



The World Bank

Bangladesh Strengthening Management and Governance in the HNP Sector

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**Achieving the MDGs through Improved
Accountability and Service Delivery**

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Outline

- ✦ Background on Bangladesh
- ✦ Corruption as a health issue
- ✦ International experiences
- ✦ Scope of work
- ✦ Findings
- ✦ Policy Options

Background on Bangladesh

✦ Political Economy

- ✦ Index of corruption is high (Transparency international survey)

✦ Health Sector Issues

- ✦ US\$ 4 per capita public expenditure in health
- ✦ 70% of total health expenses are paid by households.
- ✦ 81% of consumption of medicines are paid by users
- ✦ Less than 15% of primary health care services are covered by the public sector



Health and Corruption

- ✦ No country is free of corruption (0 tolerance not equal to 0 corruption)
- ✦ Corruption an issue -world wide but effects are worse in poor countries creating a heavy burden on the poorest
- ✦ The unwillingness to take drastic measures to deal with corruption at the top can legitimize corruption in the system
- ✦ Risk mitigation strategies are needed to reduce the trend of system losses due to corruption

The Challenge

- ✦ **Corruption and inappropriate practices** in health sector in Bangladesh is a widely discussed issue.
- ✦ The government along with the development partners are **concerned on eradicating** the problem.
- ✦ In spite of continuous effort from all parties, health sector in Bangladesh is marked with **several risk factors.**
- ✦ **Forward looking-** approach improving incentives not pointing fingers
- ✦ **Prioritize fiduciary risks**

Types of Corruption



Nepotism and Patronage

- ◆ Use of procurement to finance political agendas and systems, with diversion of public resources
- ◆ Collusion between public officials and private sector
- ◆ Patronage to favored clients



Capture of Government decisions

- ◆ Policy and procurement decisions benefit private interest
- ◆ Influence on the Regulatory activities



Administrative corruption

- ◆ Influence in the procurement process or contract administration
- ◆ Fraud
- ◆ Collusion
- ◆ Coercion

Consequences of Corruption

The cost of corruption in health care may be difficult to measure precisely- but evidences on corruption do exist. Corruption and lack of accountability are costly in terms of:

- ✦ Staff moral and motivation
- ✦ Efficient use of collected resources
- ✦ Burden to the health status of the poor
- ✦ Regressive subsidy system.

Good practices

- ✦ **An Assessment of the Impact of Bangalore Citizen Report Cards on the Performance of Public Agencies.** Citizen report cards have been an important vehicle for civil society's "voice" in Bangalore have had a significant impact on the quality of public services. Important to identify success factors and consider the replicability of the report card for Bangladesh
- ✦ **Decentralization of procurement.** In 1987, Ceara state in Brazil launched a scheme to promote the growth of locally based small businesses through demand-driven public procurement. The mechanism means redirection of state expenditures for procurement of goods and services away from large companies towards local small firms. The program was demand-driven in that state agencies purchased only what they needed and only from small firms provided they were satisfied with quality, price and delivery.

Good Practices (continued)

✦ **Albanian civil society corruption project:**

Citizen Advocacy Office-Task force in procurement and Press coverage.

✦ **Chile**, reform of pharmaceutical procurement increased accountability and transparency through the application of an electronic bidding system, decentralization of purchasing, and institutional restructuring of the previously centralized drug-purchasing agency. Corruption was reduced and the cost-effectiveness of pharmaceutical purchases increased

Scope of work

- ✦ To describe and assess the magnitude of key fiduciary risks in the HNP sector
- ✦ Disseminate and engage public, civil society and officials on successful international experiences to combat corruption
- ✦ Identify actions to mitigate fiduciary risks emerging from the study's findings, to minimize the negative impact of unauthorised practices and to support MOHFW efforts.

Method

Sample

15 randomly surveyed upazilas from 6 divisions

Interviews

Staff (470): District Manager, UHFPO (DDO), UFPO, RMO, Medical officer/ concern related to purchase of CS officer, UAO, General physician, Hospital staff, Head clerk/cashier, Statistician, Staff nurses, Storekeeper, Member of purchase committee, Trade union leader, Supplier, and Patients (300).

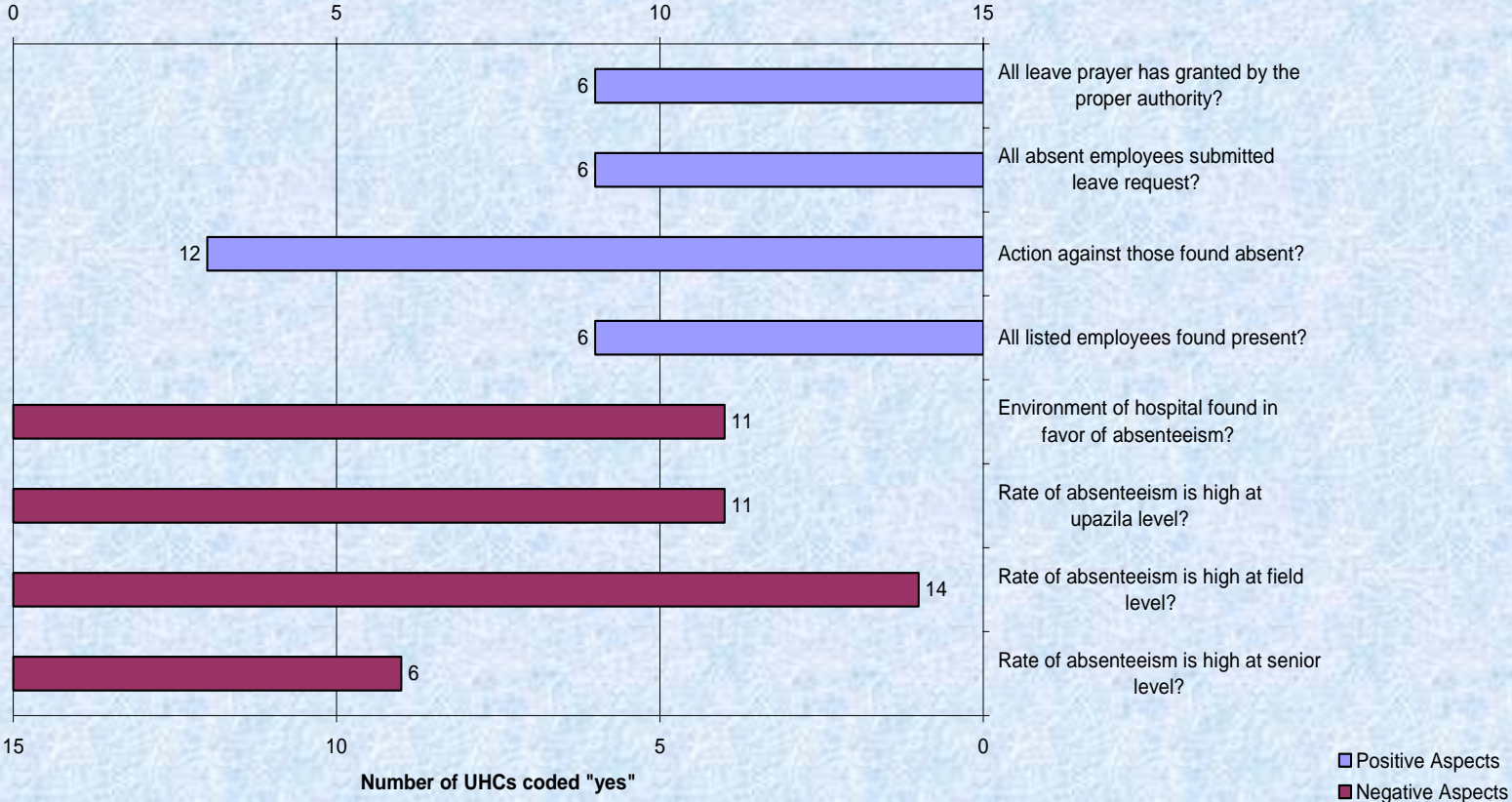
Data collection tools, Patients exit interview, Attendance register observation
Physical verification of employee, Mystery Shopping/Patient, Discussion with neighboring pharmacists, Discussion with colleagues, Cashbook and acquaintance register observation, Stock register observation, Physical verification of stock. Observation, Secondary Data Collection and Case Study

Selected Risk Areas

- ✦ **Project money spent on non-project activities**
- ✦ **Lack of control of payroll disbursement**
- ✦ **Illegal payments to Accounts Offices**
- ✦ **Purchases at higher than market rates**
- ✦ **Private practice by doctors during office hours**
- ✦ **Absenteeism of providers**
- ✦ **Negative activities of Class 3 and Class 4 trade unions**
- ✦ **Drugs pilfered and sold by employees**

Absenteeism

Absenteeism - Survey Responses



Absenteeism (continued)

Table 2.1 Percentage of attendance status by employee designation

Designation	Number of employees observed		Percentage of Absenteeism
	Expected as per record/list	Found present	
UHFPO	15	14	7
RMO	13	10	23
UFPO	13	7	46
MOM-CH	15	10	33
MO	43	32	26
3 rd and 4 th class employee	297	259	13

Source: Author's estimates based on Health Sector Risk Area Validation Survey. 2004

Private Practice

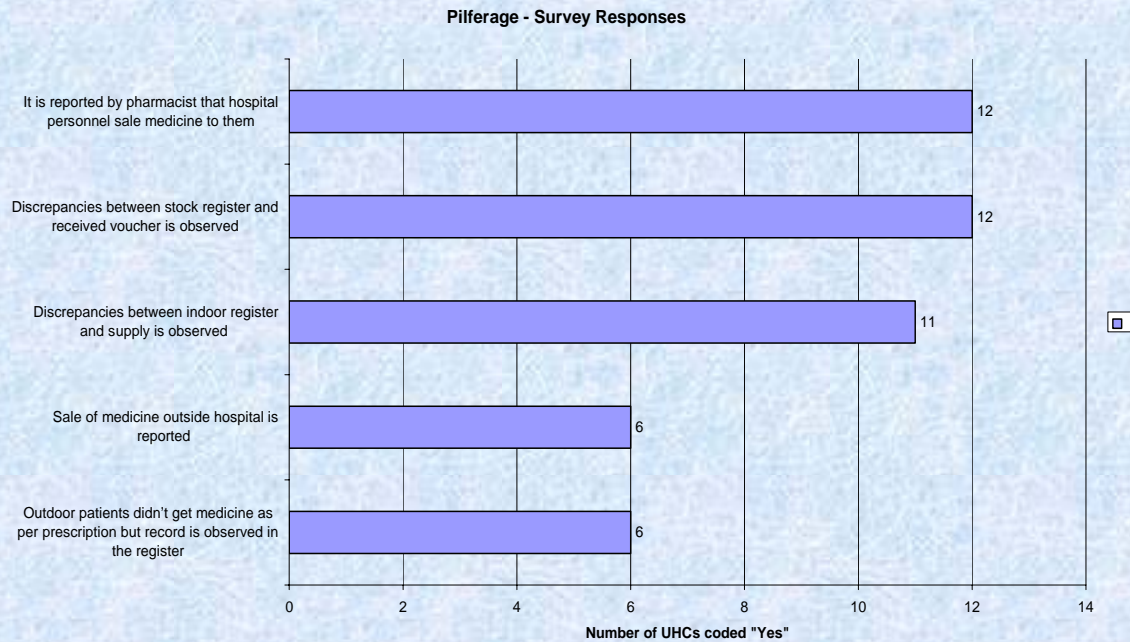
Table 2.3 Private Practice by Doctors during Office Hours: Direct Observations

DIRECT OBSERVATIONS	%
All the doctors found present in hospital complex during office tour.	20
Doctors found attentive to the patients.	47
Some patients reported that doctor received money (fee) from them.	60
Doctors found to be involved in private practice at hospital complex.	60
Doctors found to leave hospital during office hours.	53
All doctors found to leave hospital as per hospital rule.	33
Doctors encourage patients to visit their private chambers.	67
Doctor found to do private practice outside the hospital complex.	53
Sample: 15 Upazilas.	

Source: Health Sector Risk Area Validation Survey, 2004

Drug Pilferage

Figure 2.10 Findings related to drug pilferage



Source: Health Sector Risk Area Validation Survey, 2004

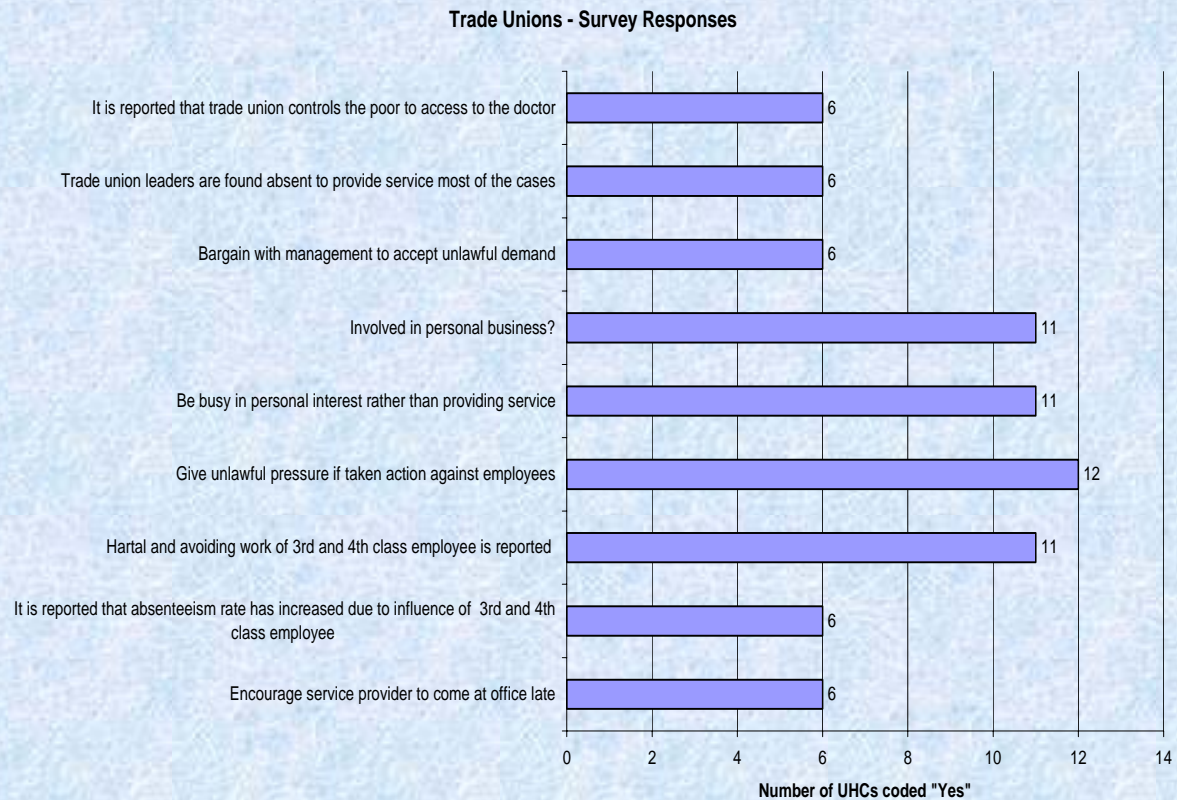
Drug pilferage (continued)

Table 2.6: Drugs supply system

	# OF UPAZILA	SOURCE OF INFORMATION
Discrepancies between stock register and received voucher is observed	3	Record Observed
It was found that patients didn't get medicine even though it was recorded	3	Recorded in the stock register but patients denied having receive it
Sales of medicine to outside stores	6	Reported by Hospital staff and doctors
Medicine supplied in the hospital found in the pharmacy	2	Doctor
Discrepancies between indoor register and supply is observed	4	Observed

Class 3 and 4 trade unions

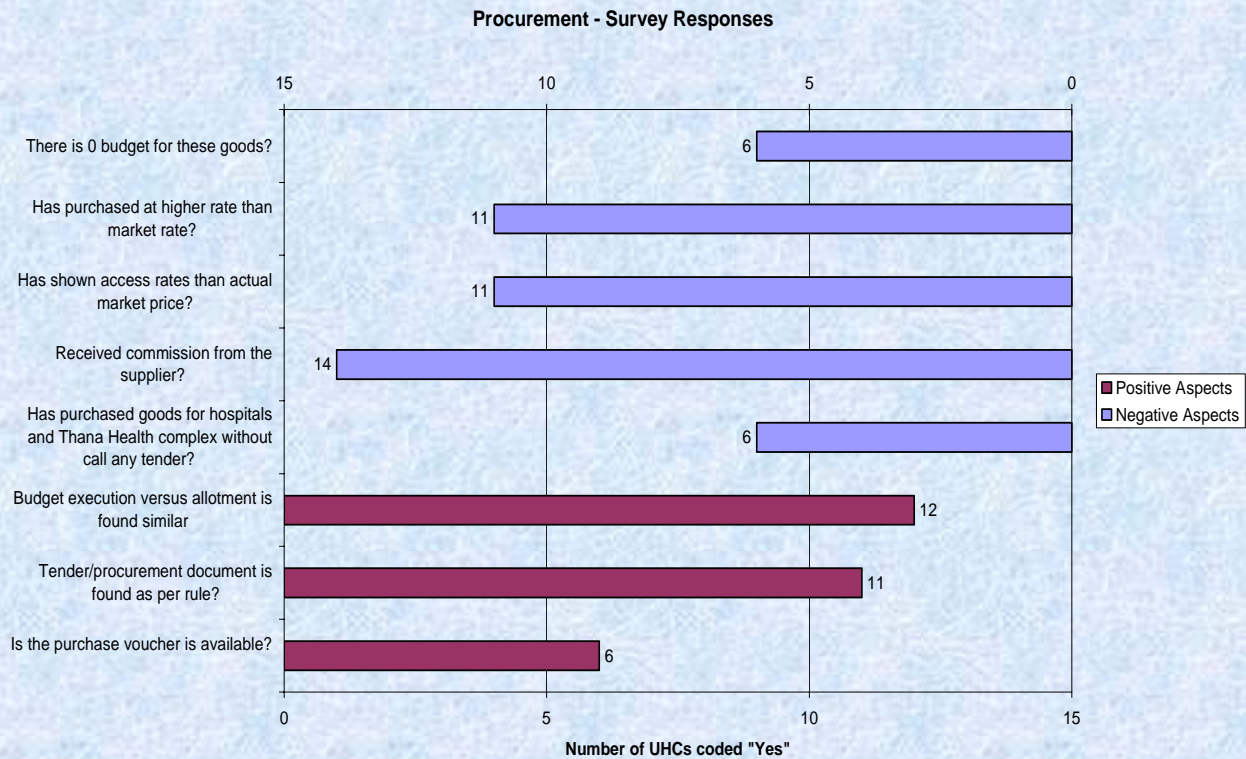
Figure 2.9 Findings related to class 3 and 4 trade unions



Source: Health Sector Risk Area Validation Survey. 2004

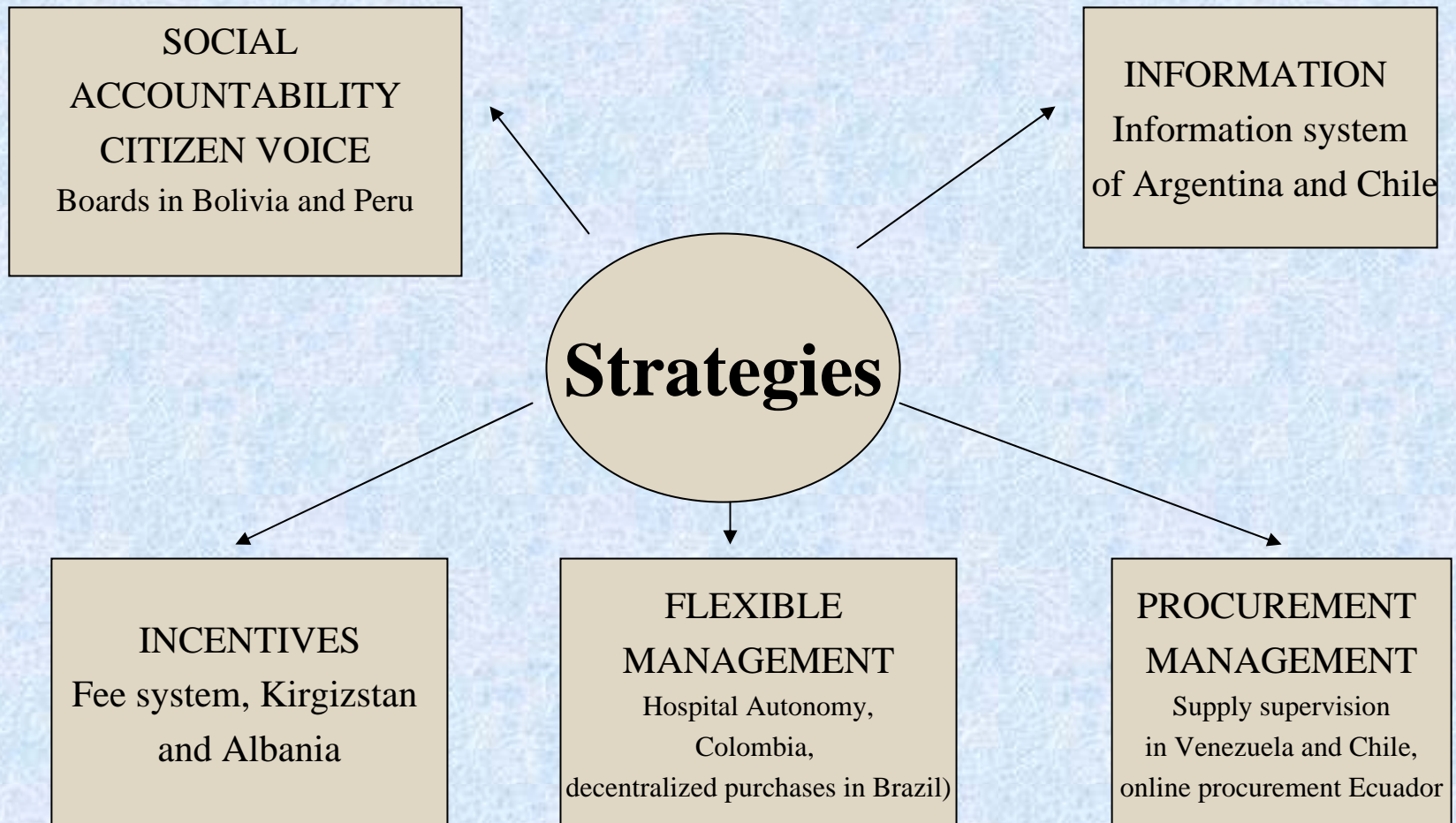
Procurement

Figure 2.7 Findings related to procurement



Source: Health Sector Risk Area Validation Survey. 2004

RISK MITIGATION STRATEGIES



Conclusions

- ✦ It is important not only to understand the ways in which corrupt practices are manifested but also to measure the direct impact of such practices on the health of the poor, and to implement an action plan to combat corruption and reduce system losses.

Policy options for key risk areas

Table 4.2 Policy Options for Key Risk areas

Risk Area.	Strategies.	Actions	Potential Indicators	Collaborating Organizations
Private practice undertaken during office hours.	Development of a more flexible framework for reward of medical staff.	<ol style="list-style-type: none"> 1. Consultative process including all major stakeholders.. 2. Learning from programmes that retain compliant staff (e.g. UNFPA/MCWC programme).. 3. Pilot a number of approaches.. 	Number of public patient contacts.	BMA.
	Making best use of mechanisms for non-salary rewards	<ol style="list-style-type: none"> 4. Identification of mechanisms available to reward good behavior including free accommodation, career development, accelerated promotion, improved staffing levels, improved working facilities. 	Average tenure in post in relation to norm.	Ministry of Finance.
	Improving the availability of free essential drugs in public health institutions.	<ol style="list-style-type: none"> 5. Identification of key constraints on essential drug availability. 6. Pilot alternative approaches to drug availability including vouchers for patients.. 	Percentage availability of essential drugs.	Civil Service Commission.
Better value for money from purchasing process	Opening-up of tendering process to more effective competition	<ol style="list-style-type: none"> 1. Establish system whereby identification of high prices can trigger re-entering by an external tendering panel. 	Average price of a basket of purchases compared to market and Maximum Retail Price	Ministry of Finance
	Development of transparent alternatives to current tendering arrangements.	<ol style="list-style-type: none"> 2. Test alternative approaches to public purchasing including e-tendering. 		Controller and Auditor General Office
	Supporting anti-corruption initiatives	<ol style="list-style-type: none"> 3. Revive role of local health development and management committees.. 	Frequency of retendering	

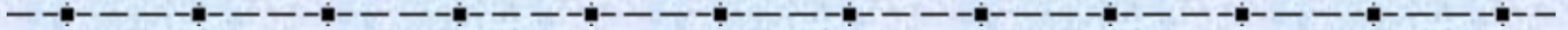
Policy options (continued)

Payments to AG Office.	<p>Progressive computerization of all accounting and payment systems.</p> <p>Selective recentralisation of authorizing procedures</p> <p>Administrative action.</p>	<p>1. Pilot salaries and allowances computerization with payment into individual bank accounts.</p> <p>2. Review and roll-out.</p> <p>3. Identification of mechanisms for centralized authorization of payments without undue delays</p> <p>4. Ensuring that the budget holder and accounts officer have access to the same information about allocations.</p> <p>5. Disciplinary action against errant officers.</p>	<p>Percentage of staff paid salary directly to bank account.</p> <p>Average time from invoice to payment</p> <p>Number of disciplinary actions related to unofficial payments.</p>	Ministry of Finance
Activities of Class 3 and Class 4 Trade Unions	<p>Pursuing strategies to increase the loyalty of staff to the institution.</p> <p>Limitation of trade union role to representation of workforce.</p> <p>Pursue contracting-out in a systematic way so as to increase management leverage.</p>	<p>1. Review and reform of appointment arrangements.</p> <p>2. Dialogue with trade union organizations to establish codes of conduct.</p> <p>3. Review of successes in contracting out of services.</p> <p>4. Development of national guidelines for service tendering in consultation with trade unions.</p>	<p>Reduction in inappropriate trade union activities (by survey).</p> <p>Proportion of contracted support services.</p>	Civil Service Commission. Trade Unions

Good anticorruption, governance and fiduciary practices

An integrated approach managed by GOB with the support of DP.

- ✦ **Prioritized strategies**
- ✦ **Economic sector work (impact evaluations)**
- ✦ **Supporting the demand for governance reform**
- ✦ **Building strategic partnerships**
- ✦ **Creating governance index for the HNP sector to measure progress in key sector governance indicators (M&E system).**



THANK YOU