The Cost of Corruption in Health Institutions

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Introduction

This paper was first written for the National Integrity Conference in Accra last year by myself and my colleague Audrey Gadzekpo, a lecturer in Journalism. The original focus was on the cost of corruption in both health and education. For the purposes of this workshop, we will focus only on health.

Methods of information gathering:

Our sources of information included the national newspapers, a national survey on corruption, and extensive interviews with public servants and health care providers.

The Newspapers:

As we grappled with the question of corruption in the health services we scanned some of the nation's top newspapers not for a scientific content analysis, but to determine the nature of the problem as manifested through them. Back issues of the Daily Graphic, Ghanaian Times and Ghanaian Chronicle of 1998 and 1999 contained a number of stories, which implicated staff, some high-ranking, in the health sector in practices that are corrupt and/or fraudulent. While the newspaper scan in no way constituted quantitative research, the articles, nonetheless, reinforced our perceptions and perhaps the perceptions of many Ghanaians that corruption is rife in many sectors of the Ghanaian economy, health inclusive.

Letters to the Graphic for instance complained of payment of illegal fees demanded by doctors at the second largest regional hospital in the country [1]. Korle-Bu hospital, the Nation's largest and teaching hospital, made the headlines in August 1998 when eight of its staff members were arrested for stealing medical supplies and equipment valued at more than 20 million cedis from the hospital.[3] Again in June and July of 1999 [2], another scandal surfaced regarding irregularities in procurement practices. A committee of inquiry had been set up, its findings submitted to the Minister of Health, who wavered in his implementation of findings as he sought a diplomatic solution between the warring factions of health service providers, and the director of administration, and it appeared that the newspapers and radio stations embarked on character smear campaigns which further muddied the waters.

The Survey

The conclusions drawn from our newspaper scan appear to have been collaborated by empirical studies conducted by Dr. Essuman – Johnson and collaborators under the auspices of the Center for Democracy and Development (CDD-Ghana). The survey[7] sought to discover public perceptions of corruption in the delivery of health care and education services in Ghana. These two sectors were picked mainly because most people were likely to have had some level of dealings with them and therefore they provided a good starting point for a national debate on issues of integrity. Those who designed the study aimed at providing vital and independent information on the nature, scope and causes of corruption, bringing it into sharper focus by

determining the perceptions of a cross-section of Ghanaians on the issue. We will discuss only the results related to health.

According to the survey at least 92% of respondents had dealt with a government hospital or clinic between 1997 and 1998. 1200 respondents from seven regions were asked 89 corruption-related questions. Generally, 36% of respondents admitted to using contacts to obtain health services. Of that number 31% said they gave money as opposed to 41% who claimed to have given nothing in return for the favour. The survey reports that where people paid, the amounts ranged between one thousand cedis and fifty thousand cedis. Asked if they "did something" 30% had paid something at the out patients department, 35% had paid for consultation and 23% had paid for services at the dispensary. Those who gave said they did so in order to either get quick service, to build a contact for the future, to show appreciation or because they needed special attention.

The survey we have just cited however, measured only the public's perception or experience of corruption. There are many corrupt practices or potential corrupting practices that go on behind the scenes, permeating various levels of the health and education sectors.

In-depth interviews

a. Administrative level:

Many of our informants told us that at the level of the ministry and regional branch of ministry, the **award and supervision of contracts** appears to be the main problem area with inflation of prices being the most obvious manifestation. A contentious newspaper report in June 1998 alleging that 51 billion cedis (approximately worth 25.5 million dollars at the time) was "blown on hospital cards" underscores this point.[4] (However, this figure has since been disputed as an error in printing).

Procurement of supplies is also a regular site of corruption. Often centralised buying of supplies are not monitored properly, and especially when money comes from donor grants, prices are inflated, e.g. in buying computers and other equipment. Recently a diagnostic manual was procured for the medical school at a cost of £500 when the manual's actual cost was estimated by some end users as not more than $80. If a hospital fails to double check what was supposed to be supplied against what was supplied there is always the possibility and the probability of being shortchanged. For example, on one occasion the Accra Psychiatric Hospital was told they had been supplied with $1 million of physical drugs (non-expensive, basic drugs such as painkillers, antibiotics, etc). In actuality the drugs received were either far less than was being claimed or could not be accounted for.

Food procurement in medical and educational institutions provides avenues for graft. In certain instances food contractors bring half of what they are supposed to supply while billing for the full supply. In a few cases food is not supplied at all or else part of the supply is delivered to the institution, part to officials in charge. These practices are covered up by clever bookkeeping. The quality of food is then routinely compromised to make up for the deliberate shortfall.

b. Institutional level

Badly managed supply rooms and lack of proper mechanisms to compel accountability mean at the individual institutional level those in charge of places where stocks are kept from store clerks to accountants to catering staff - are able to pilfer with impunity. Hospital catering staff, for example, who control food simply take their daily marketing needs from food procured for their institutions. There is little distinction between the catering staff's household food supply and that of the institution.

Laxity in supply rooms also means people help themselves to, or are "given" supplies with impunity. One of the people we talked to recounted that she saw a trainee staff member carrying a half-gallon of Izal (concentrated disinfectant) which he claimed to have been given by the store clerk. He did not show any sign that this action may have been wrong.

In many hospitals, the administration of the Cash and Carry system has generated opportunities for fraudulent practices. The policy says, for example, destitute people can be treated free. However, it has not explicitly laid down the procedures for how to determine the needy from those able to pay. Corrupt institutions or individuals are thus able to account for their missing supplies by inflating the number of destitute patients. In an apparent attempt to "check" this corruption, foolish and inhumane policies are put in place- e.g. if you landed in the emergency room from a road accident, unconscious, if no friend arrived to pay in advance for needed supplies such as a drip, or blood transfusion, you could die, with a credit card sitting silently in your pocket. If a nurse, out of professionalism, should use up her emergency supplies on a patient who later is unable to pay, even with proof of how it was used, she is charged out of her subsequent pay checks! Punishment for doing one's work well. Another example would be women who after giving birth, and who could not pay their bills, would be kept hostage on the ward with their health baby until some one comes to pay. Sometimes, the really poor or young mothers manage to run from the ward, abandoning the baby. All this, while the authorities make up their minds who is destitute!

The survey also indicated that illegal consultation fees are being charged in many institutions. Also corrupting are illegal procedures that generate money for individuals and not the institutions, for example abortions that are illegal in Ghana.

Consequences of Corruption

The cost of corruption in health care is difficult to measure precisely. It is clear from some of the examples given that corruption and lack of accountability can be costly in both financial and human terms. For instance, in the example of the Korle-Bu Probe, allegations suggest that the graft demanded on selected items ranged from a third over to twice over the original bidding price of the suppliers. As well, substandard supplies, such as sutures and catheters, led to much pain and suffering of patients, e.g., holes in skin from stitches that came apart, and catheters which could not be deflated once inserted.

Already-strained institutions are thus being bled of what little financial resources they have due to embezzlement, misuse of institutional property, pilfering and outright theft of supplies. Particularly heinous is the fact that it is often those who can ill-afford to pay money that feel compelled by circumstances to "do something." It is ironic that in places such as hospitals, the extra-legal money people admitted to paying in order to get help is generally higher than what

they had to pay officially. According to the survey, whereas the legitimate payments amounted to an average of 1,000 to 4,000 cedis, the average for extra-legal payments ranged between 1,000 and 10,000.

In human terms corruption can cost lives. When food meant for patients is diluted to make up for shortfalls due to " under procurement" or antiseptics and cleaning agents are pilfered, health is seriously compromised. Of the three to seven psychiatric patients who die each month at the Accra Psychiatric Hospital, at least half die from illnesses related to malnutrition, infection and unhygienic surroundings, especially those that have lived in the hospital for a long period of time.

The shortage of supplies (probably paid for but not delivered, or delivered but pilfered) lowers the moral of poorly paid staff who leave by the droves when better opportunities present themselves elsewhere. Of great sadness to us are the changes that our young idealistic and caring students in medicine and nursing go through as they begin their clinical years. They begin by helping poor patients by buying antibiotics, painkillers, and so forth out of their own pockets. By the time they are graduating, they distance themselves, because they are unable to keep up with the need, and they leave the country as fast as their predecessors have done before them. In Ghana, we have approximately 1000 trained and mostly ageing doctors for approximately 18 million people. They constitute approximately 10% of those trained with the taxpayers' money.

Shortage of supplies and low moral mean also that many decisions regarding patient care are not taken quickly, and not corresponded to patients. For instance, the Daily Graphic reported in 6April 1999, that a boy died because the family had not been quickly informed about the exact diagnosis and how much money would be needed for surgery. The doctors had placed the boy on the waiting list where the boy died. It is common to find patients on wards who are not told anything for long periods of time, unless they have assertive and proactive relatives. Caregivers are wary of offering treatments which are expensive, and which they assess, sometimes correctly, and sometimes not, that the patient is incapable of paying(e.g. dialysis, heart surgery, etc). Perhaps, the lack of communication is due to the fear that the patient might suspect the doctor of corruption. Unfortunately, patients die for lack of this crucial communication.

Measuring the magnitude of corruption can be elusive.

Why is corruption so rampant?

The survey notes a great reluctance on the part of respondents to complain to a superior official when improper demands are made of them mostly because of complacency towards the problem. About 52% of those questioned said they did not report when extra-legal demands had been made on them, while another 46% refused to answer the question all together. Of those who co-operated 10% rationalised that "it was normal practice." Some 5% said they were afraid of being victimised, while another 5% said they were afraid reporting would affect their next visit.

Reasons given for the practice of corruption included the low level of salaries in the public sector, the attitude of Ghanaians to get rich overnight, ignorance or lack of information about processes, and over-subscription of services.

A major contributory factor is weak institutional structures to better monitor administrative

practices and lack of transparency and accountability. While there are organisational structures and laid-down procedures in many institutions that can check corruption, there is little monitoring to back them up. Thus, for example, certain middle to top managers in health administration receive petrol allowance for their private cars but use institutional vehicles for both private and business needs. Because such corrupt practices are commonplace those managers are morally not in a position to monitor people under them for other "petty corruption," such as staff collecting overnight allowances when they do not stay the night, or petrol allowances even when they ride in an institutional car.

There are structures in public institutions that in theory compel accountability. The Controller and Accountant-General's department routinely seconds staff to institutions to crosscheck internal accounting systems. This is backed by the Auditor General's Department which is responsible for the external auditing of public institutions. The loophole, however, is that internal audit reports are not always accurate and general queries are often treated as a matter of formality with few institutions following up on these queries. Some officials within the system complain that the auditing system is designed such that as long as receipts match claims and the books are balanced, there is no problem. Auditors are not mandated to check value for money. Thus, if an institution, for example, enters that they paid $1 million for four cars and have receipts to back their claim they can get away with it. Besides, because of lack of adequate funding, not all institutions get audited every year.

Centralisation can be problematic as well. Sometimes ministries determine the needs for institutions with little consultation. Procedures of allocating and dispensing of funds and supplies are not always known to people in the ministry who could potentially police the funds and relevant people at times are not even told how much of their budgets have been approved. People are simply not vigilant enough and are often too trusting of administrative processes. Thus sometimes people sign vouchers that do not state the specific amounts, leaving room for unscrupulous officials to later fill in whatever amounts they want and to pocket the difference.

Poor management practices also mean gaps are often created especially when there is change at the top and incomprehensive handing-over notes are left behind. For instance last two years, Ghana had an unusually deadly epidemic of cerebrospinal meningitis. The director in charge of ordering the vaccine had been summarily moved to another desk. The new one had not known to order the vaccine on time, and when he finally did, the suppliers had run out of the vaccine. Quite a few thousands died that year. From the figures given by the press, I might guess between 15 and 20 000.

In many educational and health institutions the separation of powers is problematic. The head is the ultimate boss and so those who could act as a check, e.g. the accountant, do not feel autonomous enough to do so. Where there is a corrupt boss also, the rest of the staff is compromised. Also the calibre of staff is such that they do not enter books properly and are not competent enough to catch discrepancies. Spending officers in institutions, usually doctors, are not adequately trained in procurement and monitoring thus they are readily taken advantage of. Many do not even know how many accounts their institution is running. It took an incident in which a region up North lost approximately 20 million cedis for the spending officer to recognise that he needed training.

Conclusion.

Cynicism and the unwillingness to take drastic measures to deal with corruption at the top have legitimised corruption at the bottom. E.g. in the Korle-Bu probe, the chief executive told the committee that his director of administration had given him money as his share of the graft. In their recommendation, the committee simply said he needed more training in procedures, but said nothing about his admission of receiving money. In order that the problem is properly dealt with it is important not only to understand the ways in which corrupt practices are manifested, but also to consider the dire consequences of such practices on the development of crucial sectors such as health. After all, when in our lives are we most vulnerable than in sickness? In this paper we have relied on some amount of empirical data as well as informal discussions to underscore the problem. More exhaustive empirical studies will however be needed to back these efforts and to provide a de-politicised basis for more action that will combat corruption.

Reference:

[1] Daily Graphic, July 7 – 8, 1999
[2] Daily Graphic, June 26, July 22, July 28, 1999
[3] Daily Graphic, August 1, 1998
[4] Ghanaian Chronicle, June 8-9, 1998
[5] Daily Graphic, September 29, 1998
6.Daily Graphic, April 19 –20, 1999
7. CDD (Ghana) Health and Education Corruption Perception Surveys.