Strengthening Management and Governance in the Health, Nutrition and Population Sector of Bangladesh

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ACRONYMS and ABBREVIATIONS

AG	Accountant General	MOHFW	Ministry of Health and Family Welfare
BMA	Bangladesh Medical Association	MOMCH	Medical Officer Maternal and Child Health
CIDA	Canadian International Development Agency	MPH	Ministry of Public Health
CS	Civil Surgeon	MRP	Maximum Retail Price
CGA	Comptroller General Accounts	MSR	Medical and Surgical Requisite
DFID	United Kingdom Department for International Development	NGO	Non-Governmental Organization
DDO	Drawing and Disbursing Officer	PAC	Public Accounts Committee
DDFP	Deputy Director, Family Planning	PAF	Poverty Action Plan
DG	Director General	RMO	Resident Medical Officer
DGFP	Directorate General of Family Planning	Sida	Swedish International Development Cooperation Agency
DGHS	Directorate General of Health Services	SIP	Strategic Investment Plan
FMU	Financial Management Unit	SDR	Standard Rate
FP	Family Planning	SSPS	Social Sector Performance Surveys
GOB	Government of Bangladesh	Tk	Taka
HEU	Health Economics Unit	UHC	Upazila Health Complex
HIES	Household Income and Expenditure Survey	UHFPO	Upazila Health and Family Planning Officer
HNP	Health, Nutrition and Population	UHFWC	Union Health and Family Welfare Centre
HNPSP	Health Nutrition and Population Sector Program	UA	Upazila Accounts
HPSO	Health Program Support Office	UAO	Upazila Accounts Officer
KfW	Kreditanstalt für Wiederaufbau (Germany)	UDN	Ugandan Debt Network
MA	Medical Assistant	UFPO	Upazila Family Planning Officer
MO	Medical Officer		

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Table of Contents

Annexes

List of Figures

List of Tables

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Foreword

Bangladesh has sustained solid economic performance over the last decade. There has been considerable improvement in its social indicators and is well underway to achieve many of the health, nutrition and population (HNP) related Millennium Development Goals. Despite these notable achievements, losses of public resources through system weaknesses and failures are limiting the performance of the HNP sector. Correcting these systemic issues will be critical for the overall improvement a nd sustainability of the sector.

This report highlights governance issues in Bangladesh's HNP sector that hinder the efficiency and effectiveness of service delivery. This study is intended as a first step in gaining a better understanding of how to improve governance and service management in the HNP sector. It is hoped that these findings will assist the Government of Bangladesh to initiate and to implement policy decisions and strategies that will reduce system losses, strengthen accountability mechanisms and ensure value for money.

The preparation of this report was made possible through the collaborative efforts of the Bangladesh Ministry of Health and Family Welfare and the World Bank. We trust that the findings and the recommended actions will lead to significant improvements in health care service delivery especially for the poor in Bangladesh.

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Executive Summary

Improving Governance in the HNP Sector

1. For the poor, the availability and quality of public health services is of great importance. Where public services are inadequate, the poor will resort to private services but with a considerable negative impact on the family's disposable income. When government resources for health are constrained, good management of health services is particularly important to sustain health care access for the poor, at least to a minimum package of primary care and referral services.

2. The object of this study is to better understand what improvements in governance would assist the Ministry of Health and Family Welfare (MOHFW) in reducing system losses and strengthening accountability in the Health, Nutrition and Population (HNP) sector. The ultimate goal of this research is to offer the Government of Bangladesh strategies to improve HNP service delivery for all Bangladeshis and for the poor and vulnerable in particular.

3. This report examines systemic deficiencies in the HNP sector caused by fiduciary risks. The work has been greatly facilitated by the encouragement and support of upper management and senior MOHFW officials, who recognize the importance of strengthening management and governance and seek the most effective methods to effect change. The analysis has been enriched by individual discussions with many field-level officers, development partners, and the Bangladesh Medical Association, which were held during meetings and a workshop in September 2004.

4. Systemic reforms at the macro-level could result in much improved health service delivery. But the key to sustainable change at the operational level lies in strengthening organizational leadership and improving overall HNP service management. To improve leadership and management, the current system was examined to identify impediments to progress. The major contribution of this study was to determine major obstructions in the HNP system that are manifested as fiduciary risks, vested personal interests in maintaining the status quo, and the inefficient system of incentives and sanctions that negatively influence individual behavior and shape organizational culture.

5. One major limitation of the study is that it addresses difficult and sensitive issues from a technical and prescriptive viewpoint using data from a small sample rather than considering political feasibility. While the technical analysis could benefit from in-depth political and economic analysis, that research is well beyond the scope of this study. Nonetheless, that analysis could form part of a continuing research study or it could be included in the design of pilot interventions in better governance for Bangladesh.

Risk Assessment Methodology

6. Information for this report was collected through interviews with stakeholders and from scrutinizing a wide range of secondary sources. This produced a list of fiduciary risks faced by the Bangladesh public sector. From this comprehensive list, 34 fiduciary risks were identified as

being particularly relevant to the HNP sector. These risks ranged from financial management issues such as budget, accounting and auditing to supervision issues such as oversight, procurement, decentralization, corruption, interaction between public and private sector, user feedback mechanism, etc. Each of these 34 risks was then ranked by significance based on their relative frequency and severity using available information. Eight risks were selected. These 34 risks were further examined and pared to eight fiduciary risks using the following three criteria: (i) the initial review found the risks highly significant; (ii) a clear cause and effect association exists between the fiduciary risk and governance; and (iii) the risk has a significant negative impact at the middle and lower levels of health service delivery. This analysis identified the eight most significant fiduciary risks affecting the HNP sector as follows:

- Project money spent on non-project activities.
- Lack of control of payroll disbursement.
- Illegal payments to accounts offices.
- Public purchases made at higher than market rates.
- Private practice by public sector doctors during office hours.
- High rates of staff absenteeism.
- Negative and illegal activities by Class 3 and Class 4 trade unions.
- Drugs pilfered and sold by employees.

7. The criteria adopted to assess risk and the results of the survey were shared and discussed during two meetings held on September 26, 2004 in Dhaka, Bangladesh. In the first session, the full scope of the survey was revealed to senior representatives of the government, the Bangladesh Medical Association (BMA), and to international development partners. The second session was a working group of mid-level government officials and development partners who proposed and considered strategies that might be effective in reducing risks to improve governance.

8. These consultations resulted in the selected eight fiduciary risks being combined into four areas of risk as recommended by government officials and partners. The strategy options that were developed in those meetings formed the basis for further strategizing with senior government officials and partners in January 2005. Subsequent discussions further underscored the significance of the four selected areas of risks.

Short-Term, High-Impact Reform Strategies

9. Because the scope of this study was focused on fiduciary risks at the middle and lower levels of the public health system, the recommendations are directed at four particular areas of risk affecting those levels. To achieve long-term significant impact in risk reduction, overall strengthening of public sector control as well as more radical strategies to manage market-style pressures in the health sector will take considerable time and effort. In the short-term, strategies can be implemented that will begin to have a perceivable positive effect during the next five years. During this period, the lessons learned in the short-term can be used to formulate designs for longer-term strategies to reduce risks. Gaining control over key "hot spots" identified in this study will create dynamic forces of change beyond the immediate areas of risk. With greater control, the health services' clients and staff will understand that the days of lax regulation and oversight are over. To achieve maximum short-term impact, the following four areas are proposed for immediate action to reduce risk and improve delivery:

(a) **Increase the availability of medical services for the poor.** Allocate human resources in the underserved and poor areas and provide labor incentives to doctors for reducing private medical practice by public facility doctors during public health centers' business hours. This will directly and indirectly reduce staff absenteeism and the loss of public resources. The poor will benefit directly by enforcing this regulation.

(b) **Increase transparency and efficiency in procurement.** Adhering to defined procurement practices will result in better value from materials' budgets. Improved monitoring of procurement and the utilization of resources will directly benefit the poor by greater availability of drugs for common conditions. Confidence in the public sector will also be enhanced.

(c) **Combat bribes to the Accountant General's (AG) office.** A halt to these payments will unequivocally state that "business as usual" has ceased. Because these illegal fees are extorted from the highest to the lowest levels of the bureaucracy, there is a clear linkage and impact on the poor in terms of their ability to access essential services without barriers.

(d) **Agreement with the national offices of trade unions to increase** labor productivity of Class 3 and Class 4 trade unions employees (administrative and logistic support workers).

10. The potential impact of the proposed short-term actions will depend on the government's implementation of a broader initiative to control fraud. Key policies to reduce fraud should include:

- ✓ **A drastic reduction in the government's tolerance for fraudulent use of public funds, materials or time.** This will require an effective and enforceable anti-corruption policy. Independent bodies that are supported at the highest levels of government must be empowered to initiate processes to combat poor governance. Access to these anti-corruption bodies must be open to employees, citizens and their representatives to register grievances. Dialogue and forge agreements with organized bodies at the higher levels of the political system to strengthen the political feasibility of anti-corruption policies.

- ✓ **Strengthen the financial management and control of government processes and systems**. This will require realistic budget setting, effective monitoring of expenditures against budget lines and allocations, improved auditing, rapid processing of audit reports and quick actions to resolve problems. The transition to performance-based budgeting is relevant to improved financial management and control. Realism is also essential, such as the capacity to produce valid performance data. Policymakers and their partners must recognize the link between macro-level policies and the creation of incentives at the micro-level.

11. The government's broader initiative to control fraud will foster a reform environment that will include:

- Public sector reforms that create entry points for civil society to scrutinize the performance of public sector organizations. Government funding opportunities for non-governmental organizations to undertake functions where there is clear comparative advantages. Relevant government agencies will review and monitor public procurement and private entities contracted by the government.

- Civil service reforms will reward good and honest public service performance and rapidly and effectively sanction deficient performance.

- Health sector management reforms will empower the district level with authority over district health delivery. District authorities will be strictly accountable for the exercise of that authority. A realistic framework of options for the management of a mixed economy of health care will be developed.

12. It is essential to change the "cycle of inevitability" in which initially well-intentioned individuals are driven to corrupt behavior by real socio-economic needs. Government officials are actively engaged in reducing fiduciary risks. But the Government of Bangladesh (GOB) could benefit from the technical and financial support of its development partners to design and implement strategies to reduce system losses. The strategies should include process-based as well as output-based indicators for monitoring and evaluation. Tracking these indicators could be undertaken by the public sector itself, provided that the monitoring institutions, agents or think-tanks were independent in their review and evaluation.

13. It is also necessary for the government to design and implement strategies to promote government collaboration with recognized non-governmental organizations to achieve health outcomes. Demand-side approaches should be pursued with strong monitoring and supervision to reach established targets. In addition to the above-mentioned specific actions, the following tactics can also be used to reduce fiduciary risks.

- Contract commercial auditing organizations to undertake random audit reviews and report serious anomalies to the public accounts committee.

- Review the effectiveness of internal audit offices including the financial management and audit unit. Consider contracting out some aspects of the work.

- Improve the basic resources for supervision such as adequate staffing and transport for the civil surgeon's office.

- Link and improve the government's supervision mechanisms to performance management and budgeting arrangements.

- Establish and effectively use peer review teams.

- Restructure salary system to provide considerably higher rewards to those in key leadership positions in the district health system. Establish clear accountability for leadership positions, ideally as part of a long-term major initiative to foster better health leadership.

- Establish management development programs that are internationally accredited within the local institutions. Sophisticated systems will only be beneficial with associated management development.

- Build capacity to make demand-side financing and NGO contracting possible to deliver health care services more effective

- Enable effective functioning of health development and hospital management committees through necessary changes.

- Collaborate with the Bangladesh Medical Association and other professional associations to redesign staff incentives, job descriptions and responsibilities.

- Strengthen the colleges of surgeons and physicians role in training activities and in the accreditation of professionals in non-clinical areas such as health policy and management, health economics, financial management and procurement.

- To increase the service providers' accountability, encourage the media to investigate and report on misuse of public resources that have a direct impact on service delivery.

- Establish and strengthen HNP consumer associations by providing incentives.

14. This study provides some evidence of the level of corruption and lack of accountability in the HNP sector of Bangladesh. It documents lessons learned and draws conclusions on how best these experiences can be incorporated in the future implementation of Bangladesh's Health, Nutrition, and Population Program (HNPSP). The report is organized as follows: Chapter 1 assesses the fiduciary risks for the selected sample. Chapter 2 presents the main findings of the Health Sector Risk Area Validation Study Survey. Chapter 3 cites a variety of international experiences to identify the strategies that have been adopted in other countries to reduce similar risks. Finally, Chapter 4 summarizes the main points of the report and highlights some specific issues related to fiduciary risks and unauthorized practices in the broader context of strengthening management and governance in the HNP sector in Bangladesh.

Chapter 1. The Issue of Fiduciary Risk in Bangladesh

1.1 The goal of this study is to assist the Ministry of Health in correcting systemic problems and improving the overall management and governance of the health system. The issues discussed in this report are highly sensitive and difficult to resolve. The intended purpose of examining the risks and current failings within the HNP sector is to improve health service delivery. Though there are many notable successes in the Bangladesh health sector, there are also significant challenges in the areas of system losses, access and quality. This report focuses on strategies to reduce system losses and to improve the access and quality of public health, nutrition and population services for the poor. The GOB has committed itself to these reforms and has acknowledged its intention to address them in the Strategic Investment Plan (SIP) 2003-2010.

1.2 The Secretary of Health has greatly assisted this work by his encouragement and support and by the constructive involvement of his senior officials. The Ministry of Health and associated officials recognize the importance of strengthening management and governance to improve the health sector and seek the most effective methods to do so.

1.3 The key to a sustainable process of change at the operational level is a major strengthening of health leadership and overall service management coupled with a realistic, constructive, and politically intelligent approaches to managing risks. Achieving these changes requires that working relationships be forged between the senior management and organized bodies such as medical professionals both public and private. Reforms at the macro-level of the Bangladesh health system could result in dramatic improvements. For example, the Health, Nutrition and Population Sector Program (HNPSP) could be vastly improved by substantially altering the structure of incentives to providers and facilities to reward good performance and sanction bad performance.

1.4 "Workforce productivity in the government health sector appears to be uneven and generally low" (Strategic Investment Plan). The clinical staff in public facilities has little reason to excel in their performance. Their salaries are low and management structures are weak. Health staff frequently deserts their posts to engage in more lucrative private practice. Government workers are unwilling to work in remote areas. Evidence exists that funds are wasted on unnecessary diagnostic tests and prescriptions.

1.5 Insufficient attention has been paid to the supply-side barriers faced by the poor including: unofficial fees, erratic drug supplies, staff absenteeism and unprofessional provider behavior.

1.6 In an effort to provide the GOB with tools to reduce fiduciary risk in the HNP sector, the main objectives of the study are the following:

(i) To describe and assess the impact of unauthorized fiduciary practices in the HNP sector in Bangladesh, especially their impact on the poor;

(ii) To describe national and international approaches and interventions to address fiduciary risks in the HNP sector; and

(iii) To design and recommend realistic strategies, based on this study's findings, to minimize the negative impact of unauthorized practices and to galvanize the support MOHFW staff to implement the recommended strategies.

I. Methodology to Identify and to Assess Risk Factors

1.7 To identify and assess the scope of fiduciary risk affecting the HNP sector, a Health Sector Risk Validation Survey was conducted as a precursor to this report. This report focuses on the findings of the survey and examines national and international experiences of systemic reforms to improve the HNP sector.

1.8 To determine the scope and nature of fiduciary risks and unauthorized practices in the HNP sector, a comprehensive assessment of risks was conducted by the team. This wide-ranging risk assessment was the basis for the subsequent prioritization and selection of eight fiduciary risks. The selected eight risks were explored in-depth by the survey instrument.

1.9 All identified risks were evaluated and classified as "minor acceptable risks" or "major risks." Data was also collected for further evaluation and risk mitigation. To rank the risks, each risk was evaluated according to the source, severity/consequences and the frequency/likelihood of a given risk. In this study, likelihood (frequency) and severity (consequence) are defined as follow:

- Likelihood (frequency)—How likely is the occurrence of the risk?
- Severity (consequence)—How harmful to health service delivery is the realization of the risk?

The survey team adopted a detailed rating system for risk assessment to score each risk using the aforementioned criteria:

Likelihood of Risk Occurrence Rating

A. Frequent - Likely to occur frequently.
B. Probable - Would occur but not frequently.
C. Occasional - Could happen occasionally.
D Remote - Rare, not likely, but possible.
E Improbable - Highly unlikely but still possible.

Severity/Consequence of Risk Rating

A. Catastrophic - May result in death or closing of service.
B. Critical - May cause severe injury, or substantial harm.
C. Marginal - May cause injury or illness resulting, for example, in missing work.
D. Negligible - May cause minor injury or illness.

1.10 To better categorize and evaluate risks, the ratings were used to construct a table, which created a composite score for severity and frequency of risks.

Table 1.1. Composite Score for Fiduciary Risks for Severity and Frequency

SEVERITY/ FREQUENCY	FREQUENT	PROBABLE	OCCASIONAL	REMOTE	IMPROBABLE
Catastrophic	High	High	High	High	High
Critical	High	High	High	Medium	Low
Marginal	High	Medium	Medium	Low	Low
Negligible	Medium	Low	Low	Low	Low

1.11 Each priority risk factor was then assigned an associated category. This categorization provided the starting point for assessing the risks that confront health sector delivery. Table 1.1 presents the risk assessment for the complete set of risks identified in the first stage of this study using the methodology described.

Table 1.2. List of Fiduciary Risks

CODE	DESCRIPTION	DETAIL	FREQUENCY	SEVERITY	RATING
B1	Budget	Inadequate budgetary allocations to MOHFW.	Frequent	Critical	High
B2		Lack of budgetary skills.	Occasional	Marginal	Medium
C1	Accounting	Inadequate accounting of foreign aided projects.	Frequent	Critical	High
C2		Project money spent on non-project activities.	Probable	Critical	High
C3		Lack of control of payroll disbursement.	Frequent	Marginal	High
C4		Illegal payments to accounts officers.	Probable	Critical	High
D1	Audit.	Lack of independent scrutiny and follow-up of the auditor general's reports.	Frequent	Critical	High
D2		Limited capacity of auditor general's office to produce quality audit reports.	Remote	Critical	Medium
D3		Internal audit staff are understaffed and located within the accounting unit.	Frequent	Critical	High

CODE	DESCRIPTION	DETAIL	FREQUENCY	SEVERITY	RATING
E1	Oversight	Accountability cycle remains incomplete. Actions not taken on the recommendations of PAC/C&AG.	Occasional	Marginal	Medium
E2		In-camera PAC's proceedings. No contacts with media and civil society.	Probable	Marginal	Medium
F1	Procurement	Processing is prolonged.	Frequent	Critical	High
F2		Purchases at higher than market rates.	Probable	Critical	High
F3		Kickbacks, bribes, and other malpractice in procurement.	Probable	Critical	High
F4		Deliberate limited circulation of tenders.	Occasional	Marginal	Medium
F5		Centralized decision making/financial powers.	Probable	Marginal	Medium
G1	Decentralization	Highly centralized management structure	Frequent	Critical	High
H1	Human Resource	Private practice by doctors in urban areas during office hours.	Probable	Critical	High
H2		Absenteeism of staff.	Frequent	Critical	High
H3		Behavior/attitudinal problems of providers.	Probable	Marginal	Medium
H4		Political appointments to technical posts	Probable	Marginal	Medium
H5		Human resource management policy not implementing grievance handling mechanism.	Probable	Critical	High
H6		Negative activities of Class 3 and Class 4 trade unions.	Frequent	Critical	High
H7		Frequent postings and transfers.	Frequent	Critical	High
H8		Inequitable salary, promotion scale for FP, health & nursing cadres.	Frequent	Critical	High
H9		Lack of incentives for working in disadvantaged areas and for showing positive and responsive attitudes to poor clients.	Probable	Marginal	Medium
I 1	Corruption	Drugs are pilfered and sold by employees	Probable	Critical	High
I 2		Unethical practices in hospital admissions.	Probable	Marginal	Medium
I 3		Undue demands of the auditors.	Occasional	Marginal	Medium
I 4		Unnecessary referrals to private sector.	Probable	Critical	High
J1	Interaction between public/NGO and private sector	Little collaboration with professional and provider organizations, or support for self-regulation.	Probable	Critical	High
J2		Absence of system of accreditation (or effective licensing) of traditional, homeopathic and modern healthcare private practitioners and irregular practic of accreditation of private hospitals, clinics and diagnostic and imaging centers.	Probable	Critical	High
J3		Absence of either consumer or patients' organizations to play a strong advocacy role, or to engage in monitoring of servic quality and outcomes.	Probable	Marginal	Medium

CODE	DESCRIPTION	DETAIL	FREQUENCY	SEVERITY	RATING
K1	User feedback mechanism	There is lack of communication and management systems for the central authority to hear and respond to local demands.	Frequent	Critical	High

1.12 Once this risk assessment was completed, risks were prioritized by means of discussion and consensus building with relevant stakeholder groups. The stakeholders reviewed and agreed to the prioritized list of risks in Table 1.1.

1.13 To narrow the scope of this study, the larger set of risks in Table 1 was winnowed to a set of eight risks. These eight priority risks were selected on the bases of the following criteria:

- The risk was determined to be significant during the preliminary risk assessment exercise;
- A clear cause-effect association exists between the risk and negative impact;
- The risk affects the middle and lower levels of the health system,
- Governance and management are likely to be broadly affected by an in-depth reduction of the risk, and
- Feedback from stakeholders.

The resulting short list for further study includes the following eight risks:

a. Project money spent on non-project activities.
b. Lack of control of payroll disbursement.
c. Illegal payments to accounts offices.
d. Purchases at higher than market rates.
e. Private practice by public facility doctors during office hours.
f. Absenteeism of providers.
g. Illegal activities of Class 3 and Class 4 trade unions.
h. Drugs pilfered and sold by employees.

1.14 To gain a greater understanding of the scale and processes of these eight risks, a *Health Sector Risk Area Validation Study* was conducted to gather additional information. A total of 670 respondents were interviewed during the survey, including third and fourth class employees, health and family welfare managers at district and Upazila levels,[1] patients, retailers, suppliers and Upazila accounts office staff. Data were collected from these respondents using both quantitative (household and exit interview) and qualitative techniques (such as observation, in-depth interviews, mystery shopping, case study, etc.).[2] The information generated from this

[1] Bangladesh is organized administratively in 8 regions, 63 districts and 469 upazilas.

[2] Please see Annex 1 for more information regarding the respondents, the selection procedure for interviewees, techniques of data collection, and a summary of findings.

survey provides critical information on various stakeholders' perceptions and experiences in the health sector and informs much of the following discussion in this report.

Chapter 2. Assessing Key Fiduciary Risks and their Impacts in Bangladesh

2.1 This chapter presents the key findings from the *Health Sector Risk Area Validation Study* and includes descriptive statistics for each of the eight selected fiduciary risks. It also includes findings about the causes of the fiduciary risks as perceived by health staff and clients.

2.2 Estimated projections are made for the national scale of potential losses in this chapter. A full validation of these losses would require additional surveys of similar methodological precision in a greater number of locations. Such data should be available from the Public Expenditure Tracking Survey, which was recently completed and collected, and which has a nationally representative sample size. The estimates presented here should be considered as indications of the possible scale of losses at the national level, rather than a precise estimate of actual losses.

I. Absenteeism

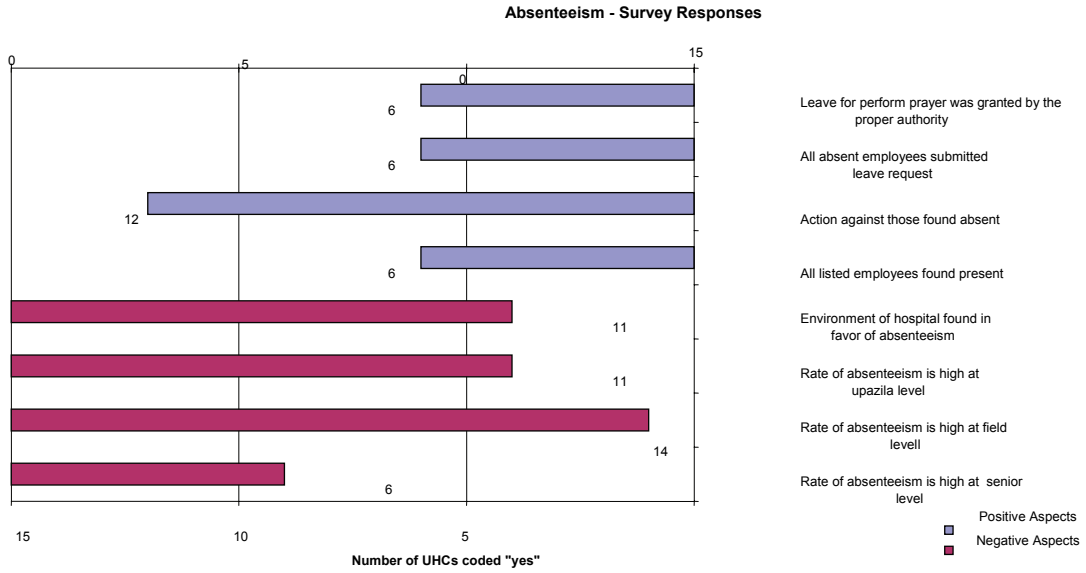
2.3 The risk assessment found a strong association between absenteeism and private practice. This correlation suggests that efforts to resolve one of these problems will likely have beneficial effects on both risks.

2.4 The survey conducted for this study found absenteeism to be a common feature in all of the Upazila health complexes studied. Overall, the absenteeism rate is approximately 16 percent of the workforce. The attendance data was confirmed by the recorded registration list in the hospital complex. At the hospital level, colleagues were asked if the absent doctor was assigned to other tasks outside the complex or was training.

2.5 Absenteeism was more common among senior staff than junior staff and was particularly high amongst doctor. These findings are depicted in Figure 2.1.

2.6 Absenteeism rates were observed to be especially high among the senior level Upazila managers. In contrast, third and fourth class employees generally had lower rates of absenteeism than the higher level employees. For example, managers from the Upazila family planning officer (UFPO) were found absent in 46 percent of Upazilas surveyed. On average, 13 percent of the third and fourth class employees (logistic and support employees) were found absent during the period under study. Their rate of absenteeism is more than two times lower than the overall absenteeism rate of those at the managerial/doctor level, which was about 30 percent. Excluding the managerial level, about two-fifths (about 40%) of the doctors were found absent from their posts over the period surveyed.

Figure 2.1. Absenteeism



Source: Health Sector Risk Area Validation Survey. 2004.

Table 2.1. Percentage of Attendance Status by Employee Designation

Designation	Number of Employees Observed		
	Expected as per Record/List	Found Present	Percentage of Absenteeism
UHFPO	15	14	7
RMO	13	10	23
UFPO	13	7	46
MOM-CH	15	10	33
MO	43	32	26
3rd and 4th class employee	297	259	13

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

Case 1. Here and No-Where: The Case of the Partly Absent

Although 16 percent of the employees were found fully absent, there are a large number of employees who remain absent for a few hours. It was frequently observed that the employees arrive late, and some employees leave the office at any time once or twice during office hours. Often, they remain outside the facility for up to a few hours. They are usually recorded as present but are in a very real sense "partly absent." A female patient attested that, *I have seen the doctor entering the office but he is not at his room. [I was] waiting for about 45 minutes. No one can say exactly where he is, but the peon said he will be back and told me to wait.*

Case 2. Attendance Only to Receive Salary - One Type of Absenteeism

The surveyors identified two employees[3] from a health complex who are simultaneously working at an Upazila health complex and also in private clinics/offices located in Dhaka. Their names and addresses were collected from other staff working in that hospital. After getting information from the staff, the researchers visited the employees' houses to conduct an in-depth interview. Their family members and neighbors said that the employees were available at specific private offices. Later, surveyor visits to those addresses validated the claims.

2.7 In addition to absences throughout the entire day, there were also significant long periods of absences observed during a given day. Formal working hours for required attendance are not observed by all staff. Late starts and early finishes to the working day are the norm rather than the exception. There appears to be a lack of action to stop absenteeism. No fixed starting time to begin work exists. Office hours at Upazila health complexes (UHCs) differ from one Upazila to another. Most of the UHCs were found to be closed at 2 PM. The starting time of most offices was 9 AM, with only a few of the UHCs starting office hours at 8 AM to 8.30 AM. Most of the employees begin to arrive at the complex between 9.30 – 10.00 AM. On average, an employee stays at work for four hours a day. According to the survey findings, an employee does not execute work-related activities for about 39 percent of his/her total office time on average. This reflects a very low level of staff productivity.

Reasons Cited for Absenteeism

2.8 The study also collected information from employees about their reasons for absenteeism. The doctors interviewed cited the following major reasons to explain their absenteeism:

Irresponsibility and negligence of duty (16%)
Not working in a preferred work place (13%)
Being out of town / outside the duty station (19%)
Personal business (29%)
Administrative weakness (26%)
Private practice (29%)

Ways to Prevent Absenteeism

2.9 The majority of Upazila managers of the UHFPO and resident medical officers (RMOs) suggested adopting administrative initiatives to reduce private practice at hospital level. The

[3] Names and designations are confidential.

most frequently mentioned proposals for reducing absenteeism, according to Upazila managers, are as follows:

Salary reduction/cut (34%)
Transfer to other areas (13%)
Higher authority stops patronizing the absentee persons (13%)
Punishment (13%)
Motivate doctors (17%)
Tightening of other administrative controls (6%)
Others (4%)

Observations

2.10 In addition to this study's survey, qualitative surveyors observed the following indicators at all the upazila health complexes. The findings in Table 2.2 further support the survey's findings.

Table 2.2. Absenteeism Indicators

OBSERVATIONS	%
All listed employee found present.	7
Rate of absenteeism is high at senior level.	53
Rate of absenteeism is high at upazila level.	53
Lack of action against absenteeism.	87
Lack of administrative control in hospitals favors absenteeism.	27
All absentees submitted leave request.	27
All leave applications approved by the relevant authority.	53

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

2.11 Absenteeism of staff and health professionals has a direct influence on the availability of care for the poor. Poor people have to pay illegal payments to health complex staff to access services. These payments represent a substantial financial burden to them.

2.12 The massive cost associated with absenteeism, especially for the poor, justifies immediate action first to ensure that the system uses resources more efficiently and second to begin to build client's confidence in the delivery of health care services.

II. Private Practice by Doctors during Office Hours

2.13 The survey found extensive private practice by upazila doctors during office hours. The main findings are:

- Doctors engage in private practice inside and outside the upazila health complex.
- Doctors actively encouraged public patients to visit them in their private offices.
- Private practice within the UHC is an "open secret." It is widely understood that fee-paying patients go directly to the doctor's room, while others must wait for care.
- Private practice during office hours is a leading cause of absenteeism.
- Many doctors feel compelled for financial reasons to engage in private practice.

The following case describes the perspective commonly held among many unmotivated doctors:

Case 3. Unless Management Looks at Us, How Can You Expect Changes?

Dr. "Z" is a very senior doctor who has worked for more than twenty years at the upazila level. He explained his "frustrating" professional experience to the interviewers.

I am working for more than two decades at the upazila level. I am a graduate doctor and I was a good student all through [my studies]. I have grown-up children who are studying but there are no good educational institutes in this upazila.

I want to see them well qualified; otherwise, in a country like Bangladesh they will have no options other than asking for money from others. I don't want to see them falling back in life. And that is why I have to maintain two houses, one in Dhaka and another in this upazila. I am staying here in the government accommodation. At least once a week I have to go to Dhaka to solve a lot of household chores. I stay in my official quarter and according to finance rules, I have to pay 40 percent of my salary (around 4,000 taka). But the overall standard of this house is absolutely poor. In Dhaka if it were rented out, the maximum rent would be 1,000-1,200, but I am paying 3,000 more. And I have no choice. I cannot maintain my family with my "low income" although I am treated as Class 1 Gazetted Officer! Therefore, without private practice, I have no way to survive.

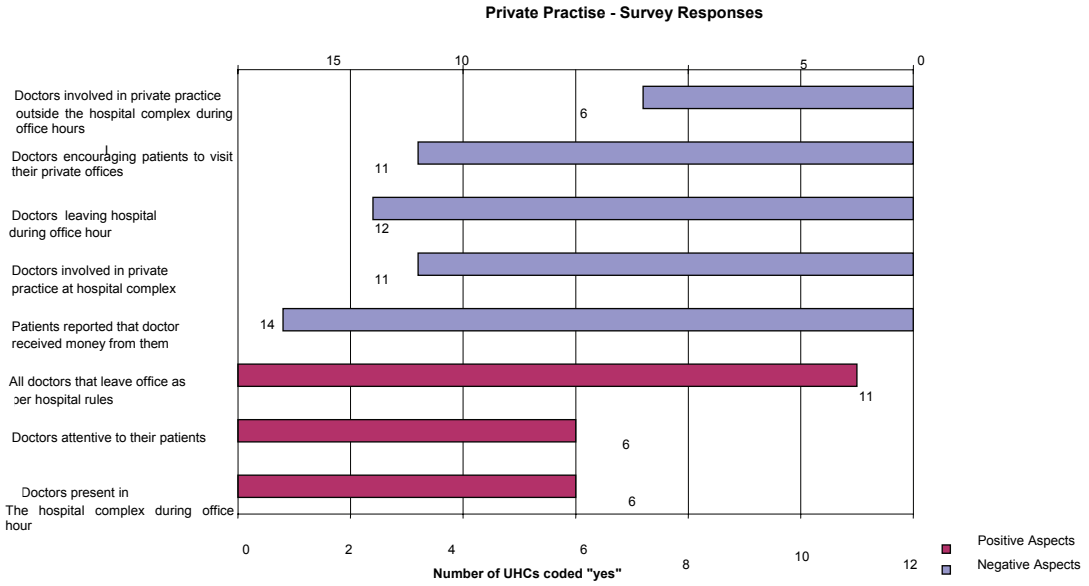
There is another problem as well. In this upazila, there is no other good doctor. Therefore, not only the patients, but also my colleagues (including third and fourth class employees) request me to give services to poor people. I am frustrated. I do not see any possibility of getting a promotion in the near future. I joined the upazila and will retire from the upazila. But there are some officers who maintain good relations with DG office. They are in Dhaka or in medical colleges, going abroad and pursuing higher studies.

I know there are professors that have practices outside Dhaka every week. But as a senior employee, how can they leave the station? But if we leave, everybody will focus just on the upazila doctors, who do not stay at their stations. This will be published in newspapers. Considering all these issues, I have decided to move to private practice. At least that is compensating to some extent. If you really want to have some changes, write all this in your report. Government should think about us. Only then can you expect some changes!

Other graduate doctors expressed similar views.

2.14 The survey's findings are depicted in Figure 2.2 below:

Figure 2.2 Findings on Private Practice



Source: Health Sector Risk Area Validation Survey. 2004.

2.15 To devise appropriate strategies to address the problem of doctors involved in private practice during scheduled work hours, the study examined how private practice is carried out by the doctors. To gather this information, the following methods were employed: interviews with district and upazila managers, exit interviews with patients, interviews with hospital staff (statisticians and nurses) and observation techniques. Team members also visited the private offices of doctors using the "mystery-shopping" technique. Other information was gleaned about specific doctors by discussing with neighboring pharmacies/drug stores. The issues investigated included the average time of private practice by a doctor, days worked, fees charged, personal reputation, etc.

2.16 The interviews and direct observations confirmed the prevalence and significance of doctors' absenteeism. The non-availability of the doctor has a tremendous negative impact on the HNP system. The magnitude of the risk is perhaps best captured by estimating the amount of time that doctors are not available to provide health services to the poor. The data on absenteeism by doctors is summarized in Table 2.3 below.

Case 3. Private Practice: In and Outside the Complex!

In almost all of the 15 upazilas surveyed, doctors were engaged in private practice both within and outside the hospital complex. In some cases, doctors engaged in private practice so candidly that they did not hesitate to conduct private practice in front of the researcher.[4] These findings were based on both direct observation and patients' feedback.

Table 2.3. Private Practice by Doctors during Office Hours - Direct Observations

DIRECT OBSERVATIONS	%
Doctors present in the hospital complex during office tour.	20
Doctors attentive to their patients.	47
Patients reported that doctor received money (additional fees) from them.	60
Doctors involved in private practice at hospital complex.	60
Doctors leaving hospital during office hours.	53
Doctors that leave hospital as per hospital rules.	33
Doctors encouraging patients to visit their private offices.	67
Doctor that have private practice outside the hospital complex.	53
Sample: 15 Upazilas.	

Source: Health Sector Risk Area Validation Survey. 2004.

2.17 At the hospital level, the findings of private practice by doctors during office hours are similar to those at the upazila health centers. Statisticians (79%) and nurses (21%) stated that private practice by doctors happens at upazila complexes and most staff mentioned it as an "open secret;" district and upazila level managers also validated the findings. Many practicing doctors perform private practice within the hospital complex: 17 doctors out of 25 in six upazila health complexes were found to engage in private practice openly.

Case 4. An Open Secret!

Usually there are five doctors in an upazila health complex. Of these five, on average three doctors conduct private practice in the complex. There is a two-tiered corrupt system of medical practice in health complexes. One is for the general patients and another is for the fee-paying patients. This system is well known to the patients and local people. Those who are not able to pay more fees to the doctor collect a ticket of Tk. 3.00 from the counters and wait. The extra fee-paying patients go directly to the doctor's room for care.

[4] The surveyors collected photocopies of prescriptions from patients that were prescribed by UHFPO and medical officer who were engaged in private practice during office hour. Due to confidentiality, the prescriptions could not be attached to the report.

Payment of Extra Fees by Patients

2.18 Patients interviewed acknowledged that they were required to make extra payments to various staff members in the health facilities to receive treatment or health services. Twenty percent of the interviewed patients said that they had paid some extra fees. Among them, 10 percent stated that payments were made to the UHFPO, 3 percent paid to the RMO, and 77 percent to the medical officer (MO). Other recipients of unauthorized money from patients included the medical assistants (MAs), peons and nurses.

2.19 Twenty-four district-level managers were interviewed about the private practices of civil surgeons (CS) and the deputy director of family planning (DDFP). Roughly half of them admitted that they regularly conduct private practice during office hours.

Case 5. Private Practice during Office Hours in Front of You!

One of the district managers said, *Private practice during office hour is happening at upazila level. If you visit different upazilas, you will find a lot of cases. They [doctors] would not hesitate to do private practice in front of you.* The researchers' observations confirm this statement.

Another manager said, *One day a medical officer of maternal and child health (MOMCH) came to me; suddenly he got a phone call and went away. After returning to me I asked him where did you go? He replied, Sir, I went out to do a caesarean in a clinic.*

Preventing Private Practice during Office Hours

2.20 During the course of interviews, district level managers were asked to provide their views on how to prevent private practice during office hours. Stern administrative action was favored by 71 percent. Twenty-one percent advocated proposals to ensure supervision and monitoring. Another, 38 percent of respondents suggested better work facilities and improved work conditions for doctors. Positive steps associated with the provision of incentives, such as provision of non-practicing allowance, regular promotions and increased salaries were not openly proposed.

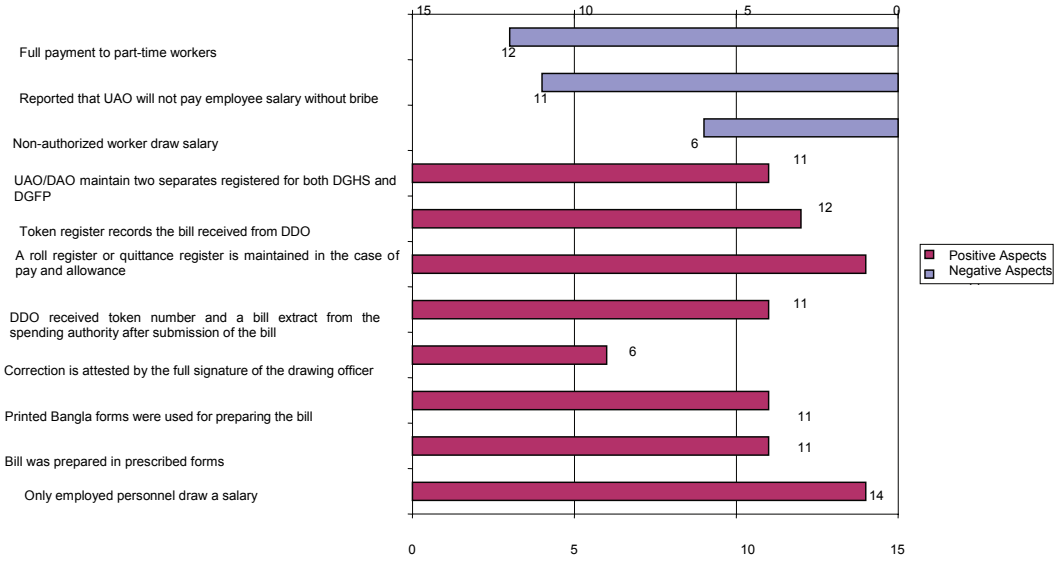
III. Insufficient Control in Payroll Disbursement System

2.21 Although the system for payroll disbursement was well understood, it was not adhered to in a number of respects. At least five of the fifteen UHCs examined were found to have unauthorized irregularities in the payroll system such as:

- Procedure for positive identification of personnel not implemented.
- Attestation of overwriting not undertaken.
- Recording in bill register not undertaken.

2.22 There is little indication that the lax payroll disbursement system is a major risk for the HNP sector. For example, there is no indication of the existence of a large number of "ghost workers" that lead to irregular payroll payments. Survey findings do indicate weaknesses in the system due to either significant level of laxness, a lack of tight supervision of payroll procedures, or a failure to act when non-adherence to regulations is discovered. (See Figure 2.3).

Figure 2.3. Findings in Payroll Compliance



Source: Health Sector Risk Area Validation Survey. 2004.

IV. Illegal Fees

2.23 There is a widespread practice of staff and health facilities paying illegal fees (or bribes) to official staff members to facilitate legitimate payments such as staff salaries, contingency and traveling fees, festival bonuses and recreation. Key findings from the survey are the following:

- An illegal fee is often made by the upazila accounts officer at the crucial step when the officer sends a bill to the bank for payment.
- A common illegal payment is the "entertainment fee." The staff pays this illegal fee to facilitate the processing of their legitimate payments.

2.24 Of the15 upazilas surveyed, 12 Upazila accounts officers confirmed that they made irregular payments to the accountant general's (AG) staff. All the cashiers and UHFPOs (DDO) mentioned paying illegal fees to the AG's staff. Remarkably, it was suggested that no payment would be received by the employee without the payment of a bribe to the AG staff. The amount of the bribe required varies depending on the type of payment, e.g., salary, contingency, traveling, festival bonus, recreation etc., but all require different bribe amounts.

Examples of Illegal Fees

2.25 The practice of illegal fees is widespread in many UHC. About one-third of the total survey respondents openly acknowledged paying illegal fees to AG staff. Forty-six percent of those surveyed mentioned paying a bribe of about 10 percent of the amount of traveling and contingency bills in order to be reimbursed. Nine percent of the respondents said that they paid bribes for recreation bills. In all cases, an illegal bribe known as an "entertainment fee" must be paid to UAO's office for bills to be submitted for payment.

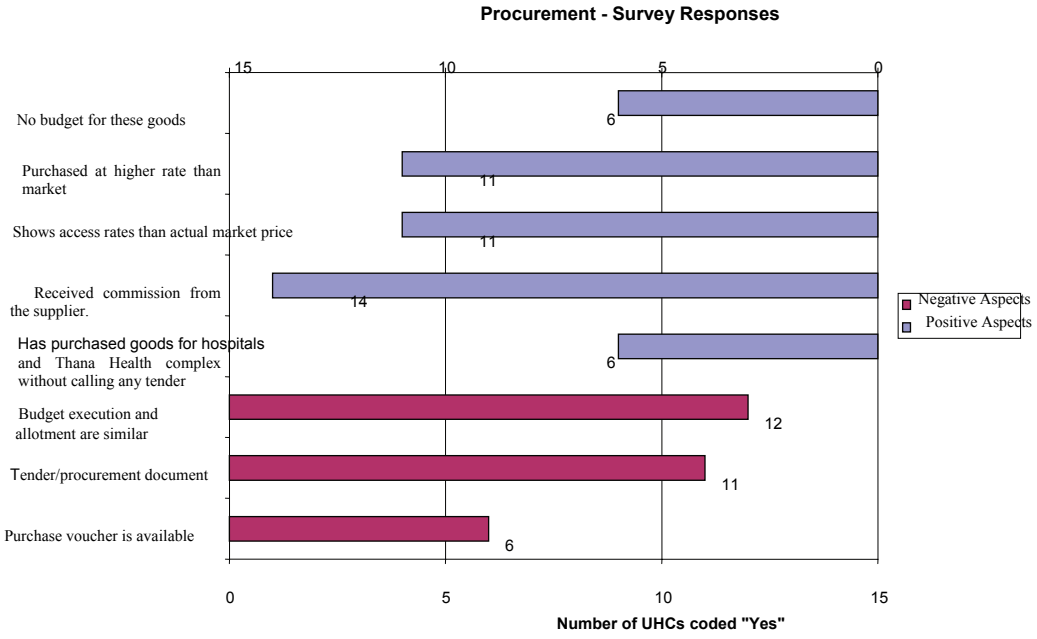
2.26 Although the staff did not complain directly about the illegal fees, this form of extortion is occurring in many UHCs. One UFPO commented, *"Illegal payments to AG staff have created new scope for corruption of the UHC."* Staff did complain that they do not get some fraction of their salary or reimbursement for payments. For instance, if a staff member's full salary is Tk. 1,512, the staff member will only receive an amount rounded down to Tk. 1,500. A health assistant explained *"This is very common and we are used to surrendering the fraction. To me it is best to just forget it!"*

2.27 The procedure for submitting Upazila health complex (UHC) bills for payment also allows corruption into the system. The cashier and head clerk were asked to explain the procedure for submitting bills for payment. Most of the respondents explained that, before a bill is submitted to the Upazila accounts officer (UAO) for payment, the upazila health and family planning office's drawing and disbursement officer (DDO) authorizes payment of the bill by signing it. The authorized bill is then submitted to the UAO's office. The UAO reviews the bill for errors before sending the bill to the concerned bank with instructions to pay the UHC's submitted bill. A few respondents explained that bribes were usually required as another "step" in the procedure for submitting bills to the UAO. As a general practice, the UAO will not submit bills to the bank for payment without receiving a bribe.

V. Procurement at Higher than Market Prices and Malpractice

2.28 There is a wide understanding and formal adherence to a well-established procurement procedure. Survey findings show that current procurement practices are another important area of risk to the HNP sector. Pharmaceutical products, for example, tend to be purchased at the "maximum retail price" rather than the quoted "wholesale price." And both retail and wholesale prices are still higher than the market prices. In addition, the form of bidding procedures can create a false indication of value for money through the averaging of infrequent and frequently used products. There exist anecdotal reports (but little conclusive evidence) of apparent collusion amongst bidders, an absence of real competition, and pressures on purchase committees to seek the lowest possible prices. Figure 2.4 summarizes malpractices in procurement based on survey responses.

Figure 2.4. Findings Related to Procurement



Source: Health Sector Risk Area Validation Survey. 2004.

2.29 The Ministry of Health and Family Welfare requires the purchase of medical and surgical requisite (MSR) products at the standard rate. The district authority is responsible for obtaining quotations for products from the supplier and awarding the winning contract. The UHC has no involvement in the procurement process. At the district level, there is a purchase committee and sub-committee; both are headed by the civil surgeon who makes procurement decisions. This fiduciary risk was verified by collecting secondary information from the district office, interviewing members of purchase committees including the CS and suppliers, collecting purchase vouchers, and by comparing prices with other secondary sources and checking market rates.

Process of Procurement

2.30 Almost all of the civil surgeons followed the government rules for procurement of products. The official process of procurement is as follows:

- Collect requisition of product from the UHC
- Prioritize the product
- List of suppliers
- Advertise for bidding
- Receive tendered bids
- Compare bids with the market price; collect market information from marketing officer
- Make comparative statement and pricing.
- Award contract to the lowest bidder
- Get approval from the director general

Bribes, Kickbacks and Malpractice in Procurement

2.31 Claims of malpractice, bribes and kickbacks in the procurement process were investigated by gathering information from product suppliers. In total, seventeen suppliers were interviewed but only four suppliers admitted to paying bribes to officials. According to the civil surgeon, deputy director of family planning, and members of the purchase committees, malpractice apparently occurs at different stages of the purchasing process. Private sector representatives noted that it is virtually impossible to win a contract without paying bribes and kickbacks of between 10 and 15 percent, which are the norm. Contracts are often steered to favored individuals and firms in a number of ways, including: allotting insufficient time for competitive suppliers to prepare bids; receiving and opening bids at multiple locations; unclear evaluation criteria; collusion amongst bidders with subsequent award of contracts by lottery; physically blocking the delivery of bids by outsiders, etc. Thus, although in principle procurement is subject to competitive bidding, in reality the actual implementation of the procurement process is unsatisfactory and suffers from severe problems.

2.32 Even though researchers could not directly identify any evidence of procurement malpractice during the bidding processes, some managers assured the researchers that the whole bidding process is done so carefully that it is difficult to trace any evidence of malfeasance from official documents. Trade union leaders were also questioned about procurement malpractices. They cited evidence of malpractice indirectly. A few trade union leaders stated that some of the bidders have been winning bids consecutively for the last 15 years. One trade union leader explained, *"A supplier has been getting the supply contract for a hospital for the last few years. We cannot tell you the exact nature of the malpractice but you should certainly have doubts about the competitiveness."*

2.33 The purpose of the procurement process is to achieve better value of products at the lowest possible price. When the system is not transparent and results in malpractice, excessive prices are paid, patients suffer the consequences due to a lack of materials for affordable diagnosis and treatments.

Case 7. 30,000 vs. 55,000?

I gave a bribe yet I still did not get the supply contract. A person named "Y" got the supply in exchange for paying Tk. 55,000 as a bribe with the help of upazila manager.

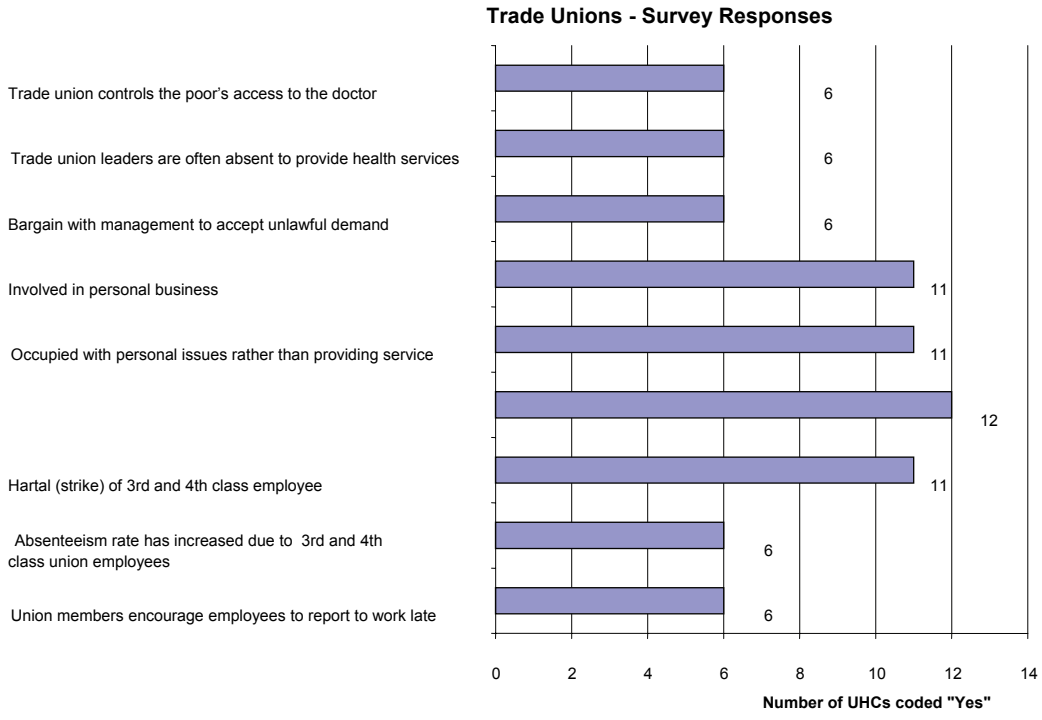
A supplier gave a bribe to a junior staff member that amounted to Tk. 30,000 in order to win a contract to supply food. But he was not awarded the job. His competitor had paid bribes of TK. 55,000 to senior staff and was in the end awarded the contract. The unsuccessful supplier attempted to reclaim the bribe given to the junior staff, but it was not returned. This created unrest in the office and the junior staff was later transferred to another health complex. The senior guy is still in his "good" position!

The father-in-law of "S" and the father of "K" were both former store keepers. They always get supply offers by making a linkage with the present storekeeper. They are masters of illegal acts.

VI. Class 3 and Class 4 Trade Unions[5], Illegal and Improper Practices

2.34 The activities of Class 3 and Class 4 trade union members create barriers to good health service delivery and were associated with many aspects of inefficiency and malpractice in hospital organization. Some of the specific problems reported included: support for illegal activities, e.g., illegal payments, barriers to proper implementation of government rules and regulations, close indoor and outdoor services, disregard of office rules, influence on hiring of staff, and demanding bribes from patients. These accusations of impropriety were verified through interviews with district level managers and UHFPOs.

Figure 2.5. Risks Associated with Class 3 and 4 Trade Unions



Source: Health Sector Risk Area Validation Survey. 2004.

VII. Pilferage of Drugs

2.35 The pilferage of drugs is a significant risk factor to the HNP sector. Pilferage on any significant scale reflects a lack of adequate systems and the breakdown of discipline and control at the workplace. On a system-wide basis, the losses from drug pilferage can be substantial.

[5] Third and fourth class workers perform logistic and support activities within the health facilities such as: cleaning, security etc.

2.36 All these losses have a cumulative and interrelated impact on the poor. A lack of the right drugs due to pilferage (or procurement issues) will result in the patient requesting to see the doctor on a private basis. This in turn encourages doctors' private work during office hours. Improvements in administrative control and management are necessary to address the drug pilferage issue and other related fiduciary risks.

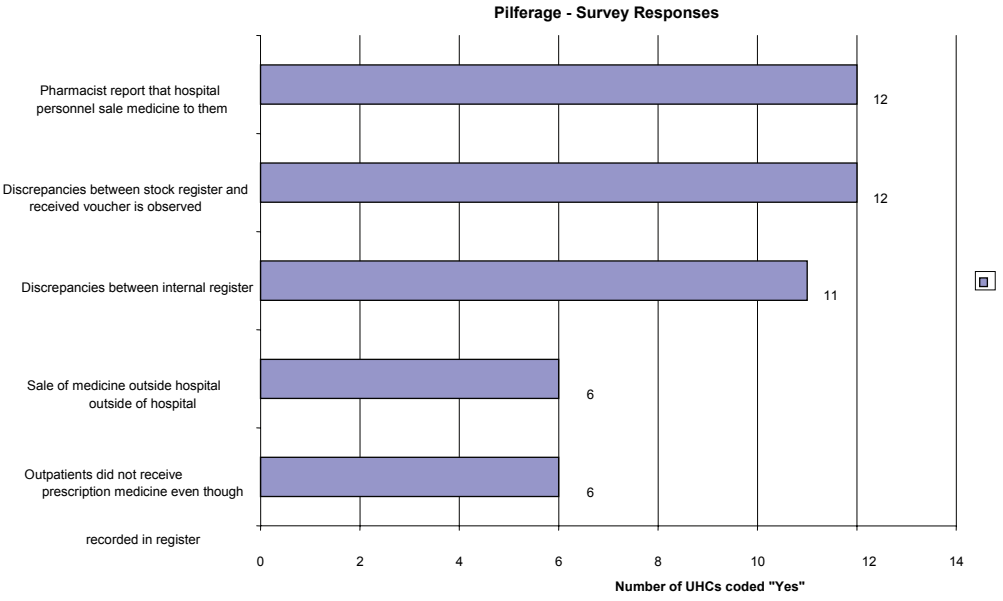
2.37 Evidence of the loss of drugs, apparently due to pilferage, was evident in at least four of the fifteen UHCs investigated. The most common symptoms of this problem include:

- Drugs not being properly recorded in the register of drug stocks.
- Misuse of drugs, including dispensed drugs being resold.
- Discrepancies found between the registration of drug delivery and drug supply.
- Inconsistencies found between prescriptions and registers.

2.38 Stolen medicine or its misuse poses serious barriers to poor people's ability to ensure good health. The fiduciary risk associated with pilfered drugs is therefore one of the main areas of focus of this study. This risk was assessed by checking indoor and outdoor (internal and external) inventory control, verifying the stock control register, comparing the ticket provided to the patient by the doctor with the stock register, visiting patients' houses, physical verification of sample drugs in stock, interviews with staff and officers familiar with methods of pilferage and interviews with drug retailers.

2.39 Evidence of drug pilferage was observed at four of 15 UHCs (27%). Table 2.5 presents survey responses of discrepancies in various drug stocks. Researchers also observed a lack of strong monitoring and control of the stock of medicine. Some medicines were not even recorded in the stock register.

Figure 2.6. Findings Related to Drug Pilferage



Source: Health Sector Risk Area Validation Survey. 2004.

2.40 A total of 9,902 items of medicine were identified as pilfered from four hospital complexes. Nonetheless, the 70 retailers interviewed suspiciously refused to comment on purchasing drugs from the hospital staff.

Table 2.4. Irregularities Regarding Drug Stocks

NAME OF MEDICINE	NUMBER OF MEDICINES DRAWN FROM THE STOR OF UHC	RECEIVED SHOWN	CURRENT STOCK RECORDED IN THE STICK REGISTER	MEDICINE FOUND IN STOCK	DISCREPANCIES
Amoxycillin	1000	1000	401	240	161
Amoxycillin	500	200	657	216	741
Amoxycillin	4000	4000	4000	-	4000
Doxycillin	5000	5000	5000	-	5000

Source: Health Sector Risk Area Validation Survey. 2004.

2.41 Similar evidence of pilferage was found in another health complex where patients did not receive medicine as per their prescription despite the fact that it was recorded in the register as dispensed. Sales of medicine to external stores were reported at six UHCs. Differences between the internal drug register and supply of medicine were observed in four UHCs. Discrepancies between vouchers for received medicine supplies and the stock register were also observed at three hospitals.

Case 8. A Case of Drug Losses

The interviewers identified at least one case of drug theft while conducting the study. The theft occurred on June 8, 2004 when the village doctor was taking some drugs from the residence of a staff nurse. Local people caught him and handed him over to the police. The police filed a case against the village doctor and staff nurse and the incident was published in the local newspaper.

Some of the UHC managers stated that drugs are often found in different nearby pharmacies. One UCH manager cited an example of purchasing essential drugs from a pharmacy in Uttara in northern Dhaka, though he did not disclose the name of the pharmacy. One upazila manager said, *While I was in "X" district I heard of a case of thousands of missing Depo-Provera.*

Table 2.5 presents some of the findings from the researcher's investigation into drug pilferage. Findings are recorded based on stock verification, opinions of the hospital staff, patients and retailers. At least three hospitals were identified and flagged for listing drugs in the record as "given to the patient," even though none were in fact given to the client.

Table 2.5. Drug Supply System

	No. of Upazila	Source of Information
Discrepancies between stock register and received voucher	3	Record Observed
Patients did not receive medicine even though it was recorded as dispensed	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	4	Observed

Chapter 3. International Experiences with Anti-Corruption Strategies in the HNP Sector

The risks and inappropriate practices in Bangladesh's HNP sector that were investigated in the previous chapter are not unique to Bangladesh. Most countries around the world—developing and developed countries—have all grappled with these issues at some point. Some of these countries have managed to make considerable progress against such threats to their respective HNP sectors through a diverse array of interventions. This chapter reviews the main features of a number of such innovative efforts, which may serve to inspire and guide future reforms to reduce system losses related to health care service delivery.

I. Social Accountability Mechanisms at Work

3.1 Thailand's infamous drug corruption case is a good example of the power of civil society to fight corruption.[6] In July 1998, the Matichon, a local Thai newspaper alleged that the Ministry of Public Health (MPH) maintained a supplementary budget for medical supplies that benefited selected companies. The MPH procurement orders that were paid from the supplementary budget were listed at abnormally high unit prices. Initially, the MPH denied these allegations outright. But the allegations were not laid to rest due to a group of doctors.

3.2 Since 1976, Thailand has had a very strong rural doctors' forum. The forum filled the professional networking needs for a large number of newly-trained doctors who were posted to rural clinics in the 1970s. A month after the Matichon's article appeared, the chairman of the rural doctor forum's chairman stated that his members also had reported that they were directed to channel procurement to certain companies at prices two or three times higher than normal. This statement triggered a slew of similar accusations from senior doctors in the health department and further independent probing by journalists. Public opinion polls showed growing public anger and petitions were collected calling for the removal of certain administrators in the Ministry. A protest movement begun by the public health community was extended widely into the public domain.

3.3 The collective voices of protest persuaded the prime minister to establish a committee of investigation in September 1998. Its findings confirmed the existence of corruption in many provinces. The public health minister and deputy minister resigned and several civil servants were fired. The administrative system of medicine and medical supply procurement were reformed as a result.

3.4 This widespread anti-corruption movement begun by civil servants was unprecedented in Thai history. The key to the movement's success was the strength of the public health community and in particular the rural doctors' forum.

3.5 **Ecuador** presents another good example of the power of information to promote collective action with government suppliers. Businesses in Ecuador have long been concerned

[6] Tritat, 2000.

by the level of corruption in public procurement. After waiting in vain for congress to modify public procurement legislation, business associations and other organizations joined forces to set up a system to offer information to the public and to state contractors. These groups were supported in their efforts to establish an internet-based service called licitenet.com by Transparency International. The project website lists public procurement processes that are underway, completed or pending approval. The website uses 18 different media outlets which are reviewed daily to gather its on-line postings. Licitenet also has a contract with the attorney general's office to receive information about contracts that have been awarded directly by the government. Within months of being launched, the website received 13,500 visits and had 37 company subscriptions. One of the main challenges for maintaining a comprehensive listing of procurement is that under Ecuador's law, public calls for tenders are only required if they exceed US$111k. Smaller contracts are granted at the discretion of each institution.

3.6 **India**'s experience on the public's right to information is notable. Mazdoor Kisaan Shakti Sangathan (MKSS) is an organization of rural people based in Rajasthan that has become well known in India for its use of public hearings to aid in accountability. MKSS has pioneered a novel method for the rural poor to access information from the government about schemes and benefits to which they are entitled. MKSS has held "public hearings" that have encouraged ordinary citizens to speak out about abuses in public works and in schemes from which they were supposed to be benefiting. These hearings have exposed the ways in which public officials have siphoned off large amounts of funds from public works budgets. MKSS's struggle to access information from public offices on corruption led its leadership to discuss the issues with the state's chief minister. MKSS's first victory was the government's notification under the Panchayats Act that all public expenditure could be inspected by the people. Subsequently, MKSS won the right to photocopy public expenditure records. Rajasthan passed the Right to Information Act in 2000, a development that was influenced greatly by the pressure of MKSS.

3.7 **Bolivia** has established vigilance committees (VC) to monitor government institutions. VCs are set up in parallel to local elected bodies in Bolivia with a mandate to monitor these bodies. They are composed of six elected leaders of traditional local governance systems, such as peasant syndicates and neighborhood councils. The VCs' main responsibility is to ensure that community priorities are reflected in municipal investment decisions. But they are also empowered to wield a legal instrument called a "denuncia" against local councils. The VC can call for regular audits of local government, and if it detects corruption, it can lodge a complaint with the national executive branch. The complaint is submitted to a senate special committee, which can suspend central funds to the erring local council until the case is resolved. The effectiveness of this committee as a mechanism of social control was displayed uniquely by the Municipality of Pucarani's local committee regarding the private use of public goods. The committee demanded that the mayor hand over the keys to the municipal pick up truck every Friday at 6:30 PM to the committee to prevent him from using it for his own personal benefit during the weekend.

II. Enforcing User Rights and Quality Services through a Third Agent

3.8 **India** has developed another method of public accountability through the use of a "report card" to rate public services including water supply, electricity and health and sanitation. Public services have been in disarray throughout the country and particularly in the poorer sections of society. Of all the levels of government, the local level has been most neglected. Unresponsive and corrupt service providers have exacerbated the problem. One problem citizens faced in addressing service-related issues was their lack of knowledge and information. They protested and wrote to the press which may have solved some individual problems but did not solve the systemic problems in service provision. In response to feelings of impotence, small movements in several cities have emerged to protest the neglect and to demand greater accountability from the authorities. What emerged was the use of the Report Card: Citizen Feedback for Enhanced Accountability in Public Services. A NGO in Bangalore catalyzed and supported this movement in a number of cities. It promoted the generation of knowledge and information which was transformed into a form of "citizens' voice" that could drive external pressure for change. The report cards on public services have given citizen groups in several cities a versatile tool that endows them with power and leverage to confront bureaucrats and politicians. Organizations of the middle class and the poor have both resorted to the use of report cards. The media has also used this tool well and has acted as an ally to civic movements in some cities.

3.9 In **Bolivia**, a USAID-funded non-profit organization called Prosalud instituted an elaborate employee incentive program in conjunction with Management Sciences for Health. Prosalud's ability to initiate such programs (despite rigidities in public sector health worker salaries) was the result of an innovative management structure. The Government of Bolivia granted Prosalud the role of managing and setting performance standards for public sector employees. In effect, the government subcontracted the management of its own employees to a NGO. Prosalud is by far the best-documented available example of an incentive plan for health care workers. Prosalud implemented three distinct incentive schemes.

(a) The first program was a model for medical specialists, including pediatricians, gynecologists and dentists. Prosalud's health centers were unable individually to support full-time specialists. Prosalud instituted an arrangement through which specialists were contracted on a part-time basis and shared the income risk. The specialists received no salary from Prosalud. Instead, the specialists kept 50 percent of revenues they generated from patient billings, while Prosalud received the other 50 percent. This arrangement has proven financially beneficial for both the health centers and the specialists.

(b) Prosalud also initiated an incentive program for physicians at new health centers. To reduce the start-up costs of new facilities and to motivate physicians to bring in more patients, Prosalud pays the physicians only 80 percent of the average salary for general practitioners. Physicians earn additional fees which are calculated as a percentage of the revenues generated from their new patients. When this amount equals the average salary for general practitioners, the base salary of the physicians at the new health centers is increased to the average.

(c) The third incentive program established by Prosalud is the most innovative. This scheme created a new system for allocating annual salary increases for health center staff. Automatic salary increases were replaced with individual performance-based increases.

> The existing policy gave all staff automatic yearly salary increases regardless of the financial status of the facility or the employees' performance. The new system made annual pay increases contingent on individual productivity, measured by the number of patients seen. Behind this contingency was a perception on the part of Prosalud managers that there was an underutilization of both curative and preventive services. The level of bonuses approximated the previous levels of automatic increases. Consequently, under the new system, the average worker had to work harder than before to earn the same level of income.

3.10 Prosalud management evaluated each employee on a scale of 0 to 100. To be eligible for a bonus, employees had to rate at least 70, signifying "satisfactory but needs improvement." In addition, the health center had to perform a specified minimum number of preventive services to qualify for the bonus. This last condition was introduced to promote delivery and consumption of underutilized preventive services. For each health center, Prosalud calculated a base level income as the average income generated from initial visits during the past eight months. Thirty percent of the revenue generated in excess of the base level for a given health center was held in reserve to buffer slow months. Any money left in reserves at the end of the year was divided between the physicians, other health center employees and Prosalud.

3.11 **Uganda** Debt Network (UDN), an advocacy and lobbying coalition of NGOs, has become the lead agency monitoring the Poverty Action Fund (PAF). The PAF was established by the government to mobilize savings from debt relief and donors to spend on priority areas identified in the Poverty Eradication Action Plan (PEAP). PAF resources are sent to the districts as conditional grants to be used according to the guidelines established by Ministry of Finance, Planning and Economic Development as well as the line ministries. UDN is monitoring PAF in 17 districts in which Poverty Action Monitoring Fund Committees (PAFMCs) have been established. The PAFMCs are composed of persons selected by the local people. These committees are responsible for continuous monitoring and evaluation of the delivery of services and the accountability for public resources at local government levels.

III. Government Regulations

3.12 In **India**, the People's Charter, Lok Satta - Andhra Pradesh is a popularized version of the citizen's charter. Instead of the government dictating to citizens their entitlements, this initiative has citizens telling government what their expectations are from particular government services. The charter evaluates the quality of government services and articulates what citizens consider minimum standards that government providers should meet. The People's Charter is a lobbying and monitoring tool. It addresses citizens' needs and rights across a wide spectrum of issues including public distribution system, utilities, land-related issues, certificates, voting rights and civil liberties.

3.13 Another successful experience in government accountability from India is the People's Hearing- Rajasthan. The "jan sunwai" or people's local audit method was introduced in Rajsthan by a small CBO called MKSS in 1994. It involves extensive research into suspected corruption in local development projects, particularly employment-generation schemes targeted at the poor. Information generated is painstakingly compared with information from local government offices about amounts sanctioned and actually spent on inputs, including labor-for

local public works and other development projects. Villagers, particularly laborers, suppliers and contractors on local projects, are asked to verify whether they received the money due to them, or whether construction took place as claimed. Discrepancies are noted and officials are asked to return missing sums. This process has now been institutionalized. A revision of the local government act in 2000 endows village assemblies with the right to audit local spending, and to demand an investigation by district officials in cases of discovery of misspending.

3.14 **The United Kingdom and Canada** have used a Report Card by a Government Service Provider Agency. This model is characterized by a government service provider agency initiating the preparation of the report card. The actual survey and draft report preparation is often contracted out to a commercial organization. The draft report is vetted by the agency, finalized and disseminated to the public. The focus of the report card may be confined to a single program (or service) or a facet of a program administered by the agency. Examples of countries using this model include Canada and the United Kingdom (UK). The Social Research Branch of the Department of Social Security, UK has been involved in the preparation and dissemination of report cards on different programs administered by the department for more than a decade. In Canada, federal government departments and some provincial government departments have been active in facilitating the preparation and dissemination of report cards on the services they provide. The results of the report card surveys are disseminated to the public and often fed back into the public expenditure allocation processes in the form of either voluntary or mandated reporting requirements to legislatures. A major strength of this model is the ownership of the exercise by the public agency. Preparation of the report card by a private firm brings some degree of independence to the exercise. The preliminary results are available to the agency and its views and feedback are included in the final report.

3.15 **Bolivia** enacted the Law of Public Participation of 1994. It empowers democratically elected municipal councils to design and implement local development policies and programs with central government financing. In addition, the law empowers CBOs, known as Organizations Territorial de Base, to participate in the development of five-year municipal plans. These groups are given jurisdiction over a defined territory and assigned rights and duties covering a range of social, infrastructural, productive and environmental matters. Vigilance committees, as mentioned earlier, are set up to act as watchdogs on municipal councils.

3.16 The National Accountability Bureau (NAB) in **Pakistan** was established in 1999 under NAB Ordnance 1999 to deal with corruption cases by public office holders and others. The chairman of the NAB is vested with the authority to enter into a plea bargain with an official accused of corruption. An accused official could be released from custody upon depositing the entire amount of funds illegally taken. This power could be exercised with the consent of the court. NAB has had an extremely positive impact on improvements in public services. Due to NAB and other similar measures, Pakistan has greatly improved its ranking on Transparency International's index of perceived corruption.

3.17 An important cases prosecuted by the NAB resulted in the successful return of pilfered funds amounting to US $7.5 million from Mansur ul-Haq, former chief of the naval staff. Ul-Haq received kickbacks and commissions from various defense contracts. He prematurely retired in April 1997 on the grounds of conduct unbecoming an officer. He left the country in

1998 to settle in Austin, Texas. NAB investigated ul-Haq's alleged kickbacks with legal assistance of foreign experts, leading to the discovery of illegal foreign assets. The former admiral was arrested by US authorities in April 2001. A complaint was filed against ul-Haq by the Accountability Court, Rawalpindi and he was indicted by the court in October 2001. Ul-Huq plead guilty and agreed to return US $3.36 million, which was rejected. In a second application, ul-Huq agreed to pay the entire amount of US $7.5 million. He paid US $6.2792 million to the national exchequer as a first installment of his plea bargain. The remaining amount was to be paid by the accused within 15 months. Ul-Huq also agreed that he would surrender all assets and properties to the Government of Pakistan if they were discovered to have been procured through illegal funds. Mansur ul-Haq was released in January 2001 but all his privileges were revoked, including the retention of the rank of admiral and retirement privileges, e.g., pension, honors and awards received during his naval service.

3.18 Another measure adopted by Pakistan to reduce public corruption was to ban trade unions in government departments. Trade unions are allowed to function in semi-government, autonomous establishments such as the railway and water and power development authority, as well as in industrial areas. In theory, trade unions are governed by the Industrial Relations Ordinance of 1969 and are supposed to protect and safeguard the interests of workers. However, the Pakistani labor movement is one of the most divided in the world. In every public sector agency and department, numerous unions and associations are registered. In Pakistan Railways alone, there are 13 registered trade unions and 152 associations. In Pakistan, an association results when illegal trade unions have organized in public sector departments where union activity is banned and the workers resort to forming an association, which has no right to strike or other basic trade union rights. For this reason, Pakistan has 8,300 trade unions, 28 federations and three confederations that represent just 2.5 percent of the total workforce. In response, the auditor general banned staff associations in provincial head and field offices of the provinces after receiving persistent complaints of illegal demands, black mailing, harassment and blocking of services by such groups. The performance of this department has drastically improved following the implementation of this ban.

3.19 Finally, Pakistani third and fourth class employee salary deposits are computerized and directly deposited in their bank accounts. This measure has considerably reduced the risk of payment problems, such as reduced or delayed payments and payments to ghost workers.

3.20 Although public corruption cannot be eradicated totally, **Hong Kong, China** has shown that the problem can be substantially reduced and controlled. But it takes a community and government with sufficient determination; regulations and procedures that are clearly understood and strictly followed; and businesspersons with a long-term commitment to steady growth rather than short-term gains. Equally importantly to secure and retain public trust and confidence, anticorruption organizations must be able to fight corruption without fear and favor and must be backed by a prosecuting authority and a judicial process that are both fair and impartial.

3.21 What lessons can be drawn from Hong Kong's experience with controlling corruption? How did it manage to resolve what was commonly considered an intractable problem? Hong Kong effectively employed the "total solution" approach—a three-pronged approach to eradicating corruption using detection, education, and prevention. The Independent Commission against Corruption (ICAC) was created in response to public demand. The ICAC has a clear

mandate, strong government support, an anti-corruption legal framework and the necessary resources. The commission operates independently as guaranteed by Article 57 of the Basic Law. The ICAC has community's support and involvement in reporting corruption. The commission has a community relations department with a staff of over 200, which has forged partnerships with civil society and specifically with the private sector to fight corruption. ICAC uses mass media, such as television dramas based on real cases, commercials exhorting the public to support ICAC and news reports of arrests and prosecutions to keep corruption at the forefront of public attention. ICAC also has developed an active internet-based publicity platform.

3.22 **Singapore** is among the most corrupt-free countries in the world. Transparency International has consistently ranked Singapore in the top ten least corrupt countries and number six in 2000. The Political and Economist Risk Consultancy has consistently rated Singapore as the least corrupt country in Asia. Singapore has managed to eliminate the widespread corruption in the early years of its independence, particularly before the 1960s. A number of factors account for this impressive turnaround.

3.23 The political will of the government is by far the single most important factor. The government has pursued a strong anti-corruption policy throughout its tenure in the post-colonial era. Political leaders have set a good example for public officers. Since assuming power in 1959, the government has punished those guilty of corruption, irrespective of their position in society. Effective instruments of control include:

a. The establishment of the Corrupt Practices Investigation Bureau to enforce corruption laws. The Bureau operates independently and is unencumbered with outside interference.
b. The Corrupt Practices Investigation Bureau has earned credibility through effective action and proving itself to be a skilled investigative agency.
c. The existence of enforceable legislation to facilitate evidence collection and eventual conviction in a court of law.
d. The review of government procedures to eliminate opportunities for corruption.

IV. The Right-to-Information

3.24 The Indian state of **Goa** enacted a citizens' Right to Information Act in early 1998. It is among the most progressive in the world and is distinguished by provisions which enable citizens to photocopy entire files relating to government business. Civil servants' and politicians' informal notes, which indicate the rational for government decisions, are also open to scrutiny by the public. Hundreds of citizens have made use of this act to investigate government decision making and service delivery problems in the education system, the banking sector, foreign investment, the implementation of environmental and health regulations, and the implementation of laws pertaining to affirmative action for the employment of "backward castes" in public sector jobs. Findings from these investigations have resulted in a number of court cases enabling citizens to secure redress for the urban poor in Bangalore

3.25 **Romania** has improved the accessibility and responsiveness of government through citizens' information centers. This program achieved some success in local government, by improving public information and citizens' willingness and capacity to make their views known.

The institutional mechanisms were the establishment of national public relations and information units and citizens' information centers in eight local councils. Using modern communication technology, these centers greatly improved the transparency of local government and encouraged citizen involvement and participation to contact and to petition officials.

3.26 To limit corruption in their community, the municipality of **Obninsk in Russia**, with a population of approximately 110,000 people, developed a mini-constitution that enshrines the community's right to voice publicly their opinion with help from external grants. During the development of the budget, the city administration put the draft budget on an Internet website. By doing so, the administration encourages comments and input from the community. The local government also posted the budget for the previous year on the Internet. Public goods are also being procured on a pilot basis over the Internet. Not only can local administrations easily access this information, but the community is encouraged to come to city hall and use one of the general computer terminals to check such information as well.

V. Decentralized Procurement

3.27 In 1987, Ceara state in **Brazil** launched a scheme to promote the growth of locally based small businesses through demand-driven public procurement. The goal was to redirect state expenditures for the procurement of goods and services away from large companies and 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. The contracting process created incentives for effective performance with a view to job-creation and economic growth. The initiative worked in cooperation with the national Brazilian Small Enterprise Assistance Service, which provided support and technical assistance. Associations of small firms, individual tradesmen and neighborhood associations were involved in decision making on expenditures for the department of education. The campaign was highly publicized and small firms and artisans' associations were encouraged to lobby to counteract negative pressures from the large companies that had dominated procurement. The scheme overcame problems that had prevented small businesses from applying for government contracts in the past. As a result, hundreds of new service and repair contractors and small manufacturers emerged.

VI. Enforcing Transparent Rules for Procurement

3.28 In **Chile**, the reform of pharmaceutical procurement increased accountability and transparency through the application of an electronic bidding system, the decentralization of purchasing, and the institutional restructuring of the previously centralized drug-purchasing agency. Corruption was reduced and the cost-effectiveness of pharmaceutical purchases increased (Cohen and Montoya 2001).[7]

[7] Cohen, Jillian Clare and Jorge Carikeo Montoya. 2001. Using technology to fight corruption in pharmaceutical purchasing: Lessons Learned from the Chilean Experience. Washington, DC: World Bank Institute, <www.worldbank.org/wbi/healthflagship/oj_chile.pdf>, accessed December 13, 2002.

3.29 From 1979 until the early 1990s, the public pharmaceutical and medical supply system in Chile operated as a traditional centralized model known as the central medical store. CENABAST, the supply agency of the National Health Service was the sole institution responsible for purchasing and distributing products to public hospitals and primary health centers throughout the country. The reform of CENABAST involved three elements, all designed to make the drug purchasing system more transparent and accountable. The centerpiece of the reform was the creation of an electronic bidding system and the use of the Internet for information dissemination. First, CENABAST was institutionally reformed. Second, an electronic bidding system was created and CENABAST became a mediator and guarantor of drug purchases. Third, a communications campaign was launched in parallel to the operational reforms. This campaign focused on winning over the main stakeholders in the pharmaceutical sector by ensuring that they knew the potential benefits which the reform could potentially offer them. Implicitly, the information campaign informed them that pharmaceutical purchasing practices would be under close scrutiny. As part of the institutional reform, CENABAST's responsibilities, such as purchasing and storage and transport of drugs, among others, were delegated to other health agencies and the private sector. Thus, the potential for monopoly and collusion was mitigated. In addition, all steps in the drug purchase and supply chain would be monitored by an information technology system that could keep a record of the types, prices, and suppliers of drug purchases. The second major element of the reform was the electronic bidding system. It helped to reduce the likelihood of collusion among suppliers by subjecting them to a competitive bidding process that made drug prices common information to all suppliers and their clients.

3.30 The bidding system operates as follows. Participating drug purchasers (e.g., hospitals) submit their projected drug needs for a six-month period. CENABAST compiles a list of all drug products needed by those hospitals that submitted estimates. Drug suppliers are then invited to participate in a price competition at CENABAST's facilities. Concurrently, drug suppliers submit their proposed prices through a computer network for the specific drug products and quantities. All suppliers are provided with information about the lowest bid made and are able to reduce the prices they originally offered in view of the new information on their competitors' prices. This bidding process continues until equilibrium has been reached, i.e., an agreed price is reached upon by CENABAST and the supplier. CENABAST also provides incentives for drug suppliers to participate in this drug bidding system because it agrees to act as a financial guarantor of the drug purchases made. The third component of the reform is an information and communication campaign. CENABAST regularly informed suppliers and purchasers about the process of reform and appealed to the self-interest of managers by emphasizing how they could benefit from participating in the new purchasing system. In particular, CEOs of pharmaceutical firms were targeted. Their endorsement was critical insofar as they helped the government reformers overcome resistance to change from the mid-level managers of pharmaceutical firms.

3.31 The Chilean model cannot eliminate corruption entirely. Nonetheless, it is a powerful example of how governments can reduce the risk of corruption with the requisite political will, financial resources, and well-designed and executed interventions. This intervention took place over of a five-year period (1995-2000).

3.32 **Argentina** has also implemented transparent Rules Related to Public Procurement. Citizens have participated in crafting transparent rules related to public procurement. The Program for Transparent Contracting consists of public hearings, integrity pacts for public contracts and the monitoring of the contract awards and implementation. The program has been implemented in the city of Moron for waste collection services, in Buenos Aires for the construction of a new subway line, and in Avellaneda for the construction of a bridge. Because the program was applied most comprehensively in Moron, this case study focuses on that particular case.

3.33 Moron was chosen by TI Argentina (a private company) as a partner for implementing the pilot program for transparent contracting, because the new political leadership of the city undertook active reform efforts and responded very positively to TI Argentina's offer to implement the transparent contracting program. In March 2000, the municipal government of Moron and TI Argentina signed an agreement of cooperation to implement the Program for Transparent Contracting for the municipal waste collection services. The contract had a value of US$ 32 million or 10 percent of the city's budget and would last a minimum of four years. On June 15, 2000, the mayor of Moron convened an extraordinary session of the city council to discuss the draft bidding documents with interested citizens and potential bidders. Monitored by TI Argentina, the meeting was announced in various important newspapers, as well as the local radio and TV station. Participants were invited more than 30 days prior to the event. The draft documents had been made available online and in print and a local group of independent experts was invited. Almost 500 people participated in the meeting and over 60 comments were submitted concerning the draft bidding document. Ten days after the meeting, the municipality published the revised version of the bidding documents as well as the reasons for accepting or rejecting proposed amendments. Notably, suggestions to include more objective criteria for the award decision and to focus regulations on outputs rather than inputs were incorporated in the new document. In September 2000, the mayor and all interested bidders signed an integrity pact. TI Argentina monitored the award decision and the municipality published the reasoning behind the decision.

3.34 In **Afghanistan,** government retail purchases are made on the basis of a single or three quotations. This process lacks transparency as the quotations are normally managed by the favorite selected supplier. In order to curb this tendency, a system has been created that uses a committee constituted by a competent authority to do spot purchasing. This reduces the risk of purchasing at higher rates.

3.35 The Government of **Malawi** has resolved to take stern measures to curb the pilfering of TB drugs. These efforts have revealed an even larger problem. Some officials are issuing market licenses to vendors to sell the TB drugs. To stop this corruption the regulations must be targeted at all levels of government. One solution to the problem may be to ban the sale of drugs in the streets. This is likely to ensure that drugs are not stolen from the drug stores.

3.36 Pilfering is one of the main problems confronting the regulation of the drug supply in Sub-Saharan Africa. Drugs are free, government-provided supplies, and the pilfering of drugs occurs at the stock rooms at local public health facilities. The health staff may be involved in the pilfering of drugs in a number of ways: (1) they may charge patients for drugs; (2) medical staff may work in a "private" practice in the afternoons or evenings utilizing the free drugs; and (3)

staff may sell the drugs to other retailers. The staff views pilferage simply as an income supplement. Since so many people at all levels of the health facilities benefit from pilfering, there are minimal incentives to improve the efficiency of the system. In **Kenya**, an estimated 25 percent of drugs were lost due to theft. With the introduction of "kits" (drugs are packed in sealed boxes) stealing was reduced to 5 percent.

3.37 In the Democratic Republic of the Congo (formerly **Zaire)**, thefts were reported from central storehouses in the Kasongo district between 1978 and 1986. Drugs were distributed through a central pharmacy and the nurse in charge of each health center would request drugs on a monthly basis. The requisition of aspirin, penicillin, chloraquine and chloramphenicol rose steadily over eight years, although the client profile and the number of clients remained constant. In the case of penicillin, the amount requested rose five-fold from 1978 to 1985. After analyzing the problem, the district staff concluded that the misappropriation of drugs was the most plausible explanation for the exorbitant numbers of drug distribution reported.

VII. Incentives, Monitoring and Evaluation

3.38 The **Cuban** health model rests on three pillars: giving clear instructions to providers, motivating staff and monitoring and evaluating the system. Clear guidelines are provided through national specialist advisory groups, which draw up standards and technical procedures (and evaluate the performance of physicians and specialists) and regulations that standardize activities in the national hospital care system. Cuban health personnel are usually highly motivated. Medical training emphasizes the altruism of medical service, which often culminates in one to two years of service abroad. Although service abroad is voluntary, there are strong social pressures to do it. Serving in poor rural areas in Cuba remains a right of passage for many newly trained doctors. Television programs lauding health workers raise their profile and contribute to a sense of pride in Cuba's doctors. Cuba also keeps close track of what is transpiring in health facilities. Monitoring is strong, with information flowing in many directions. The main monitoring elements include: (i) an integrated national health statistics system that collects data routinely from service providers. Indicators of particular concern, such as infant mortality, are collected with high frequency, some even daily; (ii) Regular inspection and supervision visits are made to health facilities; (iii) Annual evaluations of health technicians are conducted on the technical and scientific results of their work. In addition, a randomly selected sample undergoes external evaluation; and (iv) Annual reports are submitted by the Ministry of Public Health and the provincial and municipal health directorates to the People's Power Assembly.

3.39 Monitoring and evaluation go beyond statistical and expert assessments. Public dissemination of health indicators at the end of each year draws citizens into the process. In addition, citizens can complain about providers. Their complaints can be transmitted by the health system such as the policlinic that coordinates the local health facilities, the municipal health council or hospital administrators. Alternatively, they can go through political channels such as the local representative of the People's Power Assembly, which is required to respond.

3.40 In employee incentive schemes in **Benin and Guinea**, which are implemented under the auspices of the Bamako Initiative, health center staff bonuses were linked to the provision of preventive services. Health personnel received 200 FCFA (about US$ 0.75) for each child correctly and completely vaccinated within one year of birth, as well as for each pregnant woman

receiving at least three prenatal consultations, two tetanus toxoid vaccinations (appropriately spaced) and who delivered in the health center. Staff also received 50 FCFA for each curative consultation. The purpose of this program was to motivate personnel to increase coverage of preventive services, while curative care incentives were intended to generate health center revenue. A similar program was implemented in Guinea. In both cases, incentives were paid only for those cases treated according to pre-defined norms in order to discourage over-prescription of services.

3.41 Implementation of the Bamako Initiative in Guinea and Benin illustrates the positive effects of increased supervision of health facilities. A regular visit by provincial health directors to health centers was found to contribute to improved quality of care and staff behavior. The supervisors observed curative consultations with the intention of determining whether care was being provided according to established norms. A review of this experience found that this supervision sensitized staff to the negative quality implications of over-prescription, despite the opportunity it affords to increase revenues.

3.42 The **Kyrgyz Republic** has addressed informal payment issue through a modulated payment to providers plan. The government created an insurance fund to purchase services from health facilities, which are compensated for by increased use of services and providing greater access to the poor. Facilities charge fees to patients and claim payments from the insurance funds under a sliding scale based on five categories of patients: self-referred, uninsured, insured, partly exempt and fully exempt. Facilities get higher compensation for clients from the partly exempt and exempt categories that pay lower fees. Sixty-eight percent of poor patients preferred the co-payment system over the previous theoretically free system, which often required "informal" payments. Under the new payment mechanism, many informal payments were replaced by formal co-payments. The very poor also have access to treatment boosted through a reserve fund.

3.43 In **Puerto Rico**, the municipality of San Juan used provider incentives as part of its effort to improve the cost-effectiveness of AIDS care. Eighty-six percent of AIDS care was inpatient care, which was threatening to overwhelm San Juan's health care system. In 1988, the municipality contracted with a private, non-profit organization to provide comprehensive AIDS care. While the same level of government funding was devoted to the new system, the non-profit entities shifted their emphasis towards preventive activities and made an effort to reduce inpatient care. Doctors were paid three times the going salary at the municipal hospital, and nurses' salaries were increased 67 percent. Additional non-monetary incentives included support for education and opportunities for research. Tenure at the non-profit institutions was contingent upon being responsive to patients' needs. In return for these incentives, physicians were assigned particular cases, and were required to be accessible 24 hours a day (Under the previous system, physicians did not follow particular cases and were available only during the day). As a result of these changes, the mean length of AIDS inpatient hospital stays fell by 47 percent and the average annual per capita cost of inpatient AIDS care fell by 74 percent. Moreover, the study concluded that the quality of AIDS care improved during the course of these reforms.

3.44 In **Egypt**, performance incentives are a key element for maintaining quality and sustaining the progress of priority services under the new family care model in Egypt. In the first phase, the MOHP offered incentives equal to 50 to 250 percent of base MOHP salary to

government physicians who volunteered to participate in government-run pilot delivery sites. Physicians are compensated for increasing their hours of work and the number of patients seen each day, as well as for reducing time spent in their private practices. In addition, to receive the full MOHP payment, health workers in the pilot sites must demonstrate regular attendance, professional appearance, co-operation, and lack of negative commentary about patient. These initial performance incentives have produced positive results. Utilization of services increased from the previous records. Aside from increasing services to patients, the incentives to see a more adequate number of patients per day have led family care teams to improve clinic management and to structure a more efficient patient flow, thus reducing patient waiting times. Moreover, they have increased patient satisfaction.

3.45 Non-monetary incentives have been attempted to respond to the problem of motivating physicians to spend appropriate amounts of time at their assigned public facilities. Rather than making private practice illegal, several countries have initiated policies that permit physicians to see private patients at the public facilities during evening hours. The goal of this approach is to keep the physicians at the facilities. In some cases, the physicians are required to pay nominal rent to the facility for this privilege. Initiatives of this type are underway in several Sub-Saharan African countries, including Ghana, Tanzania, Zambia, and Sudan (as well as the Pakistan case reviewed above).

VIII. Local Contracts

3.46 In **Rwanda**, community-based health funds build accountability with local communities by means of contracts that local health facilities sign with community councils. Capitation payments direct facility managers' attention to patient satisfaction and service quality (Schneider *et al,* 2001). The payments have influenced the availability of drugs and trained personnel by creating a demand for quality care through better-informed consumers. The schemes organized regular general assemblies where members and health center representatives discussed issues related to the health center, the scheme or personnel behavior. Consequently, several health centers have improved their technical staff structure, which will in turn affect the prepayment enrolment rates, health centers' utilization levels, and the quality of care provided.

IX. Demand Side Financing

3.47 Service outcomes can be improved by strengthening and increasing the client's power over providers. School voucher schemes (**Colombia**'s PACES) or scholarships (**Bangladesh**'s[8] Female Secondary School Assistance Program, in which schools receive a grant based on the number of girls they enroll) enable clients to exert influence over providers through choice. **El Salvador**'s Educo program and **Guinea's** revolving drug scheme (where co-payments inspired villagers to stop theft) are ways in which client participation can improve service provision.

[8] Recently, the MOHFW started the piloting of Demand Side Financing for Maternal Care in Bangladesh; the results of this program remain to be seen following a comprehensive evaluation.

X. E-Governance

3.48 In the last five years, state governments in **India** have initiated several experiments in e-governance that have the potential to empower poor people and enable them to access essential services speedily and with minimal harassment. Most of these schemes pertain to the delivery of essential services that are particularly important to the poor. Some state governments have facilitated the flow of market information to small farmers, thus enabling them to get better prices for their crops. Information technology (IT) has also been used by some governments to speed up and simplify the issue of land records and ration cards. IT-based networks have been created that provide prompt information to the rural poor on the status of their application for government loans and other benefits. Many of these experiments need scaling up to make an enduring impact on poverty reduction.

3.49 In **Chile**, e-governance has increased the percentage of the tax paying population filing tax returns over the Internet from 5 to 30 percent. Furthermore, the combination of the latest statistical, computing, and internet technology is also promoting greater accountability in political elections, as witnessed recently in the extremely efficient, accurate, and speedy counts in Chile (also **Argentina and Mexico**), in sharp contrast with elections in a number of other countries.

3.50 The Online Procedures Enhancement for Civil Applications (OPEN) system in South Korea, Seoul provides a wonderful means of informing the public about matters such as applications for permits and licenses. The status of applications can then be monitored online which enhances transparency in civil processes.

Chapter 4. Recommendations and Strategic Policy Options

This chapter proposes specific strategies to address four areas of risk prevalent at the middle and lower levels of the public health system. A brief summary of general approaches to improving organizational effectiveness with respect to the control environment and incentive structures is first presented. These systemic changes will take time to implement and to reach their full impact. In the interim, specific strategies to improve four priority "hot spots" that were identified in this study should result in immediate benefits to clients and staff receiving and providing health care services and ensure broader impacts beyond the immediate risk areas of concern.

4.1 The widespread nature of the risks examined in this study suggests that in addition to a general strengthening of administration and management systems, change is needed system-wide to reinforce accountability among clients, service providers and policy makers.[9] Accountability is strengthened when the public is willing to seek alternative sources of supply (exit) or to exert pressure on providers to perform better (voice). This relationship between exit and voice is depicted in the following matrix of options for improving accountability.

Table 4.1. Options for Building Public Accountability

		Voice	
		Weak	**Strong**
Exit	**Low**	**Focus on encouraging voice of external representatives such as NGOs.**	**Scope for improving accountability through exit is limited; therefore, more creative ways to use voice must be sought. This might include:** **Raising the level of information on health service standards and duties.** **Increasing the relative importance of the health service to the public through promotion activities.** **Building customer involvement in decision-making, possibl through the creation of hospital boards and healthcare committees (during consultations patients are in a weak position).** **Raising the public's level of income and education.**
	High	**Expand the scope for exit, as exit is relatively less costly than voice for these services. This could include:** **Lowering barriers to entry to other health services e.g., strengthening private sector.** **Lowering spatial barriers to exit, e.g., strengthening transport links.** **Demand-side financing schemes.** **Strengthening information among healthcare consumers.**	**Privatization is the first option to explore along with public-private competition as market competition can be expected to ensure accountability.**

Source: Samuel (1991).

[9] See for example, WDR 2004: *Making Services Work for Poor People*

I. Proposed Areas for Immediate Reform

4.2 Given the time required to build voice to sufficient levels and to raise the credible threat of exit, these approaches should properly be complemented by a number of immediate reforms in the HNP sector. Rapid reforms for immediate impact will help to bolster administrative and management processes and outcomes in the short-term while long-term strategies can be implemented to increase the public's voice and demand for service. This study has demonstrated that four fiduciary risks in particular damage HNP service delivery and negatively impact upon the poor and the performance of the public health sector. The four "hot spots" include the (1) problem of private practice; (2) procurement malpractice; (3) illegal payments to the AG office; and (4) promoting positive roles for third and fourth class trade unions. Remedial action for each of the hotspots is considered in turn.

(a) *The Problem of Private Practice*. Increase the availability of medical care for the poor by reducing private practice during office hours. This would have a direct benefit on service delivery to the poor by increasing the medical staff's availability and reducing burdensome costs. It would also have an indirect and beneficial impact on absenteeism.

(b) *Procurement Malpractices*. Obtain better value from materials' budgets by increasing the transparency of procurement processes and implementing more aggressive competitive purchasing approaches. This will directly benefit the poor if improved purchasing is translated into greater availability of drugs for common conditions. It will also enhance general confidence in the public sector efforts to prevent the loss of public resources.

(c) *Illegal Payments to the Accountant General's Office*. Stopping illegal payments to the AG office will be a forceful message to all staff that the days of "business as usual" are over. These illegal fees are extorted from the highest to the lowest levels of the system. Eliminating the payments will result in a clear impact on the poor in terms of their ability to access essential services without barriers. The halting of bribes to the AG's office may also provide a basis for dialogue with national offices of trade unions about similar negative practices.

(d) *The Role of Class 3 and Class 4 Trade Unions*. There is an urgent need to confine the activities of Class 3 and Class 4 trade unions to legitimate activities within the workplace. There is certainly scope for unions to play a productive role in the HNP sector.

II. Control and Institutional Reform Environment

Control Environment

4.3 The control environment should include a substantial, real reduction in the tolerance for fraud, theft, intimidation and corruption related to money, materials and time. This transformation will require rapid and effective criminal, legal and disciplinary processes; independent bodies with support at the highest levels of government empowered to combat corruption; and access without fear for employees and citizens and their representatives to these processes. Dialogue should be maintained with those in the higher levels of the political

echelons who are able to influence organizations, like trade unions, whose role has become distorted.

4.4 Significant strengthening of financial management and control processes and systems is critical. The improved systems will include realistic budget setting, effective monitoring of expenditures against budget lines and allocations, strengthening of auditing, and rapid processing of audit reports and consequent action for non compliance and irregularities . The moves toward performance-based budgeting are relevant. Realism with respect to what can be reasonably achieved, for example, in terms of the capacity for valid performance data to be produced, is necessary. There should also be clarity amongst policy makers and their partners about linking macro-level policies to the creation of incentives at the micro-level.

Institutional Reform Environment

4.5 The reform environment must consider public sector procedures that create entry points for civil society scrutiny and opportunity to objectively review public sector performance; establish avenues funded by government for NGOs that demonstrate or have clear comparative advantages to deliver health services; review and reorganize purchasing processes in the public sector; and change the distorted roles of trade unions.

4.6 Civil service reforms are required that provide a facilitative framework for the reward of good and honest performance, and the rapid and effective sanction of poor or dishonest performance. Reforms should include delegation of key aspects of authority to the district level, strict accountability for the exercise of that authority, and a realistic framework of options for the management of a mixed economy health care system.

4.7 Development partners should support and encourage good governance in the reduction of fiduciary risks. Consideration should be given to the development of process as well as output indicators. These indicators must be tracked by government organizations but be independent in their review and evaluation.

4.8 In framing strategies that emphasize NGOs, it should be remembered that such organizations are also subject to some of the same pressures that apply to the public sector. While demand-side approaches should be pursued, very strong monitoring and accountability systems are necessary to prevent similar risks described above.

III. The "Hot Spots" of the Strategy

One – Private Practice during Office Hours

4.9 Medical staff who conduct private practice during office hours occurs frequently in the public facilities and in private consulting offices. Since doctors are perceived as being the head of a hierarchy, this problem tends to establish the ethics for the rest of the organization. Private practice happens because it is implicitly permitted, government salaries are inadequate and there are no incentives for proper working behavior.

4.10 Calls for "stricter measures" to enforce working hours are ritualistic, lacking determination or credibility. Firm action against those who flout the rules and/or permit private practice to happen must be combined with improvements in compensation and incentive structures.

4.11 Decentralization of authority can improve the structure of incentives as one means of dealing with private practice. Two specific areas of delegation of authority will be helpful:

- Full authority to take disciplinary action against all staff working within a district with a rapid appeals mechanism.
- Authority to retain user fees or other generated income.

4.12 The question of incentives is the central issue of private practice. Currently many doctors provide only a minimal level of service for the basic government salary. While this limited service may be of use to some who are less well off, it almost certainly works to the disadvantage of the poorest, who will find it disproportionately difficult to meet demands for informal payments. Further, "office hours" have largely become limited to a morning only service, which is often used mainly as a recruitment ground for private office practice. This means that for most of the 24 hours of each day, medical services are inadequate. The system of incentives that lead to these tendencies must be changed. A number of options should be considered in this regard, including:

- Convert medical services from a salaried to a contractor basis. Doctors would be contracted to undertake specified duties. Though costs might be higher, substantial increase in coverage should be expected.
- Employ doctors at higher salaries but with exclusive commitment to the public sector. This might be linked to preferential career development opportunities and/or preferential access to loans for eventual establishment of private practice or enhancement of pensions.
- Share retained user fees that are linked to the number of patients seen and hours covered. This could permit both the increase of staff income and coverage of expenses for equipment and other office items. Public disclosure of the use of the retained fees will make the local management accountable.
- Development of private facilities, including out-patient rooms in public hospital sites.

4.13 A major opportunity for improving quality and access to services in the public sector lies in the actual relationship between the public and private sectors and the relationship's impact on the market for medical services. Specifically, if the public sector institutions (probably through greater autonomy) are able to benefit from patients' out-of-pocket expenditures, it creates an opportunity to provide legitimate incentives to providers, in contrast to a "blind eye" approach to illegal practices. The information provided in the Strategic Investment Plan about the increasing penetration of for-profit private sector into urban and better-off rural areas suggests a need for urgency in this respect. If these providers become well established the government will be forced into the more complex area of transparent sharing of professional skills between public and private providers.

4.14 While this may be an area where community scrutiny could be valuable, this may not be effective at the present stage of civil society development. As a starting point it may be more effective to disclose to communities the results of monitoring and supervision or peer review processes.

4.15 It is essential that the Bangladesh Medical and Dental Council and Bangladesh Medical Association become closely involved in finding solutions to service delivery problems and in supporting the implementation of those solutions. Such involvement may include:

- Being involved in the policy-planning dialogue as a key partner.
- Establishing and advocating a professional code of conduct.
- Undertaking their own monitoring or being involved in joint monitoring and taking disciplinary action.
- Bridging the relationship between the public and private sectors.

Two – Purchasing Processes and Outcomes

4.16 There are two essential problems with the purchasing process and outcomes. First, there is a clear perception that the local purchasing processes are open to abuse and corruption. Second, rather than the scale of public sector purchasing power producing lower prices, the prices paid are higher than the market price. The scope for improving the administrative systems is limited and would not address the problems. Good procedures are articulated but in practice, adherence is uneven at best and utterly disregarded at worst. Strengthening the management of these systems is paramount. Options to be considered include:

- Establishing "independent" purchasing panels or reviewing purchasing decisions by a "distant" or anonymous panel.
- Strengthening independent audit processes and rapid action on reports.
- Creating mechanisms for challenging high prices.

4.17 There is no specific incentive to purchase more effectively. Yet there is clearly scope for more effective use of resources. Direct individual incentives would be inappropriate in this context. However, greater authority for budget flexibility at the district level would allow improvements in purchasing outcomes to be translated into resources to improve services or provide performance incentives. The purchasing process should also be opened to wider participation and scrutiny. Reforms in this direction might include:

- Forms of e-tendering.
- Regular publication of all tendering results and histories.

Three – Ending Illegal Payments

4.18 Making "informal" payments to accelerate transactions is a widespread practice that has negative implications. It is highly unproductive and demoralizing for professional staff to spend their time engaged in these unofficial transactions. Workers who pay bribes to obtain their salaries and other allowances will recoup their losses by extorting payments from others. At the

bottom of this network of extortion is the poor patient seeking access to necessary public health services. Changes in administrative practices are appropriate solutions to this area of risks. These might include:

- Well-publicized dismissals and arrests.
- Computerization of all payroll and allowance systems.
- Direct payments into compulsory individual bank accounts.

Four – Activities of Class Three and Four Trade Unions

4.19 The role of trade unions at the workplace has become distorted and corrupted. While this is part of a general problem, it may also emanate from the inability of trade union to achieve gains for their membership through legitimate labor activities. Trade unions are viewed frequently as the ring-leaders for local "mafias" operating within health care institutions.

4.20 The most extreme solution to this problem would be to ban trade union activity within health care institutions. The recommended initial approach should be national dialogue with trade union leadership about the role of trade unions in the HNP sector. A defined national framework could provide a structure in which local managers could be more proactive. This might include sanctions against inappropriate behavior, requests for replacement of union leaders, and competitive tendering for support services.

Additional Entry Points for Strengthening HNP Management

4.21 Reform and strengthen internal and external audit arrangements.

- Contract commercial auditing organizations to undertake random reviews of audits and report serious anomalies to the public accounts committee.
- Review the effectiveness of internal audit arrangements including the financial management and audit unit. Consider contracting out some aspects of the work.

4.22 Establish effective supervisory arrangements.

- Provide the civil surgeon's office the basic resources for supervision, such as transport and adequate staffing.
- Link supervision to performance management and budgeting arrangements.
- Use peer review teams from locations distant from the district being reviewed.

4.23 Strengthen leadership and management capacity.

- Establish methods of providing considerably higher rewards to those in key leadership positions in the district health system, with clear accountability arrangements ideally as part of a long-term major initiative for better leadership in the HNP sector.

- Establish management development programs at appropriate local training institutions under international accreditation. The introduction of sophisticated systems without associated management development will diminish the productivity of any changes.
- Build capacity to make demand-side financing and NGO commissioning more effective.

4.24 Development of progressively empowered local stewardship bodies.

- Assess the Health Development and Hospital Management Committees.
- Establish a local board at the hospital and primary health facilities for promoting accountability of the use of resources and promote the increase of labor productivity.

4.25 Encourage ethical approaches in professional activities.

- Work positively with the BMA and other professional associations for zero tolerance against corruption.
- Strengthen the role of the Colleges of Surgeons and Physicians especially in training activities, accreditation of professionals, and the design of incentives for the staff.
- Encourage the media to report on the performance of health care delivery and its impacts.

4.26 There is little collaboration with professional and provider organizations or support for self-regulation. Professional and provider organizations are playing the role of trade unions. There is an absence of instruments on the government side to constructively engage private actors, e.g., the absence of a regulatory mechanism to control private sector facilities.

4.27 There is no system of accreditation (or effective licensing) of traditional, homeopathic and modern health care private practitioners. The present practice of accreditation of private hospitals, clinics and diagnostic and imaging centers is also irregular and done in an unprofessional manner. A dearth of manpower and accountability within and between several regulatory and administrative bodies of the MOHFW precludes close monitoring and updating of accreditation process.

4.28 In general, neither consumer nor patients' organizations have emerged strongly to play an advocacy role or to engage in monitoring of service quality and outcomes.

User Feedback Mechanisms

4.29 There is a lack of communication and management systems to convey information from users to the central authority or for the central authority to respond to local demands. No clear system exists for conveying demands, complaints or suggestions to decision-making authorities, nor are there any procedures in place for guaranteeing a response.

IV. Outline Action Plan

4.30 The previous sections presented some of the options available to address the specific risks that are most problematic in Bangladesh. The following table presents some policy options and strategies to clarify some ideas to mitigate risks and provide a framework for long-term strategies for improving the delivery of health services.

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.	1. Consultative process including all major stakeholders. 2. Learning from programs that retain compliant staff (e.g., UNFPA/MCWC program). 3. Pilot a number of approaches.	Number of public patient contacts.	BMA. Ministry of Finance. Civil Service Commission.
	Making best use of mechanisms for non-salary rewards.	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.	
	Improving the availabilit of free essential drugs i public health institution	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.	
Better value for money from purchasing process.	Opening-up of tendering process to more effectiv competition.	Establish system whereby identificatic of high prices can Trigger re-entering by an external tendering panel.	Average price of a basket of purchases compared to market an Maximum Retail Price.	Ministry of Finance Controller and Auditor General Office
	Development of transparent alternatives to current tendering arrangements.	2. Test alternative approaches to publi purchasing including e-tendering.		
	Supporting anti-corruption initiatives	3. Revive role of local health development and management committees.	Frequency of re-tendering.	
Payments to AG Office.	Progressive computerization of all accounting and paymen systems.	1. Pilot salaries and allowances computerization with payment into individual bank accounts. 2. Review and roll-out.	Percentage of staff pai salary directly to bank account.	Ministry of Finance
	Selective recentralizatio of authorizing procedures.	3. Identification of mechanisms for centralized authorization of payments without undue delays.	Average time from invoice to payment.	
	Administrative action.	4. Ensuring that the budget holder and accounts officer have access to the same information about allocations. 5. Disciplinary action against errant officers.	Number of disciplinary actions related to unofficial payments.	

Risk Area.	Strategies.	Actions	Potential Indicators	Collaborating Organizations
Activities of Class 3 and Class 4 Trade Unions	Pursuing strategies to increase the loyalty of staff to the institution.	1. Review and reform of appointment arrangements.	Reduction in inappropriate trade union activities (Collecting data from surveys).	Civil Service Commission. Trade Unions.
	Limitation of trade unior role to representation of workforce.	2. Dialogue with trade union organizations to establish codes of conduct.		
	Pursue contracting-out i a systematic way so as t increase management leverage.	3. Review of successes in contracting out of services.	Proportion of contracted support services.	
		4. Development of national guidelines for service tendering in consultation with trade unions.		

Final Remarks

4.31 Identifying and addressing corruption and weak governance is difficult to accomplish when the main focus is expanding health care services and less emphasis is placed on the efficiency of the service delivery. This report has documented problems in the procurement of health supplies, illegal payments for services, private medical practice during public work hours, and medical staff who fail to show up for work but nonetheless collect their salaries. Severe fiduciary risks exist in Bangladesh's health sector. To reduce these risks, the government's main challenge is to promote political willingness to design incentives and new organizational frameworks to reduce absenteeism, corruption, informal payments, and mismanagement in the procurement of goods, and to increase overall accountability and supervision.

4.32 Good governance is important to ensure effective health care delivery. Remedial mechanisms and actions are discussed and mentioned, including better management, improved logistics and information systems and strengthened accountability. The fundamental reform has to be done by the government. The problems are very complex and politically sensitive. None of these proposed measures are easy to implement but they are necessary to ensure that the resources invested in the health sector reach the poor population of Bangladesh.

4.33 The study has shown empirical data as well as international experiences to reduce system losses in the health sector. More empirical studies will be needed to support the findings of this effort and to provide an apolitical basis for more action to combat corruption and poor governance in the health sector.

Annex-1. Health Sector Risk Area Validation Survey

Sample

A total of 670 respondents were interviewed during the survey, including third and fourth class employees, health and family welfare managers at district and upazila levels, patients, retailers, suppliers and UAO staff. Data were collected from these respondents using quantitative (household and exit interview) and qualitative techniques (such as observation, in-depth interview, mystery shopping, case study, etc.).

Focus

The survey was carried out to collect information on private practice during office hours, pilferage of drugs, the payroll control system, illegal payments, malpractice in procurement, activities of unions and perception of services from users.

Private practice during office hours was widely cited by all categories of respondents. In sixty percent of upazila health complexes, doctors were involved in private practice at the hospital complex during office hour. However, some doctors have offices outside the complex. Doctors also leave the public facility early to work at his/her private office. In response to a question about directing patients to the doctor's private office, about one-fifth of the patients responded positively that doctors had in fact steered them toward their private services. Patients are somewhat "compelled" to seek private services with an expectation of getting better treatment.

Recommendations

Risk Area	Findings	Recommendation
Absenteeism	Absenteeism is quite common at all the UHCs On average 16 percent of employees were found absent from the health complex during study period.	Stern administrative action needs to be taken. Frequent transfers. Monitoring and supervision of higher authority. Deduction of salary as punishment. Increase infrastructural[10] facilities for the doctor.
Private Practice of Doctor	60 percent of doctors in the hospital were found to engage in private practice during office hour.	Administrative action needs to be taken. Measures should be taken so that doctors reside in the hospital health complex. Additional accommodation may be needed. Frequent transfers. Provision of non-practicing allowance or increasing their salary.

[10] Infrastructure includes accommodation, transportation, education facilities for the children, etc.

Risk Area	Findings	Recommendation
Pilfered Drugs	Discrepancies of stock and supply of medicines is observed in many UHCs. Medicine found not to be recorded in the stock register.	Regular and strict monitoring of stock and supply of medicines needs to be ensured. Record and physical verification of medicine need to be done quarterly. Committee for supervision and monitoring the drug need to be formed. Recording of medicine in the indoor stock register need to be ensured through strict instruction and supervision
Lack of control in payroll disbursement system	Some irregularities were observed.	Involvement of UHFPO (DDO) in disbursement needs to be ensured Training on payroll disbursement system needs to be provided to the cashier and head clerk on regular basis.
Illegal payment to AG office	Paying bribes to UAO office is very common.	Strict administrative action from the top management. Motivation and mobilization.
Purchase at higher than market price	Corruption in bidding process is found.	To be controlled centrally.
OTHER ISSUES		
Health Consumers Rights	Patients are not satisfied with the current health care services. According to them they want good treatment and expect professional behavior from the doctors and other staff (such as nurse, technician, ward boy etc.).	There is no organized forum as such to protect health consumers' rights. The patients are also not aware of their rights Therefore, there is a strong need for organization for the health consumers' rights,[11] which will help to create demand-side pressure.
Improving Status of the Service Providers	Doctors suggested that their financial status should be improved.	The government should examine the possibility of improving doctors' financial status (salary, benefits etc.) so that they feel compensated to provide better services.

Methodology

The study was intended to be theoretical, explanatory and empirical in nature, i.e., analyses were done based on experiments and observations using both qualitative instruments and direct participant observation methods to capture the desired information.

Target Respondents

District manager, UHFPO (DDO), RMO, medical officer/concern related to purchase of CS office, UAO, general physician, hospital staff, head clerk/cashier, statistician, staff nurses, storekeeper, member of purchase committee, trade union leader, supplier and patients.

[11] Consumer Association of Bangladesh (CAB) is working to establish consumers' rights in Bangladesh. A civil society group that was formed recently "Health Consumers Rights Forum" is working exclusively to establish health consumers' rights. There are a few similar organizations (e.g., Association for Health Consumers Rights, Health Action Forum, etc.) but their activities are limited.

Technique of Data Collection

In-depth interview and observation of patients, attendance register observation, cashbook and acquaintance register, stock register, as well as physical verification of stock, employees, patient exit interviews, and secondary data collection and mystery shopping.

Study Areas

Rupgonj, Kapasia, Homna, Boalkhali, Thanchi, Raumari, Isampur, Jhikargacha, Kawachua, Terokhada, Dasmina, Uzirpur, Zakigonj, Baniachong and Nabinagar.

Survey Period

June – July 2004

Sample Size

The sample respondents that were interviewed and observed are included the following chart. For each type of respondents we calculated sample size at 95 percent confidence level and the degree of accuracy varies from 5-15 percent. Total population for different categories of respondents is given below:

TYPE OF RESPONDENTS	TOTAL RESPONDENT	TOTAL POPULATION
Patient	300	3000
District Manager	24	30
UH&FPO [Define & include in Acronym list]	12	15
Resident Medical Officer	11	13
Drawing and Disbursement Officer & Upazila Accounts Officer	26	30
General Physical/Medical Officer	20	43
Store-in-charge	14	14
Statistician	14	15
Head Clerk/Cashier	25	30
Nurse	28	85
Hospital Staff	33	297
Member of purchase committee	29	75
Trade Union members	26	99
Concerned personnel from CS office	10	15
Retailer	73	120
Supplier	17	70
Accountant General Staff	7	15
Total	670	

Selection Procedure of Respondents

- For retailers, a list was prepared of suitable candidates in areas near a health complex. From this list the required number of retailers was selected randomly. When there were only a small number of retail shops, all candidates were interviewed.
- Hospital staff members were selected randomly from the total list of staff. Willingness to be interviewed and availability were also considered during the selection process.
- Exit and household interviews were conducted among the required number of patients. Patients were selected at the health complexes based on their availability and willingness to be interviewed.

The survey team encountered some constraints in the collection of information, such as:

- Unwillingness of district and upazila level managers to provide documents and helpful information.
- Request for interviewer to conduct interviews in front of authorities.
- Researchers refused permission to write down interviewees' statements.
- One district manager refused permission to conduct a survey in his health complex.
- Non-availability of respondents.
- Time constraints.
- Respondents were afraid to disclose the real situation to interviewers due to the indirect pressure of authority.

Annex 2. Financial Control Environment in Bangladesh

The Financial System in Bangladesh

The constitution of Bangladesh establishes the basic framework for a sound financial system. Most of the prescribed features are compliant with the commonwealth model of parliamentary democracy. The financial provisions have remained practically unchanged. The model is based on a centralized treasury, which is supported by (i) a consolidated fund and a public account that ensures (theoretically) comprehensive coverage of all inflows and out flows, (ii) annual budgeting directed by the Ministry of Finance, (iii) grant and specific need-based parliamentary approval, (iv) centralized accounting, established as a control rather than simply as a service, (v) and an independent comptroller and auditor general that specifies the principles of accounting and who reports to the parliament.

Additional rules supplement the constitutional provisions. The rules of business of the central government establish the role of the MOHFW and each executive ministry. Each ministry is assigned a principal accounting officer accountable for public resources utilized by those in the ministry's agency or department. The parliament's rules of business direct the comptroller and auditor general reports to the public accounts committee (PAC) to ensure an in-depth consideration of the issues. The parliament's rules also require the PAC to submit a consolidated report. The general financial rules and the treasury rules govern actual spending.

The financial rules and budgetary procedures are quite clearly delineated at the central level. Budget approval is an interactive process and is broadly split into the revenue or current budget and the development budget.

The Ministry of Finance evaluates proposals initiated by line ministries and departments. Budget estimations and line item reviews are generally based on past allocations. The incremental increase is generally based on resource projections and inflation. The process of budget formulation starts with the "budget call circular" and concludes with the Prime Minister's approval of the authorized budget statement after the budget has been voted for and approved in the assembly. The introduction of the medium-term budgetary framework in several ministries is a recent development and is still in a rudimentary stage of implementation.

The process of formulating the development budget is more complex. Generally, there is a five-year plan to guide development allocations. This plan is then developed into annual plans. The different projects that comprise the development plan are generally multi-year undertakings and are quite frequently funded, at least in part, by donors. Different high level committees approve individual projects. The planning division approves the projects and reviews the annual funding requirements of different projects. This prioritization then becomes the basis of annual development budget.

Risk Areas

While the basic regulatory environment is robust, serious risk areas can also be identified. Although reforms and improvements are underway in most areas, the cumulative risk profile of the existing environment needs to be addressed.

*General regulatory environment***.** One set of risks emerges from the implementation environment. The basic system may be adequate in theory, but the manner in which it is implemented may give rise to risks. One example is the different provisions for involving the parliament in the review and grant of the budget, but in actual practice this involvement remains ritualistic. There is a similar gap in implementation with respect to legislative oversight over expenditure. The comptroller and accountant general, in fulfillment of the relevant provisions, submit reports to the PAC but action by the committee is often delayed to such an extent as to lose all effectiveness. Although a very elaborate process for project approval has been set up, project proposals are rarely rejected**.**

Obsolescence of the regulatory environment. Another set of risks emerges from the obsolescence of certain aspects of the regulatory environment. For instance, the procurement rules emphasize a set of simple procedures that may be inadequate to meet the needs of complex purchases like machinery, plants or IT systems. In general, the rudimentary procurement rules are not effective in obtaining the best value. The impact of recently adopted procurement laws has yet to be seen. Similarly, line-item budgeting approach (the traditional historical cost) although meticulously applied, has resulted in serious expenditure rigidities. The elaborate accounting system requires special efforts to reconcile figures. The current accounting system produces very little information that could add value to management. Despite continued concerns about corruption, it is not being addressed as a human resource issue and there is no move to adopt codes of conduct, reform human resource management, or train management along in modern methods.

*Traditional weakness of financial management***.** Yet another set of risks emerges from the absence or inherent weakness of certain key aspects of the financial management system. Internal controls have always been weak and there is still no recognition of their importance. There is no emphasis on accountability according to outcomes and individuals have traditionally been given sufficient leverage to override institutions. The role and status of corporate sector entities have been inadequately articulated. The linkages of these entities' funding requirements to the main budget, the reporting of their expenditure, and the accountability for their outcomes are not clear. There has been very little emphasis on transparency and accountability.

*Governance Environment***.** Another set of risks can be identified from the cumulative impact of the different sets of factors identified above. The fiscal space available to the government has eroded over time. The bulk of current expenditure (90%) is consumed by such items as salaries, pensions and basic administrative expenses. Very little resources are left available to different sectors to deliver the services that are expected from them, especially the social sectors. The salary budget is excessive even though the salaries that civil servants get are inadequate. As a result huge expenditures are incurred on a poorly qualified, poorly trained and poorly paid civil service, which is prone to misusing its power, engaging in illegal practices.

Relationship with Development Partners

The Bangladesh health sector's experience with the sector-wide approach is very extensive. The Health and Population Sector Program (HPSP, 1998-2003) was intended to be the flagship of the sector-wide approach and continued with the Health, Nutrition and Population Program (HNSP,

2004-2009). Past experience that linked project assistance—which was disbursed under tight monitoring arrangements—may have exacerbated some of the risks to which all assistance is exposed today. One of the biggest risks that emerged during that time was the fragmentation of the budgetary process. The constitution requires that all debt inflows be reported through the central consolidated fund. Yet the application of multiple funding procedures adopted under the influence of different donors requirements, direct cash flows to the project authorities, and donor insistence on their rules overriding local rules all resulted in reduced effectiveness of budgetary, financial, accounting and audit controls.

This is not to suggest that the SWAp was without fiduciary risks and that the overall governance environment in Bangladesh improved. Basic public institutional arrangements like national budgeting, accounting and fiduciary controls are still weak. These risks, however, had been identified ex ante on the basis of the secondary record and surveys. Based on the lessons from HPSP, the funding decisions for HNPSP were taken with a fair assessment of the risks involved as well as possible strategies to address them.

The Current State of Financial Reforms in Bangladesh.

Corruption and accountability have become major national concerns in Bangladesh over the past decade. Donors are also focusing on governance and reform issues. The reforms have a direct bearing on the fiduciary risk profile for SWAp in the form of HNPSP. The risks can be grouped into three distinct but inter-related areas:

Efforts to Improve Financial Management. Bangladesh's financial management was reformed from 1999-2000. A computerized budgeting and accounting system now supports a new government-wide classification system capable of supporting economic analysis and budget forecasting. Financial rules have been updated and staff has been trained on the new system. Rules defining the responsibilities of the ministry of finance and ministries' accounting officers have been issued.

Reforms in Budgeting and Expenditure Control (RIBEC) in Bangladesh started in 1993 and ended in 2001. Substantial progress has been made in these reforms. The public accounts have been reclassified and computerized according to international standards at the central government level. The reforms have improved the timeliness of submission of audited reports to the parliament.

Efforts to Improve Public Sector Accounting. The standards for central government accounting are contained in the accounts code, as are the general financial rules, treasury rules and subsidiary rules. These rules have been amended over time by the Ministry of Finance. All central transactions are computerized, but transactions at districts and lower administrative levels are done manually. The divisional accounts offices in the lower administrative levels manually summarize accounts and feed the data into a central data processing unit that prepares consolidated accounts. This system has been deficient in have been reported in capturing all public expenditure due to funds flowing outside the official government system and discrepancies between donor funding information and what is captured by the government system. For example, many accounts for public funds have been established as requested by donors to safeguard against misuse. As a result, government accounting becomes dependent on

reports by project directors for completeness (Kjeld Elkjaer, Senior Consultant for T&B Consult, Denmark, 2004).

Reforms in budgeting and expenditure control separated accounting and auditing functions of the comptroller and accounts general since July 2002 and established a working reconciliation process for comptroller general accounts. Financial management units (FMU) are established in major spending ministries. Separation of audit and accounting has brought improvements both in the comptroller and accounts general departments and CGA. The officers of both organizations are being given training to upgrade their skills.

Legislative oversight has been one of the weak areas of the accountability cycle. Reports produced by the comptroller and accounts general have received minimal attention from the PAC. This neglect has had an adverse impact on the entire accountability cycle.

Annex 3. Patients' Perceptions

A total of 300 patients were interviewed for this study.

Demographic Profile of the Patients

Of the total group of patients, 58 percent were female and 42 percent were male. The average age of the respondents was 32 years old, with males averaging 33 years of age and females 31 years of age. The education level of the patients was generally low. About half of the respondents (47%) were illiterate. Sixteen percent of the patients had six to nine years of schooling and about one fifth of the patients had one to five years of schooling.

Most of the patients (about 71%) were from lower income brackets, defined for these purposes as income under Tk. 3,000. Ten percent of patients had incomes between Tk. 3,001 to 4,000, 12 percent were between Tk. 4,001-5,000, and only 7 percent had incomes over Tk. 5,000. The average monthly income was Tk. 2,685.

Access to Health Service

The majority of the patients want to be treated appropriately by a doctor with professional demeanor who accorded the patient his/her total attention. A little over one-fourth (27%) of the respondents said they received inadequate treatment. One-fifth (22%) of the patients reported that the doctor was absent, 21 percent claimed the doctor treated them too quickly. About one in ten patients (9%) reported that the doctor was late. Six percent of the patients said they could not provide money. Five percent reported lack of a dentist and another 5 percent reported lack of orthopedic specialists.

Satisfaction Level by Patient Income

According to the patients, only 6 percent were satisfied with the doctors' professional behavior. The following figure shows satisfaction level disaggregated by income group:

Up to Tk. 3,000	Satisfied (4%)
Tk. 3,000-4,000	Satisfied (14%)
Tk. 4,001-5,000	Satisfied (9%)
Tk. 5,000 +:	Satisfied (8%)

Attentiveness of Doctor

Nearly half of the patients (46%) spontaneously mentioned that doctors do not treat patients attentively. One-fifth (20%) of the patients reported that their dissatisfaction with medical care was related to the doctors' behavior. And several patients also cited misbehavior by nurses. Six percent of the patients reported that there were no doctors in the hospital surveyed.

Financial Exploitation

Financial exploitation (illegal payments) is quite common in the health complexes and hospitals. The increased financial burden associated with illegal payments disproportionately affects poorer individuals and families. Disaggregating by socio-economic status, patients from the lower income groups were found to be exploited relatively more often in terms of paying money. According to patients that were seeking treatment, about 20 percent of them paid some amount of money. Of those patients, 57 percent belonged to an income group earning Tk. 3,000 or less, 20 percent from Tk. 3,001-4,000, and 13 percent of patients' income was more than Tk. 4,000. In terms of gender, 51 percent of female patients paid money compared to 49 percent of males.

One-fifth of the total patients interviewed said that they must pay fees to receive treatment. Of those, 77 percent said they had to pay the medical officer, 10 percent said payments were made to the UHFPO, and 3 percent was given to the RMO. The remainder of patients said that payments were made to the medical assistant, peon or nurse.

Regarding the amount of money paid, 20 percent reported paying Tk. 20. Another 20 percent claimed to pay Tk. 30 and 18 percent of the respondents paid Tk.18. However, about 12 percent of the patients said they paid less than Tk.10 for both the doctor's fee as well as the ticket fee. When asked about paying fees for drugs, almost all the patients interviewed responded that they did not pay fees for drugs.

Whether Treatment is Available after 2:00 PM

The study set parameters to identify the private practice and absenteeism rates of doctors in hospitals. Patients were also queried whether they were able to attain treatment after 2:00 PM. In response, 57 percent of the patients replied "no." A little over one-fourth of the respondents said that they would get treatment at the doctors' residence after 2:00 PM, which was near the hospital. Of those responding "no," 56 percent mentioned that the doctor left the hospital before 2:00 PM. However, 13 percent of the patients mentioned that emergency service is open 24 hours. Very few patients (3%) mentioned that treatment was possible after 2 PM if adequate fees were paid.

References

Bennett, S., S. Russell and A. Mills. 1996. Institutional and Economic Perspectives on Government Capacity to Assume New Roles in the Health Sector: A Review of Experience, HEFP working paper 01/96. Health Economics and Financing Programme, London School of Hygiene and Tropical Medicine.

Bennett, S. and M. Paterson. PHRplus, 2003. Abt Associates Inc., "Piloting Health System Reforms: A Review of Experience."

Bitran, R., S. Block. Abt Associates Inc. 1992. *"Provider Incentives & Productive Efficiency in Government Health Services."*

Bossert, T. et al. 2000. Major Applied Research 6 Technical Report 1; PHRplus; Abt Associates Inc. Decentralization of Health Systems: Preliminary Review of Four Country Case Studies.

Brinkerhoff, D. 2003. Abt Associates Inc., *"Accountability and Health Systems: Overview, Framework, and Strategies."*

Buchan, J. 2000. "Health sector reform and human resources: lessons from the United Kingdom." *Health Policy and Planning* 15(3): 319-215.

Cassels, A. 1995. "Health Sector Reform: Key Issues in Developing Countries." *Journal of International Development* 7(3): 329-347.

Chaudhury, N. and J. Hammer. 2003. "Ghost Doctors: Absenteeism in Bangladeshi Health Centers." World Bank Policy Research Working Paper 3065, World Bank, Washington, DC.

Cohen, J. and J. Montoya. 2001. "Using technology to fight corruption in pharmaceutical purchasing: Lessons learned from the Chilean experience," Washington, DC, World Bank Institute.

Di Tella, R. and W. Savedoff. 2001. Diagnosis Corruption: Fraud in Latin America's Public Hospitals. Inter-American Development Bank.

Eggar, D., and O. Adams. 1999. "Imbalances in Human Resources for Health: Can Policy Formulation and Planning Make a Difference?" *Human Resources for Health Development Journal* 3(1): 52-63.

Ferrinho P. and W. Van Lerberghe. 2002. "Managing Health Professionals in the Context of Limited Resources: a Fine Line between Corruption and the Need for Moonlighting," Institution for Tropical Medicine, Antwerp.

Ferrinho, P., M. Omar et al. 2004. Human Resource for Health. *"Pilfering for survival: how health workers use access to drugs as a coping strategy."*

Gray-Molina, G., Pérez de Rada, E., Yañez, E., and Fundación Diálogo. 1999. *"Transparency and Accountability in Bolivia: Does Voice Matter?"* Working paper #R-381; Inter-American Development Bank, Banco Interamericano de Desarrollo, Latin American Research Network, Red de Centros de Investigación, Office of the Chief Economist.

George, A. 2003. Accountability in Health Services: Transforming Relationships and Contexts'; ; Working Paper Series Volume 13 Number 1; Indian Institute of Management, Bangalore & Harvard Center for Population and Development Studies HCPDS.

Goetz, A. and J. Gaventa. 2001.*"Bringing Citizen Voice and Client Focus into Service Delivery,"* IDS Working Paper-138.

Government of Pakistan. 2002. National Anti Corruption Strategy, Pakistan.

Government of Pakistan. 2001. Devolution of Powers under Local Govt Ordinance.

Hye, H. 2003. *Health Regulation Review.* World Bank.

Institute of Development Studies at the University of Sussex; Brighton BN1 9RE UK. "Bringing Citizen Voice and Client Focus into Service Delivery," Case Study: Monitoring Quality in the Public Distribution System," "Rationing Kruti Samiti, Mumbai," India. <http://www.ids.ac.uk/ids/govern/citizenvoice/pdfs/rksmumbai.pdf>

Killingworth J. 2002. *"Official, Unofficial and Informal Fees for Health Care,"* WHO.

Martinez J. and T. Martineau, eds. 1996. "Workshop on Human Resources and Health Sector Reforms." *Liverpool School of Tropical Medicine, Liverpool,* UK.

Mills A. 1994. *"Decentralization and Accountability in the health sector from an international perspective: what are the choices?"*. Public Administration and Development, vol. 14.

Paul, S. "New Mechanisms for Public Accountability: The Indian Experience". Public Affairs Centre, Bangalore, India; http://www.undp.org/governance/eventsites/ PAR_Bergen_2002/new-mechanisms-accountability.pdf

Reinikka R. 2002. *"Measuring and understanding corruption at the micro level,"* World Bank Development Research Group, Processed.

Saltman, R. and C. von Otter. 1995. *"Implementing planned markets in health care: balancing social and economic responsibility."* Open University Press, Milton Keynes.

Samuel P, 1991. "Strengthening public service accountability: a conceptual framework," World Bank discussion papers; 136, Washington DC, World Bank.

Tilney, J. Jr. et al. 1992. Abt Associates Inc. "*The Gambia Review of Ministry of Health Cost Recovery Project."* Cambridge, Massachusett.

Transparency International. 1999. The 9th International Anti-Corruption Conference (LACC) Summary and recommendations: workshop on sectoral initiatives health, Durban, South Africa. http://www.transparency.de/iacc/9th_iacc/papers/day4/ws7/d4ws7_summary.html.

Transparancy International. 2002. *"Corruption Fighters; Tool Kit,"* Berlin.

Treisman D. 2002.*"The Causes of Corruption: a cross-national study,"* Journal of Public Economics, 76, 3.

Tritat, N. 2000. "Two case studies of corruption in medicine and medical supplies," IDS.

World Bank. 2003. "Bangladesh Private Sector Assessment for Health, Nutrition and Population (HNP) in Bangladesh."

World Bank, 2004. World Development Report.

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