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Gender, corruption and health

Query:

Can you please provide an overview of the impacts of corruption in the health sector upon girls and women, with an emphasis on how this adversely affects gender equity in development in the long-term?

Purpose:

Corruption in the health sector has a negative impact on effective service delivery. I would like more targeted information on how ineffective service delivery in the health sector, due to corruption, particularly impacts upon girls and women.

Content:

Part 1: Forms of corruption in the health sector and their impact on women
Part 2: Solutions to address gender disparities and corruption in health
Part 4: Further reading

Summary:

Access to health care is fundamental to quality of life. It is essential to inclusive human development and it is also a fundamental human right enshrined in the UN Covenant on Economic, Social and Cultural Rights.

The health sector is particularly exposed to corruption due to multiple information asymmetries, the complexity of health systems and the large size of public funds involved. Corruption in the sector takes many forms and ranges from undue influence on health policies, to embezzlement of funds, to the solicitation of bribes and under-the-counter payments at the point of service delivery. The consequences of expensive, ill-tailored, inaccessible or unsafe health products and services hit women particularly hard. This is because they often have higher and differentiated needs for health services, but also because they bear the brunt of poor services as primary providers of homecare and are less empowered to demand accountability and assert entitlements. Corruption in the health sector, therefore,

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contributes to and exacerbates in most developing countries persistent disparities in access to health services. This has hugely detrimental effects not only on the health of women, but also on their capabilities for educational attainment, income-generation and thus, ultimately, their status and the attainment of gender equity.

Strategies to address gender disparity in access to health caused by corruption include support for women's participation in both the design of health services that are responsive to women's needs and also their delivery.

Part 1: Forms of corruption in the health sector and their impact on women

Corruption and health

Health is a sector characterised by a high degree of corruption. Transparency International's 2009 Global Corruption Barometer, a large-scale household survey that reports on the general public's experience of corruption around the world, finds that - among basic services – the health sector is particularly affected by corruption. (2009 Global Corruption Barometer).

The health sector has a number of characteristics that make it particularly vulnerable to abuse:

- **Large amounts of public funds**: According to a 2008 WHO report, total expenditures on health worldwide represent 8% of the world's GDP. It is estimated that US$ 3.1 trillion is spent each year on health, most of which is financed by taxpayers. (Please see: **Transparency International's Global Corruption Report, 2006**). These large flows of funds are an attractive target for misuse and personal enrichment.
- **Asymmetric information**: Health professionals possess specialised knowledge about their patients' health that is not easily available to or understandable for patients. They have a high level of discretion in what type of treatment is prescribed. Similarly, pharmaceutical and medical supply companies have more information about their products than public officials who are in charge of purchasing these products.
- **High levels of uncertainty**: Lack of information about when and how illnesses will occur make resource management in the health sector particularly challenging. This includes the selection, monitoring, measuring and delivery of health care services.
- **Complexity of health systems**: Health systems are complex, involving a large number of parties which makes it difficult to generate and analyse information.

These features combine in ways that systematically create opportunities for corrupt behaviour, while making it difficult to ensure transparency and accountability. (Please see: **William D. Savedoff and Karen Hussmann, "Why are health systems prone to corruption?" 2006 Global Corruption Report**).

Some common areas of health services affected by corruption

All major forms of corruption are present in the health sector, including petty bribery, nepotism, informal payments and mismanagement of resources, absenteeism and state capture. As the discussion below highlights, all of these forms of corruption have a particularly severe impact on women.

Grand corruption: biased budget allocations

Corruption can enter the policy design and budget allocation stage if health policies are set and funds are allocated to benefit a particular societal group at the expense of others. Analyses of the health sector indicate that public expenditure tends to disproportionately benefit the rich in a majority of nations. It is common, for example, that priority is given to tertiary hospitals using costly equipment while smaller primary care clinics may be left without staffing and equipment. This could be the result of officials being influenced to allocate funds to benefit a supplier or to benefit a particular group. (Please see: **Opportunities for Corruption in the Allocation and Management of Health Budgets**).

Absenteeism, theft and embezzlement

In many developing countries, the quality of public service delivery is seriously undermined by high rates of absenteeism among medical staff. A study published in 2004 looking at absenteeism in rural health clinics in

Bangladesh found that, on average, 35% of staff and 42% of physicians were absent across the 60 clinics visited. In some rural areas this figure rose to 74% for doctors. (Please see: Governance and Corruption in Public Health Care Systems).

Theft of medical supplies and budget leakages lead to drug shortages and poor quality services. For example, in Cambodia health workers and administrators interviewed in 2005 estimated that between 5 and 10% of the health budget disappears before it is paid by the Ministry of Finance to the Ministry of Health. In Kenya in 2004, the US $41 million allocated to set up the National Aids Control Council, gave rise to some of the country's most flagrant acts of corruption. (Please see: WHO News Bulletin: New Report on Corruption in Health).

As a result, essential medicines and services become more costly and often unaffordable, contributing to a situation where millions of people lack access to treatment. Findings from a UN report of the MDG Gap Task Force, for example, shows that the availability of medicines in 30 countries is far from optimal, reaching only 34.9% availability in the public sector and 63.2% in the private sector. (Please see: Delivering on the Global Partnerships for Achieving the Millennium Development Goals).

Illegal referral and bribe payments

A common practice in the developing world consists of referring patients to specific private pharmacies to purchase prescribed medicines that are not on the supply list of the public facility. This is often the result of unethical arrangements between pharmacies/pharmaceutical companies and doctors. For example, according to end user interviews in Nicaragua, such practices affect at least 50% of the patients.

Another widespread practice among doctors in developing countries is to run their own private practices while on the public health system payroll. Doctors running private practices are likely to refer their public patients to their own private clinics, depriving the poorer clients of access to quality health care.

Informal payments are cash or in-kind payments made for medicine and / or services meant to be available at no or low cost and covered by the public health system. These include payments made outside official channels to physicians and service providers, drugs and medical supplies diverted from publicly financed health care services to private pharmacies, under the table payments to medical staff for preferential treatment, timely care, better drugs, etc. For example, it has been reported that in the Russian Federation such informal payments account for 56% of the total health budget. This phenomenon is also widespread in countries in Asia, Africa and South America. (Please see: WHO News Bulletin: New Report on Corruption in Health)

Corrupt oversight

Poor oversight and management result in substandard products being administered in the public system. Various studies indicate that, in China, about 30% of public drug supplies are expired or counterfeit. Lack of oversight also gives rise to fraudulent practices such as repackaging of drugs, substituting lower cost/quality medication, overbilling or the creation of 'phantom' patients to claim additional payments, prescription of unnecessary / expensive tests, etc.

Corruption therefore makes health services and medicines expensive, inaccessible and unsafe. Budget leakages and manipulated health policies lower the quantity and quality of service available, lack of transparency and accountability leads to abuse of the system by health workers and lack of oversight mechanisms mean that poor patients cannot access appropriate and safe medicines and services.

Corruption in the health sector has wider public health consequences through effects on morbidity and mortality rates. For example, it is estimated that in the Philippines, every 10% increase in perceived corruption is associated with 20% lower immunization rates, 30% increased waiting time and 30% lower user satisfaction. A 2003 study using data from 71 countries demonstrated that countries with high indices of corruption systematically had higher infant mortality, higher shares of low birth-weight babies, and child mortality, even after statistically controlling for a variety of other factors. At the global level this means that global health initiatives against infectious diseases, such as fighting HIV/AIDS are undermined and that achieving the health-related Millennium Development Goals is made more difficult. (Please see: Transparency International's Global Corruption Report, 2006).

Why are women more severely affected by corruption in the health sector?

Women have higher and differentiated demand for health services, making them the principal victims when services are poor due to corruption

While some health conditions are determined primarily by biological differences, others are the result of gender roles supported by norms about femininity and masculinity, and power relations that accord privileges to men. Most studies on morbidity from both high and low income countries show higher rates of illness among women in general. Recent research by the WHO has found that social factors - such as abuse during childhood, violence and victimization at the hand of partners, and the social experience of motherhood - may play a more important role than biological factors in women's health. (Please see: **Unequal, Unfair, Ineffective and Inefficient. Gender Inequity in Health: Why it exists and how we can change it**).

The following are some areas of health where women are disproportionately at risk.

- **Reproductive Health**: Women are exposed to greater health challenges in their reproductive years - including risks of more frequent and potentially more dangerous interventions - than men. They need special care during pregnancy and delivery. Around half a million women die every year from complications during pregnancy, 99% of them in developing countries. (Please see: **Unequal, Unfair, Ineffective and Inefficient. Gender Inequity in Health: Why it exists and how we can change it**) In Bangalore, South India, studies conducted in 2000 indicate that one out of two women in a maternity hospital have to pay extra money for a physician to be present at birth. After childbirth, 70% of patients were asked to pay to see their own babies. (Please see: **U4 Expert Answer on Gender and Corruption**).
- **HIV / Aids**: Women are biologically more vulnerable to sexually transmitted diseases, as indicated by women's HIV infection rates. In countries such as Zimbabwe, the infection rates of young women between the ages of 15 and 24 are double those of their male counterparts in the same age group. Though lower, the numbers of women living with HIV in Latin America, Asia and Eastern Europe are also growing. Women are also in a more disadvantaged position to protect themselves due to social and cultural gender norms. (Please see: **Unequal, Unfair, Ineffective and Inefficient. Gender Inequity in Health: Why it exists and how we can change it**).
- **Mental Illness**: The gendered nature of family life leads to starkly different vulnerabilities to mental illness for women and men. For example, in Syria, it was found that mental illness in women from low income families was most commonly associated with spousal violence, having many children, illiteracy, financial insecurity and lack of control over their own income. Similarly, in Iran, up to 80% of those who committed or attempted suicide were women of reproductive age who cited marital conflict as the reason for the suicide attempt. (Please see: **Unequal, Unfair, Ineffective and Inefficient. Gender Inequity in Health: Why it exists and how we can change it**).

Women's higher and particular need for access to health services therefore means they are most severely impacted by the degradation of health systems through corruption.

Women act as 'shock absorbers' of poor health-care systems, further adding to the corruption burden they face

Gender inequities in access to money, power and information place women – especially the poorest - in unequal hierarchical positions that can be easily abused for corrupt purposes. In poor households, decisions on intra-household resource allocation are gender biased, with resources primarily invested in the male members of the family, especially in terms of health, food and education. If health expenses for households exceed budgets it can be assumed that women and girls are more likely to be excluded as poor households prioritise their resources for men and boys.

Social factors also determine how likely women are to access health services. According to the WHO study, women in most developing countries are socialised to

give less importance to their own health problems. This leads them to suppress their illnesses and suffer in silence, which has severe consequences for their long-term health. Moreover, in the absence of well-functioning health services, women are expected to provide unpaid 'care' work to younger and older members of the family. Women, therefore, become the 'shock-absorbers' of health systems plagued by corruption, which takes a toll not only on their short and long-term health but also reduces their capacity to participate in education and employment.
(Please see: **Unequal, Unfair, Ineffective and Inefficient. Gender Inequity in Health: Why it exists and how we can change it**).

Women can be disproportionally exposed to corrupt behaviour at the point of service delivery

Not only do women have a higher need for health services themselves, they also traditionally play the role of carers who look after sick family members and take sick children to health centres. This makes them more likely targets for extorting bribes and illegal payments in exchange for appropriate care and treatment.
(Please see: **Engendering development through gender equality in rights, resources and voice**).

In Nicaragua, it was found that women alone represent two thirds of all patients in the public health system. (Please see: **Gender and Corruption in Public Health Services in Nicaragua: Empirical and Theoretical Conclusions for Governance**). It is hardly surprising therefore that, analysing data from Transparency International's Global Corruption Barometer, UNIFEM has presented quantitative evidence that women are more likely than men to perceive high levels of corruption and to feel that their lives are affected by it. They found these differences to be statistically significant and consistent across most regions. (Please see: **UNIFEM's Progress of the World's Women 2008 Report "Who Answers to Women? Gender and Accountability"**).

Women may also face gender specific forms of corruption. Sexual exploitation by officials providing essential services is a form of abuse of power that affects women specifically and has been documented for public services such as police and education, although less so in health. Since they lack access to material resources, sex can also be seen by women as a "currency" to improve their situation and access services they could not otherwise afford. (Please see: **UNIFEM's Progress of the World's Women 2008 Report "Who Answers to Women? Gender and Accountability"**).

Women have a weaker voice to influence health policies, demand accountability and assert their entitlements at the point of service

Women constitute a large proportion of the poor and are therefore highly reliant on public services. Corruption decreases the quality and quantity of public service and imposes disproportionate costs on women. Studies indicate that women are easier targets for corruption because they are often unaware of their entitlements or do not have the resources to seek redress. Even if women are aware of their rights, an absence of effective accountability mechanisms hinders their holding government and other actors accountable.

In some countries, corrupt officials are more likely to systematically and specifically target women. A survey conducted in Bangladesh found that requests for allowances such as maternity and sickness pay were especially subjected to informal speed payment, suggesting that female workers are more likely to be targeted by corrupt superiors. (Please see: **UNIFEM's Progress of the World's Women 2008 Report "Who Answers to Women? Gender and Accountability"**).

At the service design stage, the poor and women have fewer opportunities than elites to inform policy makers of their needs and to organise themselves effectively to demand better service provision. As a result, public services and spending may be designed and resourced by men in a gender-biased manner.

In addition, when public officials are elected through vote-buying, poor women have very little chance to influence policy making processes.
(Please see: "**Engendering Development through Gender Equality in Rights, Resources and Voice**").

Long term impact of corruption on women's health and gender equity

Inadequate access to healthcare due to corruption not only violates a woman's human right to physical integrity but also diminishes working and earning capacity. Corruption in the health sector results in ill health, loss of productivity and a reduction in opportunities for education and income generation, in particular for women.

Corruption also means that money that could be used for women's economic empowerment is allocated to the healthcare of other family members, private medicines, and informal payments, further eroding development prospects for women and reducing the possibility of achieving gender equity.

Corruption in the health sector therefore maintains and exacerbates barriers to women's empowerment. Due to women's restricted access to social and economic opportunities, the gap between the proportion of poor women and poor men has widened in recent years, leading to what is referred to in development literature as the "feminisation of poverty". Corruption in health can be considered a significant contributor to this downward trend. (Please see: **Corruption and the Provision of Health Care and Education Services**).

Gender equity and health are not only important for women, but they are also vital for long term growth of entire communities. There is now a wide consensus among the donor community on this issue - it was recently stated by AusAID that investment in women's (and girls') education and health yield the highest returns of all development investments. This is in no small part due to the tremendous effect that a mother's health and health knowledge has on her children and other members of the family. (Please see: **Gender Equality in Australia's Aid Program – Why and How**). Interestingly, it was found that greater gender equity correlates not only with better health for women but also better health for children. It has been estimated that women's lower status in South Asia is the strongest contributor to malnutrition among children. (Please see: **Closing the Gap in a Generation: Health Equity through Action on Social Determinants on Health**).

Part 2: Solutions to address gender disparities and corruption in health

Women's participation

Tackling gender and corruption issues in essential services requires ensuring that women are adequately represented at all stages of service delivery. A typical approach to anti-corruption is to strengthen transparency and accountability by bringing health service delivery closer to end users. As local agencies are in a better position to tailor services to the needs of their constituencies this approach is expected to make public services more responsive and accountable to local users. However, unless this strategy is accompanied by a deliberate attempt to involve women, gender biases and inequalities in public service delivery are likely to persist. (Please see: U4 Expert Answer on Gender, Corruption and Education, forthcoming). Efforts to promote local self governance should therefore ensure that marginalised segments of the population - including the poor and women - are empowered to participate in the design, implementation, oversight and evaluation of health projects.

A 2006 Nicaragua study on gender and corruption in public health systems more specifically recommends involving women in social or municipal audits, as well as transparency and accountability committees. This is meant to strengthen internal controls by allocating sufficient resources and capacity to oversight mechanisms, promoting civil society involvement in the monitoring of medicine and supplies, and establishing gender-sensitive grassroots level complaints and redress mechanisms. Such interventions are recommended to be accompanied by awareness raising campaigns to inform users of their rights and entitlements as well as posting user fees in all clinics and health centres. (Please see: **Transparency International's Global Corruption Report, 2006**).

Gender responsive budgeting

Another way to take into account gender inequalities before decisions on financing, resource allocation and health sector reforms are made is to promote gender-responsive budgeting in the health sector both at the national and local levels. Gender responsive budgeting (GRB) seeks to ensure that government budgets and

their underlying policies and programs take into account the specific needs of women and that budget decisions are taken in a more accountable manner. UNIFEM has developed an extensive body of experience in this area in many developing countries. (Please see: Gender Responsive Budgeting).

In **Ecuador**, for example, gender-responsive budget work has been implemented in a number of municipalities. In Cuenca, local authorities issued a decree that makes it a priority to hire women for infrastructure projects. The city's budget for the past three years has also included specific funds to foster women's equality, as set out in an Equal Opportunity Plan. Sufficient resources have been devoted to a law entitling pregnant women and newborn babies to free medical care and the government supports local women's groups on programmes to curb violence against women.

In **Mexico**, an extensive mobilisation effort by women's groups persuaded the government in 2003 to earmark 0.85% of the total national budget for programmes to promote gender equality. Since then 14 ministries have been requested to report quarterly on these programmes. In the states of Morelos, Queretaro and Chiapas, the Ministry of Health has turned to a guide for integrating gender issues in health budgets to improve the health services it offers to women and to channel more resources into priority health needs. (Please see: UNIFEM Fact Sheet: Budgeting for Gender Equality).

Women health workers

Early evidence exploring the link between gender and corruption showed a negative correlation between the number of women in the labour force and public office and levels of corruption. However, further evidence conducted in the health sector indicates that women are not intrinsically more honest than men and that with similar power and opportunities they are equally likely as men to solicit illegal payments from patients. However, as doctors, they appear to be less aggressive than men and charge smaller amounts. In addition, women are significantly less likely than men to engage in private practice outside of their official jobs. (Please see: Informal Payments and Moonlighting in Tajikistan's Health Sector). Laboratory corruption experiments confirmed these findings and established that women also tend to react more strongly to the risk of detection. (Please see: Gender Effects in Laboratory Corruption Experiments).

Women's integration in the health work force, both a right and a means for greater gender equality has also shown positive results when it comes to improving health outcomes. In Pakistan, the launch of the Lady Health Workers initiatives in the mid 1990s led to a doubling of contraceptive use and immunisation rates, as well as maternal and child health. This was achieved by bridging the social gap between women clients and service providers through the involvement of educated women from local communities as volunteers or paid workers.

Promotion of ethical standards in the heath sector

Gender-sensitivity in service delivery, less tolerance for corruption and unethical behaviour in the health sector can also be promoted through codes of conduct for health workers. At the level of the individual, such codes can help raise awareness about the consequences of acts of corruption, appeal to personal moral responsibility and help cultivate a sense of professional values and honesty. At a collective level such codes can help clarify permissible standards for acceptable behaviour and increase peer pressure for higher professional integrity.

(Please see:
http://www.healthworkerstandards.scot.nhs.uk/Documents/codeofConductHealthCareSupport.pdf
and:
http://ethics.iit.edu/codes/health.html)

Part 3: Further reading

Who Answers to Women? (Progress of the World's Women report 2008/2009)

This report shows that realising women's rights and achieving the MDGs depends on strengthening accountability to women and gender equality, by increasing the number of women in decision making and promoting gender responsive good governance. The report provides evidence that women's empowerment and gender equality are drivers of poverty reduction, effectiveness of aid and social and economic development.
www.unifem.org/progress/2008/

Informal Payments and Moonlighting in Tajikistan's Health Sector (2008)
This paper studies the relationship between gender and corruption in the health sector. It uses data collected directly from health workers, during a recent public expenditure tracking survey in Tajikistan's health sector. Using informal payments as an indicator of corruption, women seem at first significantly less corrupt than men as consistently suggested by the literature. However, once power conferred by position is controlled for, women appear in fact equally likely to take advantage of corruption opportunities as men. http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1106044#

Gender and Corruption: Testing the New Consensus (2007)
This article explores the gender probity argument to justify women's inclusion in public life as an anti-corruption strategy. The paper concludes that women may not necessarily be less corrupt than men when exposed to opportunities and networks of corruption, especially in collectivist cultures that expect civil servants to fulfil certain obligations such as nepotism and cronyism. The paper concludes that women should be integrated in public life as a right and not an anti-corruption imperative.
http://www3.interscience.wiley.com/cgi-bin/fulltext/114282706/PDFSTART

Gender and Corruption in Public Health Services in Nicaragua: Empirical and Theoretical Conclusions for Governance (2006)
The paper is based on fieldwork carried out in November 2006. In analysing corruption from a gender point of view, it was found that women are more affected by corruption in healthcare because of their biological sex (reproductive cycle); they are the large majority of service users. Corruption is also gendered on the demand side (e.g. referral to private practice of doctors at the public payroll is an almost exclusively male domain).
http://www.eadi.org/fileadmin/WG_Documents/gender_wg/workshop_corruption_seppaenen.pdf

Gender and Corruption – Measuring the disparate impact
This paper explores the gendered impact of corruption, examining the tripartite linkage between Corruption-Poverty and Gender. Studies have shown the clear nexus between gender and poverty and the further linkage to corruption as an engendering factor. This paper interrogates the possibility of measuring the disparate impact in a manner that enables informed policies.
http://www.eadi.org/fileadmin/WG_Documents/gender_wg/workshop_corruption_ekeanyanwu.pdf