

# Does corruption lurk in the health sector of Pakistan?

Dr. Sania Nishtar

Transparency International's *World Corruption Report of 2007* with its focus on corruption in the judicial system is of contemporaneous relevance to Pakistan with respect to the spotlight on the judiciary. However, its findings have also opened a debate in many sectors in the country owing to its inclusion of Pakistan amongst the 37 countries studied and the sectoral comparative rankings. The interest in the area has also been further exacerbated by reports of two recently conducted surveys in Pakistan. According to the first, a perception survey of civil servants conducted by PIDE, 93% of the respondents think that performance of the civil services has deteriorated over the years. According to the second survey conducted by Gallup, 43% of the urbanites believe corruption is prevalent in the country.

Discussions relating to the health sector are never complete without references to malpractices which fall within the preview of fiscal and ethical corruption; even if half this anecdotal evidence is grounded in reality, the fiscal costs incurred to the state and the cost of accessing care – appear to be significant.

In recent years public sector allocations for financing health have significantly increased; however, corruption stands as a key impediment to the impact of well-intentioned spending on health. Without addressing this issue, the commitment to meet goals articulated in the Millennium Declaration as well as others embodied within indigenous policy instruments such as the MTFDF simply cannot be met. It is for this reason that the government should accord high priority to the issue because of the potential it has to compromise public investments in a highly constrained environment. What should therefore be done in this regard?

As a starting point, there is a need to understand and prioritize corruption risks by corruption mapping and analyzing incentives and disincentives. This must be done at several domains.

The anecdotal reports of corruption in the *pharmaceutical sector* must receive careful and objective analysis. Corruption in this domain has a direct bearing on the performance of the health system. This practice can involve both the regulators and the private sector and may involve any step along the drug supply chain, starting from registration, licensing and accreditation to the setting of prices, marketing of drugs and sale and procurements. Corruption in this sector has its roots in the commercial interests of the *non-bonafide* pharmaceutical companies, who find compliance with regulations costly and try to bypass procedures to get their product registered, speed up the approval process, get favorable prices or to have their drugs included on the essential drug list in order to increase their market share.

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# Corruption and health

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What ails the 'prevention' medical profession?

By Sania Nishtar

The process of limited pharmaceutical or chemical shops can be corrupt. However, the most important in the pharmaceutical domain is the use of aggressive drug marketing strategies which can lead to the unethical promotion of medicines or in conflict of interest that influence physician's judgement. Instances where physicians actually have financial incentives to prescribe certain drugs are also documented worldwide.

In Pakistan, more than 650 pharmaceutical companies manufacture almost 40,000 registered drugs. Each company is coupled with hospital-based promotion activities including staff incentives, marketing, sales, and other activities. The pharmaceutical industry offers various products and treatment options of physicians. The ultimate outcome of all these practices are either higher prices for purchased medicines and/or compromised quality. Patients are the direct victims in this process as they are forced to supply their own medication.

The first area which should be carefully studied is staff incentives and staff job building. The remuneration structure is often skewed towards sales and marketing staff rather than the clinical staff. This leads to the promotion of sales and marketing staff over the clinical staff. This is a major concern as it leads to the promotion of sales and marketing staff over the clinical staff.

Other forms of abuse, fraud and mismanagement occur due to insufficient monitoring and inadequate supervision. It requires the use of modern technology to get their product registered, speed up the approval process, get favorable prices or to have their drugs included on the essential drug list in order to increase their market share.

Other than the financial incentives, the pharmaceutical industry and the government should also be held accountable for the quality of medicines. The government should ensure that the quality of medicines is maintained and that the prices are reasonable. The pharmaceutical industry should also be held accountable for the quality of medicines.

are other staffing issues that can undermine productivity in public health facilities through sharing of hours, late arrival and early departure, and frequent and long breaks. Absenteeism management and staff management and it also comprises the quality of health care across the board by setting up standard protocols for staff. The first area of assessment falls under the current remuneration arrangements at the primary health care level, where the administrative structure is also under review.

Secondly, there is a need to review procurement and financial management policies in the health sector. The procurement and financial management policies have been revised to ensure public procurement as per the Public Finance Management Act (PFMA) and a range of reforms have been implemented to enhance financial management and accounting systems. The government should also be able to reduce the cost of the procurement process.

Thirdly, the use of technology is being increasingly promoted in the health sector. Particularly in the area of building systems can enable the government to improve its financial management and accounting systems. For example, electronic procurement systems can reduce the cost of procurement and improve the quality of procurement. The government should also be able to reduce the cost of the procurement process.

A comprehensive anti-corruption strategy in the health sector also has to take into account other areas such as the reform of public services through civil and public service reform, which is the mandate of the National Assembly Government Reform Commission. In addition, there is also the need to strengthen operational linkages of the health sector with the health sector.

Corruption necessitates a mutually reinforcing anti-corruption agenda: this is where the NAB can play a strategic role – both in the investigative and preventive domains in light of section 33-B of the NA Ordinance of 1999.

The *contracting process* for the purchase of drugs offers a lucrative source of returns for corrupt officials and suppliers through kickbacks, over-invoicing, and outright graft. There is anecdotal evidence for the same in Pakistan from several public hospitals; however this needs to be assessed carefully and its magnitude quantified.

In the *procurement process*, common corrupt practices include collusion among bidders, kickbacks from suppliers and contractors to reduce competition and to influence the selection process, and bribes to public officials monitoring the winning contractor's performance. Corrupt procurement officers can also purchase sub-standard drugs in place of quality medicines and pocket the difference in price.

It is also reported that varying quantities of drugs and medical supplies are stolen/pilfered from central stores of hospitals and individual facilities and are diverted for resale. This result – it could be speculated – is due to institutionalized corruption, which involves a variety of practices such as record falsification, dispensing drugs to 'ghost patients', graft and padding of bills, clever book keeping, overpayment for supplies, over-invoicing or simply pocketing the patient's payment. Other forms of abuse, fraud and mismanagement can occur due to insufficient management and monitoring capacity; e.g. supplies do not meet expected standards, or they are only partially delivered or not delivered at all, or selling low quality, expired, counterfeit and harmful drugs at cheaper prices.

The process of licensing pharmacies or chemists' shops can also be corrupted. However most important in the pharmaceuticals domain is the issue of aggressive drug marketing strategies, which can lead to the unethical promotion of medicines or to conflict of interest that influence physician's judgments. Instances where physicians actually have financial/material incentives to prescribe certain drugs are also well described anecdotally. In Pakistan, more than 450 pharmaceutical companies manufacture almost 45,000 registered drugs. Such competition coupled with hospitality-based incentive-intense marketing can lead to unethical marketing practices, which have the potential to affect medical practice and treatment decisions of physicians. The ultimate outcome of all these practices are either higher price for purchased medicine and/or compromised quality. Patients are directly affected in this process as they are forced to supply their own medications.

The second area which should be carefully analyzed is *staff absenteeism and dual job holding*; this undermines service delivery and leads to closed/under utilized public health facilities; this in turn, conflicts with the equity and health objectives of publicly financed health care. In a minority of cases, absenteeism is unavoidable; for example, rural health workers often need to travel to larger towns to receive their payments, fetch supplies or drugs and are sometimes delayed by poor infrastructure. However, in most cases absences are frequently motivated by responsibilities at a second job. Other than absenteeism there are also other staffing issues that can undermine productivity at public health facilities through shaving off hours, late arrival and early departure, and frequent and long breaks. Absenteeism is symptomatic of ineffective management and translates into high cost for the public sector with little output; it also compromises the quality of health care across the board by relying on ill-trained providers or *quacks* for care.

The third area of assessment falls under the current *restructuring arrangements* at the primary health care level, where the administration of Basic Health Units (BHUs) and Rural Health Centers (RHCs) is being handed over to the private sector. Though a step in the right direction, an important caveat here is that this may open a potential avenue for lack of transparency in contracting arrangements, which flags a clear imperative for ensuring procedural clarity and transparency.

Corruption can also be ingrained at a *regulatory level* in the healthcare domain. Several regulatory can institutions form settings for such practices. Pakistan does not have an institutional mechanism for quality control, hospital accreditation or provider credentialing except for the Pakistan Medical and Dental Council, which serves the role of provider registration only. Pakistan is, however currently underway to establishing the National Drug Regulatory Authority. Experience from many developing countries suggest that if such regulatory institutions are created without awarding the right incentives to regulators and institutionalizing the right checks and balances then paradoxically they compromise the health system rather than strengthen it.

Furthermore corruption also needs to be quantified at the governance level particularly with reference to the losses incurred through the anecdotally reported kick-backs, pilferage, and embezzlement – a manifestation of a poor fiscal control over public funds. Other forms of intellectual and ethical corruption such as deliberate lack of over-sight, unfair hiring practices, inattention to staff accountability for misconduct and preferential treatment with connected individuals and basing priorities on political expediency and benefaction rather than evidence have also been reported. The magnitude and determinants of these needs to be quantified.

The assessment should guide strengthening of anti-corruption measures; which brings us to the action level. Here it must be appreciated that corruption necessitates a mutually re-enforcing anti-corruption agenda; this is where the National Accountability Bureau can play a strategic role – both in the investigative and preventive domains in light of section 33-B of the NA Ordinance of 1999. A number of next steps should logically follow.

**First**, is to ensure that laws are in place to deter corruption. A range of legal instruments exist in Pakistan that makes corruption a punishable offence. However, new statutes representing a stronger commitment to eradicating corruption are also needed. It is true that laws have limitations in our environment owing to the limited capacity of enforcing agencies and true that anti-corruption work cannot be complete without enhancing institutional capacity. Notwithstanding, statutes must still be the first step; ensuring that they are not open to interpretation and are not exploitable will aid their implementation. In addition, other laws such as freedom of information laws also need to be updated/developed.

**Secondly**, there is a need to review procurement and financial management policies in the health sector. A number of new regulatory institutions have been created to streamline public procurement such as PIPRA and a range of reforms have been institutionalized to streamline financial management and accounting systems. The guidance that these can offer to the health sector should be reviewed and leveraged. Policies should also be able to mitigate collusion in the procurement process.

**Thirdly**, the use of technology is being increasingly promoted in the health sector; however the most effective use is in the area of establishing systems that can enable and promote greater transparency. For example, electronic national health accounts promote greater transparency in health systems; electronic public expenditure tracking procedures and electronic equipment and supply inventories can track leakages from the system and a nation-wide database for matching staff and wage payments can maintain up-to-date personal records and therefore can assist in eliminating abuses such as paying ghost workers. In addition, drug procurement reforms centered on electronic bidding can promote greater transparency in the process of drug registration and pricing.

In the **fourth** place, Local regulations will have to be strengthened in line with the international code of marketing practises and should be strictly enforced as minimum requirements for the pharmaceutical industry and the medical community to comply with. Other measures should be promoted to check mushrooming of spurious drugs – an area which was significantly in the limelight a year ago with the suo moto action by the Chief Justice. Strict penalties should be implemented for violations of the law which make it possible for spurious drugs to gain access to the market such as fake licenses to sell, duplicate documents, absence of warranty of purchase of all products, gaps in the sale purchase record of all products, inadequate storage practices at outlets, and the absence of unqualified personnel at outlets.

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

and warrants health system reconfiguration; this goes beyond incentives and has to do with health systems' reforms in a broader sense.

A comprehensive anticorruption agenda in the health sector also has to scope much further than what has been stated and has to take into account other overarching issues such as remuneration of public servants through civil and public service reforms - which is the mandate of the national Commission on Government Reform. In addition there is also the need to create operational linkages of the National Accountability Bureau with the health sector.

In a nutshell therefore, healthcare provision depends on a system which efficiently combines financial and human resources and supplies to deliver services; good governance and transparency are critical factors in making such a system function.

However on the other hand, both poor governance and corruption in the health system are manifestations of a broader systems phenomenon in a country. Addressing these issues requires mandates and prerogatives both within but also outside of the health sector, which is why ideally, an anticorruption drive in health must ride a much larger wave.

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