, successes involving direct public provision of health care services are rare. In the most effective ones, health services do reach the bulk of the population (e.g. Chile, Cuba, Malaysia). In most cases, however, the public systems have been unable to reach large segments of the population or to provide adequate services (e.g. Venezuela and Indonesia). In the absence of complete coverage, countries sometimes finance, or at least subsidize, non-profit health care institutions, such as mission hospitals in Africa or NGO health clinics in the Americas.

The evidence available on corruption in health systems with direct public provision is largely focused on informal or illegal payments for services in developing or transitional economies. This form of corruption has a particularly negative impact on access to care for the poor when they cannot afford these payments.

For example, case studies in seven Latin American countries found that **illegal fees** were being charged in public hospitals (reported in Di Tella & Savedoff, 2001a). Among these, the evidence from Bolivia and Costa Rica was quite strong. In Bolivia, at the time of the study, the national Mother-Child Insurance Program guaranteed free care for the services included in the defined package. Nonetheless, 40% of surveyed patients indicated having paid fees for such services. The average payment was approximately US\$6.60 (G Gray-Molina *et al.* 2001). In Costa Rica, more than 85% of doctors and nurses stated that they knew of cases in which physicians unjustifiably charged for their services. About half the patients who were surveyed indicated they had paid as much as US\$35 for health services in the public sector – a value which is close to the average price of private sector consultations (J. A. Cercone *et al.* 2000).

Other studies of systems with direct public provision have focused on **theft** by employees. Studies of public hospitals in four Latin American countries – Bolivia, Costa Rica, Nicaragua, and Venezuela – found theft of supplies to be a serious problem. In Venezuela, about two-thirds of hospital personnel reported in a survey that they personally knew of cases in which supplies or medications were stolen (M. H. Jaén, D. Paravisini 2001). They estimated that an average of 10% to 13% of all supplies and medications were stolen. In Costa Rica, more than 70% of doctors and nurses reported that staff members stole equipment or materials from their hospital. When asked whether there was "a lot", "some", or "little" theft, about 22% of the nurses and 15% of the doctors reported "a lot" of theft, while another 57% and 41%, respectively, reported "some" (J. A. Cercone *et al.* 2000).

**Absenteeism** appears to be a common problem in many integrated public health systems. For example, staff in 22 Venezuelan hospitals indicated that doctors were absent about one-third of their contracted hours, while residents and nurses were absent about 13% and 7% of the time, respectively (M. H. Jaén, D. Paravisini 2001). In a Costa Rican survey, more than two-thirds of doctors and nurses responded that absenteeism was a problem in their hospital; and of these, 80%

characterized the absences as either "daily" or "once or twice a week" (J. A. Cercone *et al.* 2000). A similar study of four hospitals in Peru, 32% of the doctors and nurses classified absenteeism among doctors as "very common" or "common" (L. Alcázar, R. Andrade 2001).

Less commonly studied, but clearly of substantial importance, is the problem of **kickbacks and graft in procuring medical supplies**. Four studies in Latin American public hospitals demonstrated that the prices paid for simple homogeneous products varied significantly in ways that could only be attributed either to gross mismanagement or fraud. After controlling for different volumes, distances, size of hospitals and other factors, the unexplained variation across hospitals in prices paid for cotton, dextrose, saline solution, or simple antibiotics continued to vary by margins of as low as three-to-one and as high as 30 to 1 (R. Di Tella, W. D. Savedoff 2001).

#### *Systems that separate public financing from provision*

In many health systems, the entity that finances health services is separate from the entity providing those services. This is common in countries with social insurance systems such as France and Germany, in large federated countries such as Brazil and Canada, and in systems with public safety nets such as Medicaid and Medicare in the United States. This separation of public financing and provision is rare in low-income countries, but is common in high-income countries, and in the middle-income countries of Latin America and Asia.

When public financing is separated from provision, the character of abuses is likely to change, focusing on ways to divert the flow of payments and reimbursements. One central aspect influencing the type of abuse is the payment mechanism chosen by the financers to pay providers for their services. For example, medical professionals who are reimbursed on a fee-for-service basis have no incentive to be absent from work, but dishonest ones may be tempted to overcharge for services, bill for services that were not provided, or order tests and procedures that are not medically indicated. Provider payments on

a capitation basis may introduce the right incentives for providers to focus more on preventive than on curative care, but it may also motivate the dishonest ones to neglect the provision of necessary care or to reduce quality below acceptable standards.

The public financing agent itself may be a focus for corruption, with officials diverting funds to improper uses or for personal financial gain. Furthermore, public reimbursement of private providers, in systems where this is permitted, raises a wide range of regulatory issues. The government frequently establishes regulations to assure that private providers meet minimum quality standards. Such regulations create opportunities for corruption in licensing procedures and inspections.

In Latin America, the problem of **inducing treatments** that are not medically indicated for pecuniary gain has been documented in several instances. For example, in Peru, a review of four hospitals – one private that was reimbursed by insurers, the other three public – demonstrated that after controlling for risk factors, the private hospital performed an excessive number of Caesareans. The differences were not even marginal. More than 70% of the births at the private hospital were Caesareans deliveries compared to "only" 20% in the public hospitals, despite the fact that the population in the private hospital was lower risk (as indicated by mother's age, infant's weight and head circumference, etc.) (L. Alcázar, R. Andrade 2001).

**Billing fraud** has been addressed extensively in the business and public management literature but is less well documented in Latin America. A Transparency International highlighted the problem of billing fraud in the United States (L. Aronovitz 2002); insurance fraud in Colombia (Londoño Soto 2002); and billing fraud in Canada (N. Inkster 2002). In each of these cases, governments were billed for services that were not provided or they were overcharged. In the Colombian case, the Secretary of Health found that the newly reformed health insurance system was vulnerable to fraud by insurers who continued to bill the government for clients who had died or switched their enrolment to other insurers. In this

case, developing an effective information system to track enrolment was the first priority for stemming the diversion of funds.

#### *Common forms of corruption in all health systems*

Cutting across both types of systems are forms of abuse in the processes of allocating public funds and transferring public funds between national and sub-national entities. Sometimes there is **large-scale diversion of funds** at the ministerial or senior management levels of a health system; in other cases, funds are diverted from their intended purposes when they are transferred to lower-level political administrators. Though these forms of embezzlement can potentially cost the system more than other forms of corruption that occur at the facility level, they are studied less often and are poorly documented.

Both types of health systems also share the vulnerability to abuses related to counterfeit drugs, selling faulty equipment, misrepresenting the quality or necessity of medical supplies and conflicts of interest between purchasers, providers, suppliers and researchers.

#### *A tale of two countries: health systems in Venezuela and Colombia*

A closer look at two countries demonstrates how corruption manifests itself differently across health systems. Colombia and Venezuela are neighboring Latin American countries with comparable incomes that share many similarities in history, culture and language. Until 1990, the two countries also had similarly fragmented health systems, comprised of a large social security institutions that served the formal sector; national or state-level governments that directly provided health care services to the rest of the population; and an active private sector that relied predominantly on direct payment for services by patients and their families.

In the early 1990s, Colombia implemented health reforms that decentralized public services to the municipal level and, in parallel, created a mandatory universal insurance system with the participation of non-governmental insurers (for-profit and non-profit). Under the new insurance

system, individuals were given the option of choosing their insurer. The content and price of the benefit package was defined at the national level with the hope that insurers would compete on quality of care and service.

To make the system more equitable, the reform created a national fund that taxed away a portion of the relatively high contributions made by upper-income individuals so as to subsidize the relatively low contributions made by lower-income individuals. As a result of this system, insurers are guaranteed a fixed premium for each member, adjusted by age and sex, which should be invariant to the individual's actual income. In this way, Colombia shifted from a segmented system dominated by large public institutions with integrated provision, to an increasingly universal system dominated by a separation of payers and providers.

Unfortunately, both countries have experienced a great deal of corruption in all sectors, and the health systems are no exception. A comparison between the two countries at the end of the 20<sup>th</sup> century reveals that corruption was widespread, but had taken somewhat different forms as their health systems diverged. For example, a large share of staff in public hospitals in both countries reported a range of irregularities, including theft, graft, absenteeism and bribe taking (R. Di Tella, W. Savedoff 2001). However, 59 per cent of staff surveyed in Bogotá's public hospitals reported that such irregularities had declined since implementation of the health reform. Staff in Venezuelan hospitals reported that doctors were absent from work about 37 per cent of the time while absenteeism in Colombia's public hospitals apparently accounted for less than 6 per cent of doctors' time. Although the available evidence is sparse, and certainly not conclusive, the differences suggest that public hospitals under the new system in Colombia may have been characterized by fewer irregularities.

On the other hand, Colombia's health reform opened an entirely new avenue for corrupt activities. The large flows of funds involving contributors, non-governmental insurers and government subsidies for low-income subscribers became targets for abuse. In the mid-1990s,

Bogotá's Secretariat of Health – responsible for administering subsidies for low-income subscribers – began to audit the lists of members submitted by insurers for reimbursement. They found that benefits were being received by 114,000 new affiliates, far beyond the increase that could be expected through the extension of universal coverage. Instead, the Secretariat found that insurers kept individuals on their books, so they could continue to receive government subsidies, even after the same individuals had signed on to a new insurer. The practice was facilitated by the fact that individuals were often unfamiliar with the insurance system and didn't understand the implications of signing a new application. Some insurers failed to issue their members with the required documentation, undermining their ability to access the services to which they were entitled. Finally, some insurance agents simply submitted false applications. As a result, Bogotá was defrauded of millions of dollars until it established a unified database, and began to scrutinize and investigate claims more intensely. Similar practices, however, were likely to have continued in the rest of the country wherever claims were less actively scrutinized.

In sum, corruption and fraud have been documented in Latin America and Caribbean health systems. These abuses are most clearly seen in the transactions between key health system actors: regulators, payers, providers, suppliers, and clients. The abuses include forms that appear to be most common in integrated public health systems, such as kickbacks in procurement, theft, illegal charges to patients, reducing the quality of care and absenteeism. The forms that appear to be most common in systems with separate financing and provision include excessive medical treatment and fraud in billing. Other forms that are less well documented but which are likely to affect both kinds of systems include large-scale embezzlement, bribing regulators, counterfeit drugs, and conflicts of interest in medical research and drug prescription. Because Latin American and Caribbean countries have such complex health systems, frequently incorporating elements of both kinds of systems, the range of corrupt and fraudulent practices is quite wide.

# What To Do About Corruption in Latin America and The Caribbean's Health Systems?

## EXISTING ANTI-CORRUPTION INITIATIVES

Initiatives aimed at improving governance and reducing corruption have been around for centuries – wherever social leaders have pointed fingers at malfeasance in government. But in the last twenty years, initiatives that involve civil society and international agencies have proliferated. The following discussion of existing anti-corruption initiatives presents only a few internationally prominent initiatives, selected for their relevance to the IDB's work and for the availability of documentation. The choice of initiatives presented here is not a comprehensive list of international initiatives nor is it meant to imply that domestic initiatives are less important or less successful.

Anti-corruption initiatives take many different forms. For example, such initiatives can be:

- explicit and open about controlling corruption or discreet and focused on improving governance and management without explicit attention to corruption
- general to all aspects of domestic governance or specific and focused on one or a few sectors
- led by the government or by civil society
- focused on improving public sector management and administration or on increasing accountability to citizens
- aimed at identifying and punishing specific instances of corruption or at implementing measures to reduce corruption in the future
- aimed at primarily increasing information and transparency or at reducing impunity and increasing penalties

### *The World Bank's Governance Initiatives*

As an example of general anti-corruption activities, the World Bank has been promoting better governance through national level consultations and action plans. The World Bank

assists countries in appointing high profile committees to investigate the scale and scope of corruption in their societies, to set priorities for anti-corruption activities, and to develop and implement action plans. Frequently, these committees are supported by empirical investigations, including surveys that seek to identify the most egregious problems. So, for example, one country may focus on cleaning up corruption in its customs service and trade programs, while another may focus on reducing corruption among local security forces. The key attributes of such initiatives are that they are publicly led, require high-level political commitment, rely on surveys and focus groups for information, and involve the media and the public both through dissemination strategies and by opening channels for participation.

### *Expenditure Tracking Initiatives*

At the sector level, the World Bank has a number of initiatives aimed at measuring the extent to which resources are diverted from their intended use in delivering public services. One of the key instruments is a Public Expenditure Tracking Survey (PETS) that utilizes a combination of government budget analysis and surveys of service facilities to ascertain the extent to which budgeted resources are actually arriving at decentralized levels (R. Reinikka, J. Svensson 2003). An associated instrument is the Quantitative Service Delivery Surveys (QSDS) that goes beyond the PETS focus of tracking funds. It examines the efficacy of spending, as well as incentives, oversight, and the relationship between those who contract for a service and those who deliver it.<sup>1</sup>

---

<sup>1</sup> For World Bank work on PETS and QSDS, see list of web resources in the appendix.

### *Audits and Action Plans*

Numerous governments have researched their own performance or engaged external firms to audit their accounts and help them control corruption. The IDB's support for research on corruption in public hospitals in Bogotá, Colombia provided information that assisted the Secretary of Health in reducing theft and improper billing in public hospitals (U. Giedion *et al.* 2001). The Secretary of Health in Bogotá also initiated a review of insurance rolls to detect duplicate enrolment and reduce corruption (B. Londoño Soto 2002).

### *Citizen Voice and Empowerment*

Transparency International has promoted a highly diverse number of initiatives aimed at increasing information about government activities in ways that empower citizens to take action and hold politicians accountable. An early example of effective community empowerment began in 1993 when the Public Affairs Centre (PAC) of Bangalore, India began to survey citizens about public services and publish Report Cards (K. Gopakumar 1998). One of the more dramatic and widely reported stories from these Report Cards related to bribes that people paid in order to see their babies in maternity wards. The Report Cards are used for advocacy, priority setting, identifying problems, and assisting in designing remedial actions. A similar strategy has been employed in Mexico, where a National Survey on Corruption and Good Governance in 2001 and 2003 assessed the performance of 38 different public services in 32 states using responses from approximately 14,000 households (Transparencia Mexicana 2005). The State of Chiapas responded to its low ranking in 2001 by implementing an e-government program for public service delivery and its ranking rose from 16<sup>th</sup> out of 32 states in 2001 to 6<sup>th</sup> out of 32 states in 2003.

### **WHAT CAN THE IDB DO?**

As mentioned earlier, most initiatives to improve the efficiency of health systems already contain numerous measures that should reduce corruption. Systems that are better managed are more likely to have information that brings illicit activities to

light; systems that are held accountable for their results cannot tolerate diversion of scarce resources that are necessary to achieve good performance. Thus, many of the IDB's health system projects are probably already addressing corruption, if only indirectly.

The IDB would be well advised, however, to address corruption more openly in the health sector, if only to provide project team leaders and their counterparts in member countries with additional tools for improving the delivery of health services to the population. In some cases, a project focused on reducing corruption might be politically difficult to initiate and implement; but in other cases, framing a project in terms of reducing corruption may garner additional support from new stakeholders inside and outside the health sector. The best way to proceed will depend on the context.

The IDB should consider promoting activities to address corruption in the health sector in the following six areas:

- Advocacy,
- Research,
- Sector-Wide Strategies,
- Functional Projects,
- Citizen Empowerment, and
- Special Issues.

In each case, since this is such a new area of work, it is important to design programs in such a way that they are well documented and their results can be disseminated. For this reason, the standard form for all anti-corruption programs should include financing and components for gathering initial information; developing action plans and implementing them; documenting the entire process from design through implementation; and disseminating the experience through documents, workshops and press releases.

A model Technical Cooperation for addressing corruption in public hospitals (see appendix) provides an example of such an approach. It involves (1) contracting a forensic accounting firm to gather information about the current state of public hospital finances and identify areas where abuses may be most problematic, (2) propose action plans to control problems that are

identified, (3) document the process of analysis and implementation, and (4) hold workshops to disseminate the experience.

### *Advocacy*

One of the most powerful ways to combat corruption is to increase transparency accountability. Public pressure cannot be brought to bear against corruption and fraud if it is either invisible or accepted as a social norm. Advocacy initiatives can reduce corruption by bringing public attention to corrupt acts and by confronting social resignation. Some possible activities include:

- The Special Topic of Transparency International's 2006 Global Corruption Report is on the health sector. It was published in January, 2006. The IDB could partner with Transparency International to hold panel discussions on the Report at the IDB's annual meetings and other prominent forums in the region.
- The IDB has already co-sponsored several panels at Transparency International's annual conference on corruption in the health sector. Additional panels can be co-sponsored on new topics *and their results should be better disseminated in the Region.*
- The IDB could partner with the World Bank and Transparency International to hold regional workshops on how to combat corruption in the health sector. This would include exposing member countries to the existence of many tools for measuring and confronting corruption such as survey instruments (e.g. PETS) and citizen initiatives (e.g. TI's toolkits).
- Health reform projects could include small components to hold workshops upon project initiation that disseminate the content of the program and its funding so that citizen groups can hold the government (and the IDB) accountable for the use of project funds.

### *Research*

Research provides the information necessary to support strong advocacy, draw attention to more critical problems and design effective solutions.

Some possible research activities that the IDB could promote include:

- Develop aggregate health sector indicators of corruption (e.g. absenteeism, prices, share of people paying bribes, share of expenditures reaching service points), collect data, and publicize it (similar to aggregate corruption indices that are published by TI and the World Bank but specific to health services).
- Conduct case studies. The IDB has already published a volume on corruption in public hospitals using the Latin American Research Network that is widely cited and represents one of the few public documents with a strong empirical basis for understanding health sector corruption in the region (R. Di Tella, W. Savedoff 2001). Similar research could be done on topics such as public sector drug management and distribution; construction of facilities and procurement of equipment; fraud and abuse in health insurance funds; and expenditure tracking.

### *Sector-wide strategies*

One of the most important ways the IDB can support its member countries is to help them assess the scope of corruption in their health sectors, set priorities and develop action plans. Activities in this category might include:

- Support the creation of a high-level health sector anti-corruption steering committee that would hold meetings, commission research through surveys and focus groups, develop a consensus on the scope and forms of corruption in the country; and propose a national action plan to address corruption. Some of the recommendations coming out of such a committee would be widely publicized and disseminated and could form the basis for future IDB-funded programs.
- Contract consulting firms (e.g. Forensic Accountants) to review public expenditures in the health sector, identify areas with a high risk of corruption, and propose remedial actions.
- Compare national public expenditure information against facility level surveys to identify if and where funds are being diverted away from service delivery (e.g. PETS and QSDS).

### *Functional Projects*

Once specific functions within the health sector have been identified as vulnerable to corruption, specific projects can be designed to address them. Depending on the country's interest and the problems it faces, the IDB could support a variety of operations to combat corruption.

In each case, the general approach would be to collect information on the scope and forms of corruption, analyze the factors that are most problematic, develop action plans, implement changes, document the process, and disseminate the lessons learned. Specific functional areas that might be the focus of such programs include:

- Procurement, distribution and use of drugs within public health services
- Management of public hospitals (including procurement and human resources)
- Provision of primary health care services in public facilities (including illegal charges)
- Construction of public health facilities and procurement of equipment
- Billing practices of insurance entities and private providers
- Expenditure tracking for social insurance entities

### *Citizen Empowerment*

A variety of initiatives mobilize citizens through information, participation or direct involvement in accountability structures. The IDB could finance activities that include:

- Collecting data about public health services and publicizing them as "Report Cards" (similar to the Public Affairs Centre program in Bangalore, India)
- Convening stakeholder meetings at local levels to discuss information about expenditures for, availability of, and quality of local health services
- Supporting government efforts to create formal citizenship oversight for public health services (e.g. local hospital boards that were established in Bolivia with public participation).

### *Special Projects*

A number of special projects could be supported to address corruption in areas that may not be directly related to the provision of public health services but which, nonetheless, may be critical to maintaining trust and confidence in the professional practice of medicine. For example, some of the Region's wealthier countries have strong professional associations, medical education establishments, medical research institutions and pharmaceutical corporations that may be vulnerable to conflicts of interest. The IDB could convene and support national efforts to assess the scope of such conflicts of interest, their implications for population health, and potential actions that can be taken, including: reviewing and revising codes of ethical conduct, establishing professional oversight boards, or strengthening citizen watchdog organizations. A range of experiences is already available to learn from in countries from both within (e.g. Brazil) and outside (e.g. US and UK) the Region.

### **BUT WE CANNOT DO EVERYTHING ...**

In order to avoid concluding this paper with an open-ended list of potential projects that the IDB could undertake, this section focuses attention on five specific activities that, in the opinion of the author, are the most practical and feasible. As mentioned earlier, each of these initiatives should be designed to recognize the pilot nature of the experiences, to document the experience, and to include funding to disseminate and teach whatever is learned from the process.

1. **Advocacy.** The IDB should partner with Transparency International and hold sessions at its Annual Meetings to review the findings of the 2006 Global Corruption Report on corruption in health. Follow-up seminars should be held in partnership with Transparency International country level organizations (e.g. *Transpar ncia Mexicana*).
2. **Public Hospitals in Large Cities.** The IDB should finance stand-alone technical cooperation or components of large health sector operations to contract forensic

accountants to analyze public hospital revenues and uses of funds, identify major leakages, design remedial actions, support implementation, and disseminate lessons. See the appendix for a model Technical Cooperation.

3. Public Sector Drug Management. The IDB should finance stand-alone technical cooperation or components of large health sector operations to contract forensic accountants to analyze public sector procurement, distribution, and use of drugs, identify major leakages, design remedial actions, support implementation, and disseminate lessons.

4. Social Health Insurance. The IDB should finance stand-alone technical cooperation or components of large health sector operations to contract forensic accountants to analyze the accounts of social health insurance entities, identify major leakages, design remedial actions, support implementation, and disseminate lessons.

5. Local Health Service Delivery. The IDB should finance stand-alone technical cooperation or components of large health sector operations to conduct expenditure tracking surveys, convene and disseminate results to citizens, and encourage the formation of public watchdog associations to assure that funds reach their intended uses.

## Reference

- Alcázar, L., Andrade, R. "Induced demand and absenteeism in Peruvian hospitals," Di Tella, R., Savedoff, W. D., *Diagnosis, corruption: fraud in Latin America's public hospitals*. Washington, D.C.: Inter-American Development Bank, 2001, 123-162.
- Aronovitz, L. "Allegations of inaccurate billing in the Medicare system in the United States," *Corruption in Health Services: Papers presented at the 10th International Anti-Corruption Conference Workshop "Corruption and Health", Prague, Czech Republic, October 2001*. Washington D.C.: Inter-American Development Bank, 2002, 5-9.
- Bardhan, P. "Corruption and development: a review of issues." *Journal of Economic Literature*, September 1997, 25 1320-1346.
- Cercone, J. A., Durán-Valverde, F., and Muñoz-Vargas, E. Compromiso de gestión, rendición de cuentas y corrupción en los hospitales de la Caja Costarricense de Seguro Social. R-418. 2000. Washington, D.C., Inter-American Development Bank. Latin American Research Network Working Paper.
- Di Tella, R., Savedoff, W. *Diagnosis corruption: Fraud in Latin America's public hospitals*. Washington, D.C.: Inter-American Development Bank, 2001.
- Di Tella, R., Savedoff, W. D. "Shining light in dark corners," Di Tella, R., Savedoff, W. D., *Diagnosis corruption fraud in Latin America's public hospitals*. Washington, D.C.: Inter-American Development Bank, 2001, 1-26.
- Giedion, U., Morales, L. G., Acosta, O. L. "The impact of health reforms on irregularities in Bogota Hospitals," Di Tella, R., Savedoff, W. D., *Diagnosis, corruption: fraud in Latin America's public hospitals*. Washington, D.C.: Inter-American Development Bank, 2001, 163-198.
- Gopakumar, K. Citizen feedback surveys to highlight corruption in public services: the experience of Public Affairs Centre, Bangalore. 1998. Transparency International.
- Gray-Molina, G, Pérez de Rada, E., Yañez, E. "Does voice matter? Participation and controlling corruption in Bolivian hospitals," Di Tella, R., Savedoff, W. D., *Diagnosis corruption fraud in Latin America's public hospitals*. Washington, D.C.: Inter-American Development Bank, 2001, 26-56.
- Gupta, S., Davoodi, H., and Tiongson, E. Corruption and the provision of health care and education services. 1-28. 2003. International Monetary Fund (IMF Working paper).
- Inkster, Norman. A Case Study in Health Care Fraud Ontario, Canada. 17-22. 2002. Washington, DC, Inter-American Development Bank. *Corruption in Health Services: Papers presented at the 10th International Anti-Corruption Conference Workshop "Corruption and Health", Prague, Czech Republic, October 2001*.
- Inter-American Development Bank. *Economic and social progress in Latin America, 1996 report :special section, making social services work*. Washington D.C.: Distributed by the Johns Hopkins University Press for the Inter-American Development Bank, 1996.

- Jaén, M. H., Paravisini, D. "Wages, capture and penalties in Venezuela's public hospitals," Di Tella, R., Savedoff, W. D., *Diagnosis corruption: fraud in Latin America's public hospitals*. Washington, D.C.: Inter-American Development Bank, 2001, 57-94.
- Karcher, H. L. "German heart valve scandal escalates." *British Medical Journal*, January 1996, 312 78.
- Lewis, M. "Informal health payments in central and Eastern Europe and the former Soviet Union: issues, trends and policy implications," Mossialos, E., Dixon, A., Kutzin, J., Figueras, J., *Funding health care: options for Europe*. European Observatory on Health Care Systems, 2001, 219-245.
- Londoño Soto, Beatriz. "Corruption and the Colombian Health System Reform," *Corruption in Health Services: Papers presented at the 10th International Anti-Corruption Conference Workshop "Corruption and Health", Prague, Czech Republic, October 2001*. Washington, DC: Inter-American Development Bank, 2002, 23-26.
- Reinikka, R. and Svensson, J. Survey techniques to measure and explain corruption. 1-16. 2003. Washington, D.C., The World Bank. Policy Research Working Paper Series No 3071.
- Sen, Amartya. *Development as Freedom*. Oxford: Oxford University Press, 1999.
- Transparencia Mexicana. "Measuring Corruption in Public Service Delivery: The Experience of Mexico," *Global Corruption Report 2005*. Ann Arbor, MI: Pluto Press, 2005, 248-251.
- Transparency International. *Global Corruption Report 2005*. Ann Arbor, MI: Pluto Press, 2005.
- World Bank. *World Development Report 2004: Making Services Work For Poor People*. Washington, DC: World Bank, 2004.
- World Health Organization. *The World Health Report 2000. Health Systems: Improving Performance*. 2000. Geneva, World Health Organization.

# Annexes

**Table 1: Health System Actors' Roles and Potential Forms of Corruption**

From \ To	Govt Regulator	Payer	Providers	Drug & Equipment suppliers	Other Suppliers (construction, etc.)	Patients, Family & Friends
<b>Govt Regulator</b>	X	Extortion by auditors	Extortion by inspectors	Extortion for drug approvals or to overlook non-compliance with standards	Extortion to overlook non-compliance	
<b>Payer</b>	Bribes to overlook financial malfeasance	X	Pressures to reduce costs by compromising health care	Pressures to reduce costs by relaxing quality standards or misinformation	Pressure to reduce costs by relaxing quality standards	Misinformation about insurance coverage Wrongful denial of claims Embezzlement
<b>Providers</b>	Bribes to overlook compliance with laws & norms	Overprovision Underprovision Absenteeism Overbilling Phantom patients Theft	X	Kickbacks and graft	Kickbacks and graft	Overcharges Illegal charges
<b>Drug &amp; Equipment suppliers</b>	Bribing regulators	Bribing decision-makers	Misinformation Bribes to alter prescription practices Kickbacks in procurement Fraud in quality of products delivered	X		Excessive prices Knowingly selling counterfeit and poor quality products
<b>Other Suppliers (construction, etc.)</b>	Bribing regulators	Bribing decision-makers	General procurement Kickbacks		X	
<b>Patients, Family &amp; Friends</b>		Misrepresentation Identify theft False claims	Bribes for privileged attention			X

**Table 2: Selected classification of corruption and fraud by where it is expected to be most problematic**

<b>Integrated Public Systems</b>
<ul style="list-style-type: none"> <li>Kickbacks and graft in Procurement</li> <li>Theft</li> <li>Illegal charges to patients</li> <li>Diverting public patients to private practice</li> <li>Reducing or compromising the quality of care</li> <li>Absenteeism</li> </ul>
<b>Separate finance and provision</b>
<ul style="list-style-type: none"> <li>Excessive medical treatment</li> <li>Fraud in billing: fictitious clients or services</li> <li>Fraud in billing: upcoding</li> </ul>
<b>Cross-cutting forms of abuse</b>
<ul style="list-style-type: none"> <li>Large-scale diversion of funds</li> <li>Bribing or influencing regulators</li> <li>Counterfeit drugs</li> <li>Misrepresenting the quality or necessity of medical supplies</li> <li>Conflicts of interest between purchasers, providers and researchers</li> </ul>

**Table 3: Forms of abuse detected in public hospitals in Latin America (Di Tella and Savedoff 2001)**

	Venezuela	Argentina	Bolivia	Perú	Colombia	Costa Rica	Nicaragua
<b>Theft</b>	X		✓			✓	✓
<b>Absenteeism</b>	X	✓		✓	✓	✓	✓
<b>Illegal Fees</b>			X			✓	✓
<b>Overpayment for Supplies</b>	X	X	X		X		
<b>Excessive Cesareans</b>				X			

A check mark indicates that the problem was identified as serious. An X indicates that it was identified as a serious problem and was analyzed with a statistical model in Di Tella and Savedoff 2001.

## RESOURCES ON THE WEB

### Methods of measurement:

Governance Diagnostic Capacity Building at  
<http://www.worldbank.org/wbi/governance/capacitybuild/index.html>

Reinikka, R. & Svensson, J. Survey techniques to measure and explain corruption. 1-16. 2003.  
Washington, D.C., The World Bank. Policy Research Working Paper Series No 3071.  
<http://econ.worldbank.org/view.php?type=5&id=27279>

Public Expenditure Tracking Surveys:  
<http://lnweb18.worldbank.org/ESSD/sdvext.nsf/81ByDocName/ToolsandMethodsInstitutionalanalysisPublicexpendituretrackingsurveys>

Quantitative Service Delivery Surveys:  
<http://lnweb18.worldbank.org/ESSD/sdvext.nsf/81ByDocName/ToolsandMethodsInstitutionalanalysisQuantitativeservicedeliverysurveys>

### Methods for reducing corruption through increased transparency, including community participation methods:

Coté-Freeman, Susan "What NGOs Can Do About Corruption", Transparency International, March 1999.  
[http://www.transparency.org/working\\_papers/cote-freemann/scfreeman.html](http://www.transparency.org/working_papers/cote-freemann/scfreeman.html)

<http://www.transparency.org/toolkits/index.html>

### Accounting approaches to deterring fraud:

American Institute Of Certified Public Accountants. "Management Antifraud Programs and Controls: Guidance to Help Prevent and Deter Fraud." <http://www.respondanet.com/english/index.htm>

### Using public electronic procurement to reduce corruption:

"The Pharmaceutical Supply and Distribution System: The Chilean Experience, " Jillian Cohen, Sandra Rosenhouse, Julio Sanchez Loppacher and Jorge Carikeo Montoya. Montoya. World Bank , IESE and World Bank (2000), prepared for Europe and Americas Forum on Health Sector Reform, Costa Rica, 2000.  
<http://www.worldbank.org/lachealth>

Ministry of Health, Chile. Central de Abastecimiento del SNSS web page:  
<http://www.cenabast.cl/>

**MODEL IDB TECHNICAL COOPERATION  
Inter-American Development Bank  
Technical Cooperation Program (Trust Funds)**

**T/C BRIEF**

**TC N°:** \_\_\_\_\_

**I. GENERAL INFORMATION:**

Name of the T.C. Project: Control of Misuse of Resources in Hospitals in CITY, COUNTRY  
Name of the Fund: TRUST FUND  
Beneficiary Country: COUNTRY  
Beneficiary Agency: Secretary of Health of CITY, COUNTRY  
Estimated Total Amount to be Financed:  
- Amount to be financed by trust fund US\$230,000  
- Amount to be financed by local counterpart US\$120,000  
Execution and Disbursement Deadlines 1 Year Project from signature

**II. OBJECTIVES:**

The long term goal of this operation is to reduce the misuse of resources in public hospitals in Latin America due to fraud and other illegal activities. The specific objective is to demonstrate how Latin American and Caribbean countries can reduce the misuse of resources in public hospitals through a practical experience in five hospitals. The operation will generate (1) an action plan for reducing resource abuses in five hospitals in CITY, COUNTRY, and (2) guidelines and training for supporting similar operations in other Latin American and Caribbean countries.

**III. DESCRIPTION:**

This operation has two main components. The first component will contract a consulting firm to work with the Secretary of Health in developing an action plan to reduce and control the major channels of fraud and abuse in five public hospitals. The second component will finance the development and dissemination of guidelines for addressing fraud and abuse in public hospitals.

This operation will contract a consulting firm capable of analyzing and implementing action plans for reducing the misappropriation of resources in the public health sector. The firm must have staff with demonstrated expertise and experience in forensic accounting, hospital management, and public administration in a variety of international and cultural contexts. The firm will be responsible for carrying out the following activities:

**Component 1: Action Plan for Reducing Fraud and Abuse in 5 municipal hospitals (US\$150,000)**

1. The firm will identify the main areas of misappropriation of resources (money, materials, staff time) in five hospitals in one Latin American municipality through an initial inquiry in collaboration with the municipal government.
2. The firm will analyze the existing and potential administrative and managerial mechanisms for detecting, punishing, and preventing the misuse of resources.
3. In collaboration with the municipal government, the firm will develop an action plan for implementing institutional changes, administrative procedures, and managerial controls aimed at reducing fraud and abuse.

**Component 2: Dissemination and Replication of the Pilot Experience (US\$80,000)**

1. The firm will prepare guidelines that present a concise introduction to the issues, problems, and strategies for controlling misuse of resources in public hospitals as relevant to the Latin American context – with specific reference to the experience of the pilot project
2. The firm will present the guidelines, along with training in specific aspects of controlling corruption to IDB Staff in a one day seminar, and
3. The firm will draft a model “Plan of Operations” that could be used by IDB staff in cases where member countries request support for similar operations, either as stand-alone Technical Cooperation or as components of health sector loans.

The operation will require 6 person-months of senior level consultants and 20 person-months of junior level consultants over a period of one year. It will also cover travel expenses.

**IV. JUSTIFICATION:**

The proposed operation is a direct outgrowth of the Bank’s efforts to respond to member country interest in addressing fraud and abuse as detailed in the OAS Anti-Corruption Convention of 1996. It is a logical part of the Bank’s “Strategy for the Reform of Social Service Delivery” (GN-1932) and “Strategy for the Modernization of the State” (GN-XXXX). The operation is of direct interest to the Municipal Government of CITY, COUNTRY, which has requested support in addressing fraud and abuse in its municipal hospitals. The successful completion of this operation will not only benefit the municipality and its citizens by making hospital services more effective and cost-efficient. It will also provide a model for similar operations in other municipalities in COUNTRY and other member countries, through stand-alone technical cooperations or as components of IDB-financed health programs addressing changes in hospital management more broadly.

**V. BUDGET:**

Category	IDB	Counterpart	Total
Honorarium	US\$180,000	-	US\$180,000
Per Diem	US\$ 35,000	-	US\$ 35,000
Travel	US\$ 15,000	-	US\$ 15,000
Subtotal			US\$230,000
Counterpart Staff Time, Equipment, and Facilities		US\$120,000	
	US\$120,000		

**VI. RESPONSIBILITY IN THE BANK:**

SDS/SOC will have technical responsibility for this operation. STAFF MEMBER (number, fax, email) will be the Bank Officer responsible for this project, and will assure coordination with LEG through the collaboration of STAFF MEMBER and with REGIONAL DEPARTMENT through the collaboration of STAFF MEMBER.

**Responsibility for Disbursements:**

Disbursements will be authorized by the responsible bank officer according to the following schedule:

30% of the Contract will be disbursed upon signature

40% of the contract will be disbursed upon completion and acceptance of the Action Plan (See Component 1)

30% of the Contract will be disbursed upon completion and acceptance of the guidelines and training (See Component 2).

**MODEL IDB TECHNICAL COOPERATION (continued)**

**Terms of Reference  
Consulting Firm  
Control of Hospital Fraud and Corruption in CITY, COUNTRY  
DATE**

***Objectives:***

The goal of this operation is to improve the use of resources in five public hospitals in CITY, COUNTRY that might otherwise be diverted through fraud and corruption. Specifically, the operation will generate (1) an action plan for reducing fraud and corruption in five hospitals in CITY, and (2) guidelines for supporting similar operations in other Latin American and Caribbean countries.

***Description:***

This operation has two main components. The first component will contract a consulting firm to work with the Secretary of Health in developing an action plan to reduce and control the major channels of fraud and corruption in five public hospitals. The second component will finance the development and dissemination of guidelines for addressing fraud and corruption in public hospitals.

This operation will contract a consulting firm capable of analyzing and implementing action plans for reducing fraud and corruption in the public health sector. The firm must have staff with demonstrated expertise and experience in forensic accounting, hospital management, and public administration in a variety of international and cultural contexts.

The operation will require 6 person-months of senior level consultants and 10 person-months of junior level consultants over a period of six months. It will also cover travel expenses.

The firm will be responsible for carrying out the following activities:

1. The firm will identify the main areas of misappropriation of resources (money, materials, staff time) in five hospitals in CITY through an initial inquiry in collaboration with the municipal government.
2. The firm will analyze the existing and potential administrative and managerial mechanisms for detecting, punishing, and preventing the diversion of resources through fraud and corruption.
3. In collaboration with the municipal government, the firm will develop an action plan for implementing institutional changes, administrative procedures, and managerial controls aimed at reducing fraud and corruption.
4. The firm will prepare guidelines that present a concise introduction to the issues, problems, and strategies for controlling misuse of resources in public hospitals as relevant to the Latin American context – with specific reference to the experience of the pilot project.

***Requirements:***

The operation is expected to require 6 person-months of senior professionals and 10 person-months of junior staff over a period of six months. It will also cover travel expenses.

***Disbursements:***

The responsible bank officer according to the following schedule will authorize disbursements:

30% of the Contract will be disbursed upon signature.

40% of the contract will be disbursed upon completion of the draft Action Plan.

30% of the Contract will be disbursed upon completion and acceptance of the Action Plan and guidelines.

***Supervision:***

The consulting firm will report directly to the Secretary of Health for CITY, COUNTRY. Upon receiving notification from the Secretary regarding completion of contractual obligations at different stages, the Bank will review the submitted documentation and consult with the Secretary. The Bank will authorize disbursements if the documentation is found acceptable.