Governance in the Health-Care Sector: Experiences from Asia

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Abstract

This paper considers the significance of good governance in the health-care sector as a means for improving health outcomes. Good governance encompasses the need to minimize corruption, as well as other attributes, including participation, transparency and equity. Moreover, although other stakeholders may play an important role, the role of the government in the financing, provision and regulation of health care is essential to protect the most vulnerable from ill health, especially in developing countries. The paper uses examples from Asia with regard to how governance in key components of health systems can have an impact on the equitable utilization of health services and puts forward a series of related recommendations.

Keywords : *Good governance, health-care sector, Asia*

1. Introduction

With the recent advent of a major global financial crisis, the situation with regard to aspects of human development in Asia is uncertain. Nevertheless, over the last few decades this part of the world has become a powerful driver of global economic growth. For instance, during the period 1988-2005 Asia's developing countries experienced an average growth rate of 7.5 per cent per annum – more than twice that of the rest of the world. Along with economic growth has been the sharp drop in the infant mortality rate experienced by almost all countries in Asia. This has contributed to a 70 per cent rise in life expectancy, from an average of 40.19 years in 1960 to 68.17 years by 2004 (ESCAP, 2007).

Crisis or no crisis, development in both economic and social spheres, though impressive in aggregate terms, has been uneven, with certain segments of society benefitting little. Significant differences in human development exist among countries. However, it is within countries where some of the starkest variations exist, with the vulnerable – whether the poor, women, migrants or older persons – losing out relative to others. Their weak performance in terms of health outcomes threatens the achievement of equitable provision and usage of health-care services as well as the health-related Millennium Development Goals (MDGs). In order to achieve the MDGs by the target year of 2015, greater investments are needed, especially in developing countries. In light of the financial crisis, this is becoming more difficult to realize. On the other hand, if the existing resources were used more efficiently, significant progress could be made even without greater investments. Though difficult to achieve in many settings, one of the most straightforward ways of using resources efficiently is by means of functioning in accordance with good governance. This entails, among other matters, minimizing corruption. However, efficiency does not ensure equity. This is especially so in the health-care sector, where market failure and corruption can occur very easily. The reasons for this susceptibility include uncertainty, the multitude of actors, physicians often acting as self-regulating professionals, the asymmetry of information, significant investments in health coming from governments and hence the scope for unwieldy bureaucracies where malpractice may occur, and large-scale involvement of the private sector in a domain where ethical issues (both in individual and public health contexts) are fundamental.

Studies may come up with numbers, for instance 80 per cent of non-salary funds fail to reach health facilities (Lindelow, Kushnarova, & Kaiser, 2006), yet accurately measuring the

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extent to which the resources spent on health care actually reach the end-users is difficult to achieve. Despite the difficulty of ascertaining exact quantifications, a crucial matter that is becoming increasingly evident is that "[f]ew of the resources spent in the health sector reach the poor" (Yazbeck, Gwatkin, Wagstaff, & Qamruddin, 2005; p. 3). Therefore, emphasis on prioritizing the efficient use of resources as well as moving beyond just economic arguments is needed to ensure that all people enjoy good health and benefit from development.

2. Governance and the Provision of Health Care

Corruption is bad for health. A study by the International Monetary Fund (IMF) that used data from 71 countries reveals that countries with high corruption indices systematically have higher infant mortality rates than those with lower such indices (Gupta, Davoodi, & Tiongson, 2001). So how does governance fit into the picture? The concept of "governance" relates to the process of decision-making and the process by which decisions are (or are not) implemented. Good governance, as discussed below, among other things, implies minimized corruption, though it is broader than that, with a mutually reinforcing relationship between the components or characteristics of good governance. In the context of health care, governance implies the implementation of decisions within and beyond health systems that have an impact on people's health and in particular health outcomes. Health outcomes include health status, financial risk protection and public satisfaction (Roberts, Hsiao, Berman, & Reich, 2004). Such outcomes are relevant, as improving these can help in poverty reduction, the achievement of the MDGs and bolstering economic growth, as well as simply improving the quality of people's lives. Though it is recognized that decisions and interventions outside the health-care sector can be very influential (such as those which relate to road safety, trade and employment) and have an impact on health outcomes, in this paper emphasis is primarily on what occurs within the health-care sector and how governance contributes to this.

When considering health outcomes, other factors also come into play, such as levels of expenditure, quantity and quality of human resources and a gamut of cultural and political issues, many of which are specific to particular societies. Nevertheless, by just improving governance, dramatic changes can be achieved and existing resources can go a long way further than they currently do, especially in developing countries where there tends to be the greatest need to use limited resources efficiently. This is so because "[c]orruption has a direct negative impact on access and quality of patient care and is one reason why, so often, increased spending on health does not correlate with improved health outcomes" (Transparency International, 2006, p. 23).

Given that health is a public good, as well as that all people should have the right to good health,[1] equity issues become very significant. So does the role that governments play in providing those in need with health-care services. Breaking down the concept of good governance into its components gives a clearer picture of what needs to be done to improve the situation in so many settings. According to ESCAP (2009a), good governance, characterized by eight core elements, is:

- Participatory – implying that it is informed and organized and includes women and men and all social groups;

- Consensus-oriented – implying what is in the best interest of the whole community, taking into account different interests, and how this can be achieved. It also requires a broad and long-term perspective on how to achieve sustainable human development;

[1] Article 25.1 of the Universal Declaration of Human Rights affirms that "everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services." Article 12 of the International Covenant on Economic, Social and Cultural Rights, the most comprehensive article on the right to health, recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."

• Accountable – implying that organizations or institutions, be they governmental, from the private sector or from civil society, are accountable to those who will be affected by their decisions or actions. Accountability is not possible without transparency and the rule of law;

• Transparent – implying that the decisions made and their enforcement need to follow rules and regulations. It also implies that information is freely available and directly accessible by those affected by such decisions and their enforcement;

• Responsive – implying that institutions and processes serve all stakeholders within a reasonable time frame;

• Effective and efficient – implying that processes and institutions produce results that meet the needs of society while making optimal use of the resources at their disposal and ensuring protection of the environment.

• Equitable and inclusive – implying that every person, especially the most vulnerable, feels that he or she has a stake in matters and does not feel excluded from the mainstream of society;

• Subject to rule of law – implying minimized corruption and that fair legal frameworks are enforced impartially by an independent judiciary and just police force, and human rights, particularly of minorities, are fully protected.

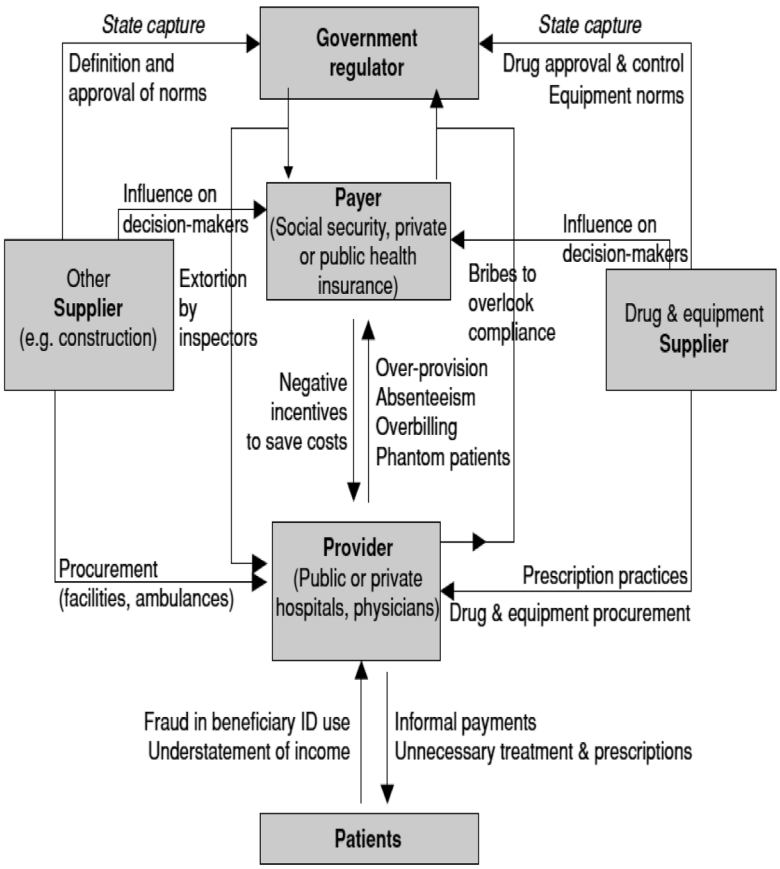
A look at "general 'enabling' conditions" which contribute to good practices reveals the importance of good governance. The enabling conditions cover a variety of factors, including political stability, a strong institutional and policy environment, commitment to equity, good evidence-based decision-making and strong stakeholder support (Gottret, Schieber, & Warers, 2008). In all of these, the principles of good governance can have a significantly positive impact and, with the correct social orientation, benefit those in greatest need.

Many actors are involved in governance, though in the context of health, especially in developing countries, governments should play the main role. This is so because, without government intervention, vulnerable groups suffer disproportionately from "market failures" that occur in the health sector. Moreover, recent studies (for example, Oxfam, 2009) reveal that publicly financed and delivered health-care services continue to dominate in countries with higher performing and more equitable health systems. In the section that follows good governance is examined with regard to some of the aspects of greatest significance within the health-care sector.

3. Spheres within the Health-Care Sector Needing the Most Attention

As with the nature of many illicit or morally reprehensible activities, the extent of corruption and other aspects of poor governance are not possible to quantify accurately. All the same, "it is evident that it amounts to tens of billions of dollars," though the "real costs… must also be measured in terms of those people who suffer because they cannot afford brown envelope payments to health care workers… and those who are forced to pay far more than they should for hospital services and pharmaceuticals due to rampant corruption" (Transparency International, 2006, pp. 23-24). Figure 1 shows that there are five main categories of actors in the health-care sector, namely government regulators, payers, providers, consumers (patients) and suppliers. It also shows that there are many ways in which corruption, fraud and other malpractices can occur, given the complex relationships between the actors.

Figure 1. Five Main Actors in the Health Sector: Relationships between Them and Scope for Malpractice



Source: Savedoff and Hussmann (2006).

In the analysis that follows emphasis will be on the roles played by government regulators, suppliers of drugs and providers of health-care services, as well as patients, since ultimately they suffer as a consequence of malpractice and a lack of good governance. This is not to say that the role of payers is not significant, nor that of suppliers of products which indirectly have an impact on health care, such as the construction of hospitals and the supply of ambulances. However, the issues around supplying products of the aforementioned nature are common to many other sectors in addition to health. Moreover, in Asia it is a fact that the vast majority of people, and in particular the most vulnerable, do not have the privilege of social security or some form of health insurance, something more common in developed countries (where, of course, corruption may also occur). Research in China shows that direct patient expenditure on medications and health services, respectively, makes up 55 per cent and 35 per cent of the revenue of community health care (Zhang, Yang, & Gao, 2006). Such out-of-pocket expenditures are in fact the principal method used by poor people across Asia to finance their heath care. This form of payment is problematic since, with weak institutions and regulations, there might be overcharging, the funds might not go beyond the staff who receive them from those seeking heath care and the costs are largely non-reimbursable.

In most of Asia out-of-pocket expenditure as a percentage of private health expenditure is significantly higher than in other parts of the world, including sub-Saharan Africa. Out-of-

pocket payments can be harmful, especially for the poor. For instance, they increase the rate of poverty by 33 per cent in Viet Nam, 19 per cent in China, 17 per cent in Bangladesh and 12 per cent in India (Durairaj, 2007). The implications are that much still needs to be done by governments to develop universal health-care coverage schemes, whether through tax financing or social health insurance. In order to make this possible, good governance can certainly help, as it makes the setting up and running of such schemes easier.

3.1 Government Regulators

A lack of good governance among government regulators, to a large extent, sets the scene for how operations are carried out in the health-care sector. If there is inefficiency, or a lack of accountability and transparency here, the impact of regulations and the implementation of health-care interventions from the top down would be adversely affected. Investors may not be willing to put their funds into a corrupt system, knowing that much of their investment could be diverted into the pockets of the unscrupulous. Government regulators can influence controls over the quality of products, facilities, services and professionals. This can be done though a variety of means, such as certification, accreditation or licensing procedures being undertaken in a biased manner, expediting approvals for pharmaceuticals without consideration of quality, influencing research results or ignoring them if they go against what is desired by those with vested interests. Often there is significant scope for corruption within the process of the allocation of budgets.

In 1998, the Thai Ministry of Public Health developed a scheme in which budgetary allocations to hospitals was increased, but drugs and medical equipment were to be purchased from companies named by senior persons in the Ministry and at fixed prices, which in certain cases were two or three times greater than normal. When questioned, the Ministry denied irregularities and refused to allow an investigation into the matter. Nevertheless, a combination of pressure from physicians, university lecturers, non-governmental organizations and the media forced the Minister of Public Health to resign, and led to dismissal and disciplinary measures related to corruption offences being taken against officials and senior officials (Phongpaichit, 2001). The afore-mentioned case shows how things can be done to bring an end to corrupt practices, but for this to be possible recognition of problems is necessary as is having the frameworks and institutions to put change into effect.

In neighboring Cambodia, much still needs to be done to weed out corruption in the health-care sector. Research suggests that 5-10 per cent of the health-care budget disappears before the Ministry of Finance disburses the money to the Ministry of Health, while more money is diverted as funds are channeled from the national government down to provincial governors and directors of operational districts, and subsequently on to directors or managers of local hospitals and clinics. The problem is confounded by the alleged practice of paying up to US$ 100,000 for a post as director at the Health Ministry's provincial or national offices and even US$ 3,000 for a job as a low-level public servant in the health sector, when government employee salaries are on average US$ 40 per month (Prevenslik-Takeda, 2006). When the possibility of earning many times an official salary exits and is even institutionalized (albeit in an informal manner) it becomes difficult to change the culture and introduce good governance at the highest level, let alone at the lower levels.

3.2 Suppliers of Drugs

In developing countries, 20–50 per cent of the recurrent government health budget is often used to procure drugs or pharmaceuticals. These are among the most important and cost-effective elements of health care and frequently a key factor for successfully reforming the health-care sector. Asia is one of the fastest-growing markets in the world for pharmaceuticals and numerous multinational drug companies have plans to expand their investments and operations in Asia (UNDP, 2008). In addition, many hospital and clinics rely largely on the sale of pharmaceuticals as a source of revenue. In China, pharmaceutical

medication sales contribute a key proportion of the revenue of township hospitals and village clinics in some areas, accounting for 61.58 per cent of total revenue (Pan, 2006). Nevertheless, drugs are frequently being used irrationally, principally as a result of market imperfections in the health-care sector (Falkenberg & Tomson, 2000). Indeed, it is in the supply of drugs where some of the most troubling malpractices occur. Many of these take place at the regulatory level and have an impact all the way down to patients, since the pharmaceutical industry, in addition to supplying drugs, plays a substantial role as a purveyor of information and persuasion (Dukes, 2002). Malpractices often directly affect consumers or patients. Estimates by WHO reveal that over half of all medicines worldwide are prescribed, dispensed or sold inappropriately, and that half of all patients fail to take them in the correct manner (WHO, 2009a).

The hazards to health are obvious when considering that irrational use of medicines could lead to over-prescription, incorrect prescription and questionable quality of drugs. The Declaration of Rome (February 18, 2006) states: "Counterfeiting medicines, including the entire range of activities from manufacturing to providing them to patients, is a vile and serious criminal offence that puts human lives at risk and undermines the credibility of health care systems" (WHO, 2009b). A lack of knowledge, or unethical behavior among prescribers, as well as a lack of awareness and knowledge among patients, may be part of such problems. It is the poor who are most adversely affected, often having to pay for drugs that are supposed to be free of charge. The poor, especially when facing high costs, may also opt for self-medication and be at greater risk of the harm associated with this practice.

In 2003, investigations following complaints of alleged malpractice in the Indian state of Karnataka showed that certain drug-producing companies which had paid bribes to officials were permitted to circumvent drug standards, while those that had refused to pay ended up being harassed. Additional irregularities included price controls not being enforced, kickbacks being accepted and no action being taken in response to the discovery that a blood bank had dispensed HIV-positive blood. Pressure groups were instrumental in pushing for disciplinary action, but the case also shows just how vulnerable patients may be owing to the lack of information regarding their entitlements or health standards, as well as their fear of losing access to services if they proceed to file a formal complaint (Cameron, 2006). Incidents of this nature regrettably occur all over the developing world and to a certain extent also in developed countries. They all highlight the relevance of good governance in dealing with these problems, as well as the significance of the efforts to promote such approaches by all stakeholders from governments and international organizations to civil society, academia, the media and communities.

3.3 Providers of Health-Care Services

The provision of health-care services comes from various sources, including both public and private hospitals, health centers and clinics, and officials and administrators dealing with health, physicians and other health-care professionals. The main aspects of such malpractice include the diversion of hospital budget allocations, bribes for admission to hospitals, theft of user fees, informal payments made by patients for health-care services which should be free, induced demand for unnecessary medical interventions, absenteeism, immunization programmes being compromised and public facilities being used for what is in effect private practice.

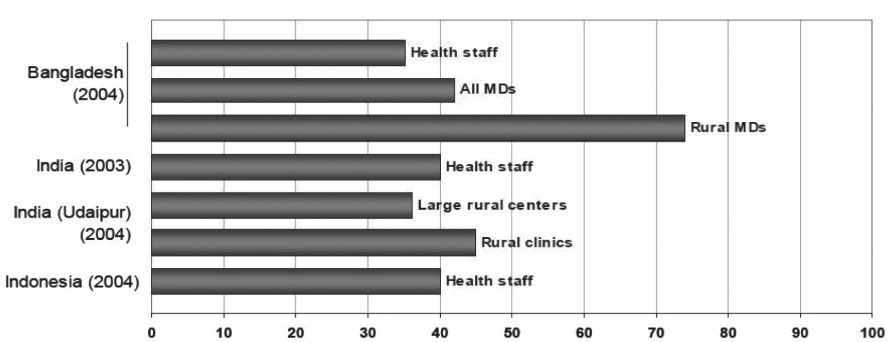
Malpractice in the provision of health-care services, in particular "under-the-table" payments, may arise as a consequence of low salaries and limited opportunities for performance-based rewards. This may lead some people to feel justified in giving "donations" or "gifts" (such as "red envelopes" in China). It also may be exacerbated by patients' lack of knowledge and their view of health as so significant that they are often willing to pay virtually anything to attain optimal outcomes.

Extra payments have become so institutionalized in numerous settings that many people accept them and even consider them useful. This is especially so in countries where public sector health care is weak and such informal fees work as a type, albeit unreliable, of quality assurance (UNDP, 2008). The consequences of malpractice in the provision of health-care services are, understandably, that many people are unable to pay for services, the near poor are made poor, the poor are made poorer, priorities are distorted, people lose faith in the public health system and inefficient use of resources and unprofessional behavior are encouraged. Addressing just one aspect of a problem, such as finding a way to stamp out informal payments, may simply bring about other problems, such as physicians moving to the private sector and thus public services being compromised.

Incidents of bribes being frequently demanded by health workers for admission to hospital, for a bed and for receiving subsidized medications occur in Bangladesh, India, Nepal, Pakistan and Sri Lanka. In addition, these countries have high proportions of health-care service users who make informal payments, with figures of over 90 per cent in Pakistan and Sri Lanka (Lewis, 2006). Seen from another angle, in Azerbaijan and the Russian Federation, informal payments make up 84 per cent and 56 per cent, respectively, of total health expenditure (Lewis, 2000). Whatever are the arguments for or against informal payments, from the point of view of equity they are problematic. Such payments are regressive, since the poor pay more, at least as a proportion of their income.

Absenteeism, in the form of staff not turning up for work while still getting paid, is also a problem across Asia. It can even take the form of "ghost workers," in which payments are made to non-existent staff members and end up in the accounts of government officials. It may be that the absenteeism is due to legitimate sickness, a phenomenon found even in developed countries, and this could reflect work conditions, including issues of morale. The need for good governance could be relevant in such cases if there are problems that relate to matters including transparency, accountability, consensus-orientation and participation. Whatever the case, the situation could be ameliorated, as echoed by India's Minister of State for Health and Family Welfare, Panabaka Lakshmi, who openly stated that addressing absenteeism among health workers would "sustainably improve" health facilities in India (Thaindian News, 2008). Figure 2 indicates the levels of absenteeism in certain countries in Asia. From this and other sources (for example UNDP, 2008) it can be seen that rural areas often suffer the greatest incidence of absenteeism. Reasons for this include difficulties in getting to work, poor working conditions, which act as disincentives and weak supervision. Malpractice also occurs in terms of bribes given to influence recruitment, as well as with regard to aspects of accreditation, licensing and certification.

Figure 2. Absence Rates among Health-Care Workers in Selected Asian Countries



Source: Adapted from Lewis (2006).

4. Addressing the Challenges at Hand

Subsequent to the identification and assessment of some of the main challenges being faced with regard to good governance in the health-care sector in Asia and before conclusions are made and recommendations are put forward, some examples of what is being done to address corruption, malpractice and other negativities are considered.

In order to promote good governance in the health-care sector a combination of approaches needs to be adopted. These approaches include ways of generating greater awareness of the negative impacts of corruption and malpractice, enhancing institutional capacities to prevent these practices and deal with them if they arise; reforming management and accounting practices; improving performance reward systems; and allowing for greater participation from civil society, including pressure groups. It all entails involving the various actors in the health-care sector and adopting both top-down and bottom-up approaches. Moreover, in recognizing that the corruption and malpractice existing in the health-care sector is largely indicative of general shortcomings in governance in the public sector and may often relate to other sectors, approaches should fit in with wider good governance and anti-corruption initiatives.

In Vietnam, regulatory measures have been put in place to combat corruption in the public sector at large, including the issuance of new decrees on corruption, the simplification of administrative procedures in ministries and agencies at the central and local levels, and the introduction of more transparent personnel procedures. As a result disciplinary action following investigations by the state inspectorate and the Vietnamese Communist Party have been increasing (Wescott, 2003).

In the Republic of Korea, anti-corruption committee directly under the president and anti-corruption investigation departments of the Ministry of Justice, work to crack down on corruption by public officials at all levels. The anti-corruption investigation departments categorize corruption-prone areas into 16 categories, including health. In addition to the collection of information on irregularities and investigation into complaints, ethical behavior is promoted among the staff of the Prosecutor's Office, within the Ministry of Justice, and where the anti-corruption investigation headquarters is located. This has "won the public's respect and confidence" (ADB & OECD, 2001, p. 54). When government regulators receive reasonable pay and are guided by upright principles and where effective institutional frameworks exist it is easier to prevent corruption, as well as identify it and respond to it when it occurs. This is likely to be more straightforward in more developed countries, but even in those which are developing there is much potential for tangible improvement. For instance, in India information technology has been used to streamline services and reduce corruption, with transactions and the issuance of certificates being done electronically in the health sector and other sectors to improve efficiency and reduce corrupt practices (Purohit, 2007).

In the field of pharmaceuticals many initiatives have been undertaken to reduce corruption and malpractice. With regard to halting the sale of counterfeit medicine, a WHO study in Myanmar and Vietnam came to the conclusion that inspections at various stages of the pharmaceutical value chain could prove essential (Wondemagegnehu, 1995). In Thailand, results have been achieved by focusing on transparency and accountability as effective, efficient and feasible steps of good governance when dealing with medicines. Essential drug lists have been established, with controls on registration, pricing and procurement; furthermore, effort has gone into raising awareness about good governance and ethical practices (Tharathep, 2008). China's experiences in working with essential drug lists and controls on purchasing and allocation have also yielded positive results. By moving away from the practice of medication sales generating special allowances for doctors toward remunerating them with fixed salaries and bonuses determined only

by performance reports, the quality of care has also been targeted. From another angle, diagnostic principles have been established and physicians' prescriptions are checked on a regular basis; if prescription fees exceed a set amount the doctor responsible is penalized by forfeiting his pay (ESCAP, 2009b). This latter strategy also directly targets providers of health-care services.

Other efforts to improve governance in the provision of health-care services include tackling informal payments. In Cambodia, in stark contrast to most developing countries, the introduction of official user fees at government facilities was associated with greater utilization of public health services, mainly because the official fees in the majority of cases replaced the more expensive "under-the-table" charges (Barber, Bonnet, & Bekedam, 2004). The introduction of a regulated fee system at Cambodia's National Maternal and Child Health Hospital was associated with higher patient satisfaction, increased utilization and bed occupancy rates and a greater number of hospital-based natal deliveries (Akashi, Yamada, Huot, Kanal, & Sugimoto, 2004). This specific case shows how efforts to institutionalize matters can reduce certain unfavorable practices; yet, there may still be a need to attend to equity issues, such as exempting the poor from user fees. Another approach that is being adopted in India directly targets the poor; it involves providing them with heath insurance and "smart cards." Such cards make transactions cashless and paperless for 725 pre-agreed medical procedures, hence preventing fraud and corruption. The cards can track expenses day to day in hospitals and money is deducted automatically following each procedure (OneWorld South Asia, 2008).

To tackle absenteeism and staffing issues different strategies may be needed for different occupational groups and people in different settings. For instance, performance-based non-financial incentives, including career development, training opportunities and fellowships, have been found to be suitable for central and provincial managers in Sri Lanka. On the other hand, hospital managers there have been seen to prefer financial incentives (Bandaranayake, 2001). In Bangladesh and some other countries, regular audits, physical head counts, questionnaires and reconciliation of different data sources are used to help identify ghost workers and reduce the number of unauthorized absences, especially with such information being made publically available, and the institutions affected being empowered to take corrective actions (WHO, 2006). In any situation it is important to consider that polices should be as comprehensive and coordinated as possible. Hence, when addressing matters such as health worker dissatisfaction, incentives should not be used in isolation; rather, they should be part of a package which considers good governance in its entirety.

5. Conclusions and Recommendations

A lack of good governance in the health-care sector and the related ills that result from its absence are of the greatest harm to those who are most vulnerable. Corruption and malpractice – whether involving government regulators, suppliers of drugs, providers of health-care services, or other actors – are the cause of tremendous inefficiencies and contribute to great inequities. It is developing countries, often characterized by weak institutional capacities, which find it most difficult to put into effect the measures that promote good governance and ultimately contribute to better health outcomes. Experiences in Asia show that efforts to stamp out corruption and malpractice can result in success. Nevertheless, there is a need for more resources and better use of existing resources, careful planning and monitoring, as well as a wide array of other facilitating factors, ranging from generating greater awareness and promoting transparency to engendering greater participation and more actively enforcing regulations.

As a consequence of the above-mentioned issues, it is recommended that more research and analysis should be undertaken with the aim of understanding the causes and consequences of corruption and malpractice in the health-care

sector, as well as developing related databases. In doing so, emphasis should be on ways to effectively minimize corruption and malpractice and promote good governance by generating greater awareness among all stakeholders and developing supportive institutional structures and incentive and payment schemes that enhance quality and equity. This applies to those at the top and bottom of the spectrum, as well as to all those in between. It also involves coordinating with sectors beyond health, particularly in other public domains, given the need to protect all, especially the poor and other vulnerable groups. Other important areas of action are improving regulation and monitoring, including with regard to quality, as in the case of pharmaceuticals, using information and communication technologies to simplify and rationalize transactions and other administrative procedures, and allowing for greater participation from civil society and other interest groups which aim to help consumers. In the broader scheme of things, cooperation and sharing of information within and beyond sub-national and national boundaries can facilitate the development of good governance, as can assistance – technical or financial or that which enables acting as an arena for cooperation – from donors and international organizations.

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