



The impact of information and accountability on hospital procurement corruption in Argentina and Bolivia

Argentina and Bolivia have both attempted to curb corruption in procurement of hospital supplies. With varying degrees of success, their experiences tell a lesson: unless there are consequences attached to identified mal-practice, monitoring and publicizing information will not guarantee sustained gains.



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Introduction

While most studies on corruption have focused on abuses by police, customs, courts and public works, a great deal of public money and trust is squandered in other public services, including public hospitals. Hospitals spend a great deal of money on supplies and have been the object of a wide range of scams, including kickbacks and delivery

of expired and substandard products. In the world's wealthy countries, this may lead to higher costs, but in the world's poorer countries, such corruption can mean the difference between having an equipped facility and one that cannot offer life-saving treatments.

One set of studies in Latin America found substantial corruption in public hospitals, ranging from outright theft to absenteeism. A common problem in most public hospital networks, however, appeared to be kickbacks in procurement. Studies in different countries show it is possible to investigate and measure this kind of corruption and that publishing information about prices paid for supplies can mitigate the problem. However, the studies also suggest that unless individuals engaging in corrupt practices have some positive chance of being detected and punished, information alone is not sufficient to deter corruption.

Buenos Aires publicizes hospital procurement prices

The City Government of Buenos Aires operates the second largest hospital network in Argentina. In 1995, it comprised 33 hospitals and 8,375 beds for a population of almost 12 million. At the time, procurement was decentralized to procurement offices in each hos-

“...in the world’s poorer countries, (..) corruption can mean the difference between having an equipped facility and one that cannot offer life-saving treatments.”

pital. Expenditures to maintain and operate these hospitals makes up a significant share of the City’s budget and when concerns were raised about the possibility of corruption in procurement, the City’s Health Secretariat decided to try an experiment. It began to collect information about prices paid for a wide range of non-pharmaceutical medical supplies commonly purchased by hospitals – including needles, syringes, intravenous solutions, x-ray films and sanitary materials – and announced that it would report this information back to the city’s purchasing managers. The first data was collected in August 1996 and the Secretariat began to circulate the price information back to hospital procurement offices in October 1996, allowing them to compare the prices that they paid for supplies with other hospitals. The experiment was eventually stopped in January 1998 when the Secretariat implemented a new accounting system that included new financial controls.

The data revealed very wide dispersion in prices paid for very simple and homogeneous products. For example, the ratio of the highest to lowest prices paid for ethyl alcohol was 10 to 1 (i.e. ten times higher) and for disposable needles was 9.5 to 1. Among the 15 products reported by researchers, the lowest ratios were still large – 1.8 to 1 for x-ray film; 2.9 to 1 for physiological solution; and 3.1 to 1 for tubular gas. Even after taking into account differences in volume, credit, and distance, the prices paid varied widely.

Data collected by the Secretariat showed that the dispersion of prices, as well as the average price, fell quite dramatically in the first months of the experiment (See Figure 1). One explanation for the decline in prices could be that corrupt procurement officers feared being discovered; but it could also reflect the response of honest procurement officers who may have been ill-informed about the prices available in the market. This latter argument, however, doesn’t explain why the prices fell in September, *before* the first report on prices was circulated. In other words, prices fell *in anticipation* that the prices would be reported, not as a consequence of procurement officers learning from the information.

From October 1996 until July 1997, the simple act of collecting and circulating price

Figure 1:
Impact of reporting requirements - coefficient of variation for purchase prices in Argentine hospitals

(Source Di Tella and Savedoff 2001.)

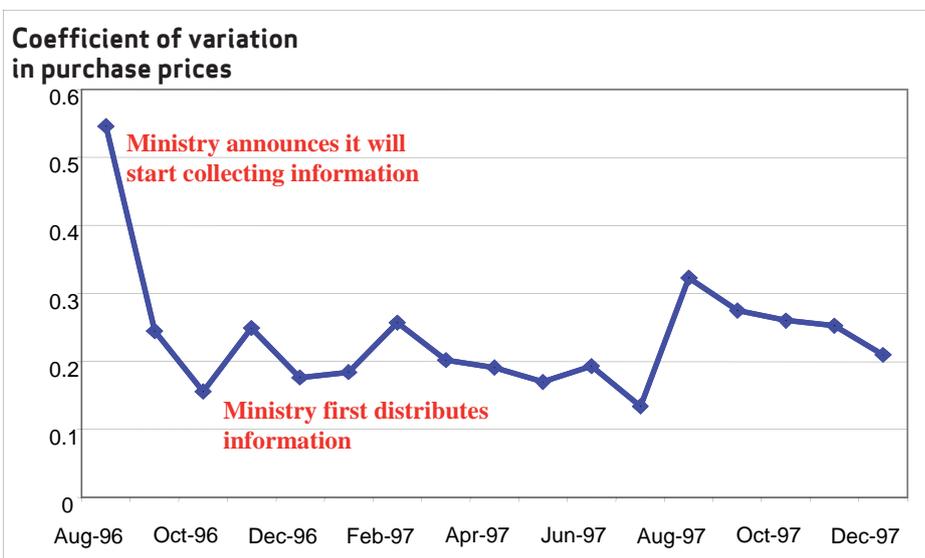
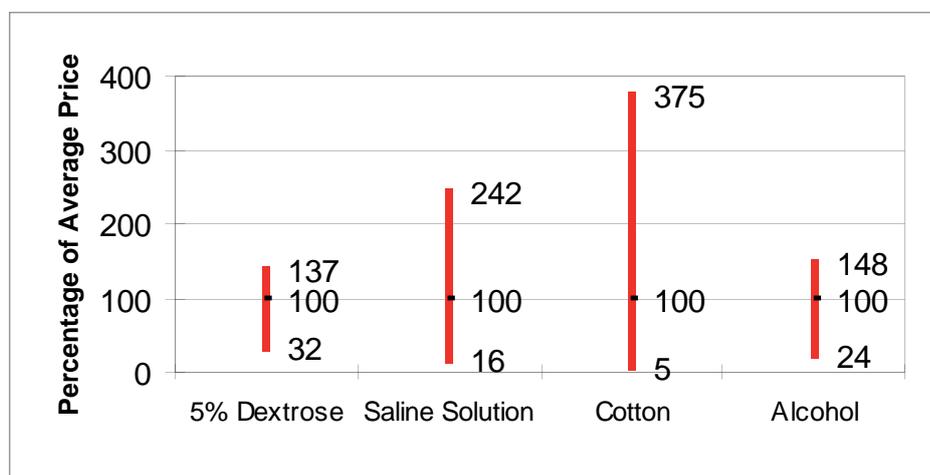


Figure 2:
Accountability inhibits corruption - range of prices paid for medical supplies in Bolivian hospitals, 1998

(Source Di Tella and Savedoff 2001.)



data appeared to constrain costs and, presumably, corruption (See Figure 1). Unfortunately, the price range and average increased during the last five months of the initiative, suggesting that the impact of information, by itself, was transitory. If the price information were improving efficiency, prices would tend to converge across hospitals. Instead, it seems that procurement officers became accustomed to the process of reporting and noted the absence of consequences for “poor performance.” In other words, revealing that a particular hospital was overpaying for certain supplies had led to no investigations, reprimands, or additional scrutiny. In the absence of such consequences, it is probable that corrupt individuals resumed their prior illicit activities.

Bolivia promotes local accountability

In Bolivia, prices paid by hospitals also varied substantially from one place to the next, despite a system of reference prices set by the national Ministry of Health. For example, in 1998, the Ministry’s reference price was Bs5 per liter for sugar water (5% dextrose), but prices paid across 24 municipalities ranged as low as Bs2.04 per liter to Bs8.75 (See Figure 2). As in Argentina, a study found that the differences in prices could not be explained by differences in volume, credit, or distance to markets.

Though Bolivia did not specifically aim to reduce corruption in

hospital procurement, another public sector reform in the mid-1990s apparently did have an impact. In that period, Bolivia implemented a national law that devolved numerous responsibilities to municipalities and to representative bodies that included local citizens. Most health care facilities were handed over to municipalities and supervised by newly created “Local Health Directorates.” These directorates included local government officials as well as citizen representatives. Some of these directorates were quite active, while others rarely met or acted.

“...local supervision appeared to be more effective at controlling corruption than the standard “vertical” controls embedded in the (...) public health system”

Researchers collected price data on four different supplies – 5% dextrose solution, saline solution, absorbent cotton and ethyl alcohol – in 30 hospitals and statistically tested whether the presence of active local representatives influenced the hospital’s performance in terms of procurement prices. They found, for example, that hospitals that were supervised by *active* directorates paid 40% less on average for 5% dextrose solution.

Furthermore, this measure was correlated with other subjective measures of corruption in the same hospitals (e.g. results from surveys with patients and health professionals). In this particular case, local supervision appeared to be more effective at controlling corruption than the standard “vertical” controls embedded in the management and administrative channels of the public health system.

Messages from Argentina, Bolivia and elsewhere

The stories of hospital supply prices in Argentina and Bolivia are not isolated instances. In Venezuela and Colombia, researchers found similar issues (see Figure 3). The most common thread in all cases was that corruption was common wherever impunity was the rule. This applied to graft in procurement as well as to absenteeism, theft, and charging illegal fees.

The Argentine case demonstrates that shining light in dark corners can modify behaviors initially, but unless publicizing information has some consequences – whether through convictions, loss of employment, disciplinary actions or moral disapprobation – the gains from publicizing corruption may be short-lived. The Bolivian case suggests that active local oversight can modify behaviors as well, though the study did not follow the cases to see if these gains were sustained. Both cases show that collecting data

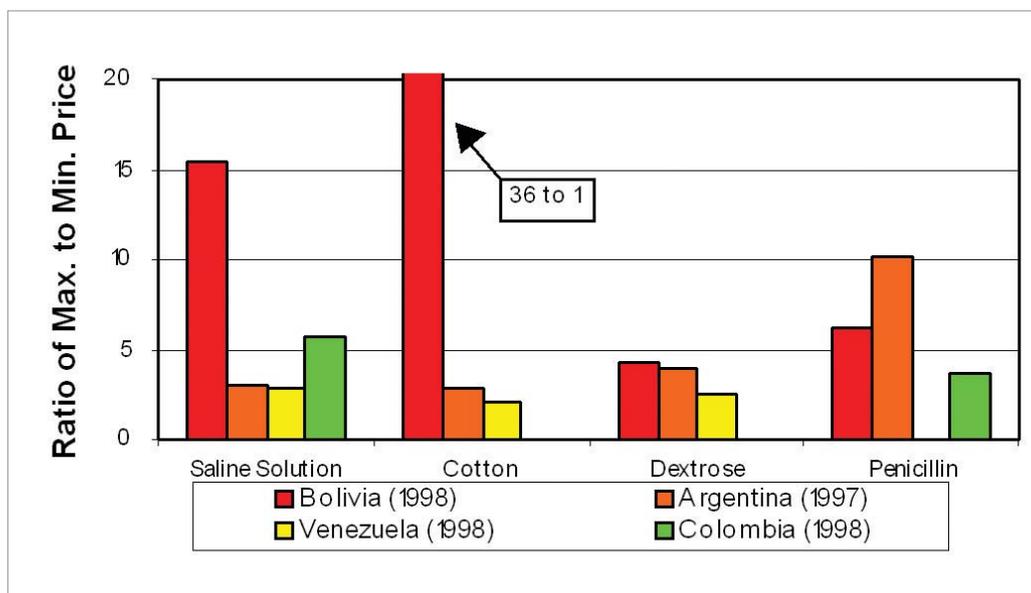


Figure 3:
Medical supply price differences across hospitals in four countries

(Source: Di Tella and Savedoff 2001.)

and comparing facilities can provide hard facts that not only assist in detecting corruption but also in understanding how it responds to different strategies. ■

*This brief draws heavily on research conducted by Ernesto Schargrodsky, Jorge Mera, Federico Weinschelbaum, George Gray-Molina, Ernesto Pérez-Rada, and Ernesto Yañez and reported in Rafael Di Tella and William D. Savedoff, eds. 2001. *Diagnosis Corruption: Fraud in Latin America's Public Hospitals*. Latin American Research Network, Inter-American Development Bank: Washington, DC.*

Further reading

David Nussbaum, 2006, "Corruption in health: what every policymaker should know," Transparency International: Berlin. www.transparency.org/content/download/6729/40507/file/CMRB-Nussbaum.pdf

R. Di Tella R and W. Savedoff, eds. 2001. *Diagnosis corruption: Fraud in Latin America's Public Hospitals*. Inter American Development Bank: Washington, DC.

Vian, Taryn. 2006. "Corruption in Hospital Administration," in Transparency International, *Global Corruption Report 2006: Corruption and Health*, Transparency International: Berlin. pp. 49-61.

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