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# ANALYTICAL PAPER ON CORRUPTION IN THE HEALTH SECTOR

AZERBAIJAN ANTI-CORRUPTION STRATEGY STUDY

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AZERBAIJAN ANTI-CORRUPTION STRATEGY STUDY

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## ACRONYMS

CCM	Country Coordinating Mechanism
DAI	Development Alternatives, Inc.
GDP	gross domestic product
GTZ	German Technical Cooperation Agency
HAI	Health Action International
LFA	Local Fund Agent
MOH	Ministry of Health
NGO	nongovernmental organization
NRHO	National Reproductive Health Office
PR	Principal Recipient
TB	tuberculosis
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNOPS	United Nations Office for Project Services
USAID	United States Agency for International Development
WHO	World Health Organization



## **FOREWORD**

This report's focus is on analysis of root causes of corruption in the health sector and vulnerabilities that allow corruption (as well as inefficiency and other forms of waste of public resources) to occur. In the course of this study, some people interviewed expressed concerns about maintaining anonymity, fearing potential repercussions from disclosure of personal experiences with or knowledge about corruption. To address these concerns and protect confidentiality, we have not listed contacts or field sites except to describe official meetings held with Ministry of Health (MOH) officials.

This anti-corruption assessment in the health sector was conducted under the previous Minister of Health. During the final days of the consultancy, the Minister was replaced, and other people within the MOH have also left since, including several who were interviewed for this study. The assessment reflects the situation and MOH direction at the time of the analysis, and recommendations should be considered in light of any changes that the new administration may put in place.

The authors are solely responsible for the substantive content of the paper. The views expressed in this paper have been reviewed by the study team leader but have not been endorsed by Development Alternatives, Inc.



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## I. PURPOSE AND METHODS

This review of health and anti-corruption in Azerbaijan is part of a larger USAID/Azerbaijan Anti-Corruption Study and Strategy Development, implemented with assistance from Development Alternatives, Inc. (DAI). The purpose is to:

- Assess the adequacy of the administrative and regulatory framework for the Ministry of Health (MOH) and describe constraints to effective operation;
- Assess the extent, nature, and organization of corruption in the health sector;
- Identify corrective actions and changes to fully implement laws and regulations and monitor operations; and
- Identify resources needed and supporters of reform activities.

The review was conducted through document review and interviews. We met with MOH officials, government medical staff and former staff, staff and former staff of externally funded projects, private providers, and members of the general public.

The study viewed corruption as the result of vulnerabilities in government institutions and policies, unregulated discretion, and poor control systems. Within this environment, government agents can easily act to pursue their own self-interests instead of serving the public interest: with little chance of being caught or punished, the rewards of corruption outweigh the costs.<sup>1</sup> To deter corruption, we must change the policies and systems that allow this economic equation to favor corruption.

We applied a control systems review approach to 1) identify areas of high vulnerability to corruption based on risk factors, and 2) evaluate the adequacy of existing control mechanisms to minimize risks. This approach focuses mainly on prevention of corruption through improvement of incentives, administrative management structures and tools, and transparent monitoring.

The study was not designed to measure corruption indicators or experiences such as inflated supply prices, absenteeism rates, or reported experience offering bribes or being asked to make them.<sup>2</sup> It also was not designed to identify healthcare fraud using forensic accounting techniques. In working only with individuals' perceptions of corruption rather than with measures of actual experience with corruption, we recognize that we may be overestimating the extent of corruption in the health sector. In Bulgaria, comparisons of measures of perception and experience with corruption show that perceptions are consistently higher than actual experience.<sup>3</sup> Nevertheless, perception that corruption is involved in public services can weaken confidence in government and is therefore cause for concern.<sup>4</sup> In addition, strategies to reduce the risk of corruption can also reduce government inefficiencies and waste, and are worth pursuing for this reason as well.

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<sup>1</sup> Klitgaard, Maclean-Abaroa, and Parris, 2000, pp. 22–7.

<sup>2</sup> These methods have been used to identify and deal with problems of corruption in Latin American hospitals, as documented in DiTella and Savedoff, 2001. Such studies take more time to plan and implement, however.

<sup>3</sup> Krastev, 2004, pp. 84–5. See also Miller, Grodeland, and Koshechkina, 2001.

<sup>4</sup> World Bank, 2003.



## II. BACKGROUND AND CONTEXT

This section provides basic background information on the organization and financing of the health sector in Azerbaijan and health status indicators. It also discusses current issues and controversies that have implications for progress in reducing vulnerability to corruption, and reviews experiences in selected other countries.

### A. HEALTH SYSTEM AND HEALTH STATUS

The constitution of the Azerbaijan Republic guarantees the people the right to protection of health and to medical care. This has been interpreted to mean that healthcare is the responsibility of the state, and that most healthcare services should be provided free of charge. Government services are provided through an extensive network of more than 4,300 health facilities, with an oversupply of hospitals including republican (teaching) hospitals, central district hospitals, rural hospitals, polyclinics, and private hospitals. The country has ample medical personnel, although medical practice protocols and education curricula are outdated and non-evidence-based in many areas. Azerbaijan has a high number of hospital beds per population when compared to the European Union-15 average. Bed occupancy is low, while length of stay is long: the World Health Organization (WHO) estimated in 2003 that average bed occupancy in acute care hospitals was only 26 percent, while length of stay was 15.8 days.<sup>5</sup> There is a small but growing private sector in Azerbaijan, and almost all pharmacies and dental clinics are privately owned. Parallel healthcare systems serve the Ministries of Oil, Railways, and Defense.

The healthcare system is severely underfunded, with unequal access to services and poor quality of care, especially in rural areas. Government funds are insufficient to cover salaries at a level required to meet basic living standards or finance infrastructure and pharmaceuticals. The government spent less than 1 percent of gross domestic product (GDP) on health in 2004, and the hospital sector received the greatest share of spending. Healthcare services are mostly paid for by out-of-pocket expenditures (about 75 percent of total health expenditures). Informal payments represent approximately one-third of all out-of-pocket spending. While mandatory health insurance has been approved as a policy reform in 1999, it has yet to be implemented.

External partners and financing sources in the health sector include the U.S. Agency for International Development (USAID), the World Bank, the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), WHO, the German Technical Cooperation Agency (GTZ), and the Global Fund. Azerbaijan recently completed a five-year, \$5 million Primary Health Care project funded by the World Bank and implemented in collaboration with UNICEF. The UNICEF implementation component ended under a cloud of corruption allegations, and the country representative has been replaced. Negotiations for a second, larger follow-on loan for \$50 million have been slow and the MOH has threatened to turn down the loan. The Azerbaijan MOH also declined to participate in a multisector early childhood development project financed by the Asian Development Bank. UNICEF and WHO are collaborating on immunization program support, and GTZ assistance is supporting tuberculosis (TB) treatment services. Azerbaijan won its first Global Fund grant, for HIV/AIDS program support, in 2004, and a second award, for the TB program, in 2005.

USAID funds projects supporting primary healthcare service delivery and health reform, reproductive health, child survival, emergency medicine, health information (demographic and health survey), and marginalized children. In addition, USAID's accomplishments in the area of community development

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<sup>5</sup> World Bank, 2005.

are relevant to anti-corruption strategies that rely on participation of civil society. For example, under the recently ended Azerbaijan Humanitarian Assistance Project, which involved several international nongovernmental organizations (NGOs), community members were mobilized to create health facility boards or community health funds to manage community-based cost recovery schemes in order to solve health problems using local resources. This approach promoted accountability through community oversight and management tools such as accounting and information systems. Such tools have been associated with reduced informal payments and input prices paid.<sup>6</sup>

## **B. ISSUES AND CONTROVERSIES**

Data reliability is an important concern in Azerbaijan. The World Bank and WHO have noted that official health statistics may not reflect real health needs because many people do not seek care in the government facilities from which the official statistics are generated.<sup>7</sup> At the same time, more than one government official interviewed suggested that external development agencies may be exaggerating estimates of mortality in order to paint a dismal picture of the situation in Azerbaijan and raise more funds for themselves. Survey statistics from UNICEF's multi-indicator cluster survey, and a USAID/Centers for Disease Control and Prevention-sponsored reproductive health survey, indicate that mortality rates are several times higher than those reported in MOH and vital statistics reporting systems. Indicators of healthcare-seeking behavior and expenditures, collected from household-level surveys, show large numbers of people not accessing care due to lack of funds. While external partners and government officials agree that there is a pressing need to increase government financing in the health sector, questions about data reliability prevent agreement on priority interventions to pursue.

Disagreement also exists on the need to “rationalize” the hospital sector by decreasing hospital beds and reducing staff. Several government officials interviewed were not in favor of reducing beds or staff, and the WHO representative suggested that beds needed to be kept at current levels in order to be prepared in case of natural disaster or a bioterrorist attack. The inability to agree on a statistical baseline and to gain traction on health reforms are important contextual factors affecting anti-corruption strategies.

Factors outside the health sector also influence the nature and extent of corruption in health. In Azerbaijan, some of these factors include the radical transformation of political and economic systems post-Soviet Union, increasing poverty and social inequities associated with social and economic change, the legacy of war with Armenia and the resulting large population of internally displaced people, the influence of relationships and clanship on public choices and government, the ineffective judiciary and legislature, and the expected large increase in GDP in 2005–2006, estimated at 26–30 percent per year, due to increased oil prices (Azerbaijan's major export).<sup>8</sup>

Finally, this consultancy took place during the run-up to parliamentary elections in the first week of November. On October 20, 2005, several ministers were dismissed from office on the order of the President, including the Minister of Health.<sup>9</sup>

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<sup>6</sup> DiTella and Savedoff, 2001.

<sup>7</sup> G&G Consulting, 2003, p. 7.

<sup>8</sup> Kostanyan, 2003. Increasing GDP was noted by USAID officials.

<sup>9</sup> Sultanova, 2005.

## C. OTHER COUNTRIES' EXPERIENCES

Other countries in the region are beginning to confront corruption in the health sector. Studies have been completed on corruption in reproductive health and maternal and child health services in Armenia,<sup>10</sup> pharmaceuticals in Bulgaria,<sup>11</sup> and the health sector in general in Albania.<sup>12</sup> In addition, the 2006 Global Corruption Report by Transparency International will focus on corruption in the health sector.<sup>13</sup> Findings from these efforts may help inform policy in Azerbaijan.

In both Armenia and Azerbaijan, most healthcare spending is private and much is informal: out-of-pocket spending is 3.5 to 4 times greater than state budget allocation in Armenia,<sup>14</sup> compared to Azerbaijan, where out-of-pocket spending is about 3 times higher than state budget spending.<sup>15</sup> A large portion of out-of-pocket payments in Armenia are informal. Informal payments are made to all levels of staff, from doctors and nurses to janitors. Even hospital visitors may be asked to pay informal fees. Patients are either unaware of their right to free services or too vulnerable to demand them, and analysts believe that unnecessary restrictions on who can provide certain services at what levels, including deliveries and abortions, have increased the informal and formal costs of care and restricting access.<sup>16</sup>

Systemic pressures also reinforce the practice of informal payments in Armenia, including very low government funding for public health, medical reimbursement rates set lower than true cost, and problems with accrual accounting in public financial systems.<sup>17</sup> Many stakeholders in Armenia are confused about how public financing flows in the state-funded system. Facility heads had little understanding of budgeting and forecasting and were not prepared to manage scarce funds efficiently. This situation appears similar to Azerbaijan's.

In Albania, government officials perceived that most informal payments were based on tradition and were gratitude payments.<sup>18</sup> Qualitative and quantitative studies helped to demonstrate that this was not the case. Quantitative studies documented out-of-pocket expenditures, separating gifts from other informal payments. Qualitative studies revealed objections to informal payments, not only by patients but also by providers who felt trapped into asking for them. Senior leaders now recognize that informal payments are not, for the most part, based on tradition, and that they have harmful effects. This in turn has built support for reforms to decrease the payments.

Like Azerbaijan, Armenia also has problems with data reliability. In examining the drivers of official misreporting in Armenia, Pereira (2005) identified the primary factors as rigidity in financial systems (lack of line-item flexibility) and poor management control systems that punished managers for failure to achieve plans, without any analysis of reasons for variance. Other factors identified as

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<sup>10</sup> Pereira, 2005.

<sup>11</sup> Study conducted for USAID on government effectiveness and pharmaceutical provision, looking especially at weaknesses in the supply chain from drug approval and registration to selection, pricing, procurement, distribution, and use. Center for Institutional Reform and the Informal Sector (IRIS), Department of Economics, University of Maryland. Contact: Patrick Meagher, Associate Director (meagher@iris.econ.umd.edu). The study was conducted in 2004 but has not been released.

<sup>12</sup> Vian, 2003.

<sup>13</sup> Transparency International, forthcoming.

<sup>14</sup> Pereira, p. 4.

<sup>15</sup> World Bank, 2005, p. 36, citing G&G Consulting, 2005.

<sup>16</sup> Pereira, 2005, p. 4.

<sup>17</sup> Pereira, 2005, p. 8.

<sup>18</sup> Vian, 2003.

“enabling” corruption included health policies and standards that are not well-disseminated and sometimes inconsistent, and a pressure to implement health reform without first building the necessary regulatory framework and management capacity. Finally, analysts have noted that “clanism” in Armenia has created an environment where powerful interests are tied to the current informal systems, making it more difficult to mobilize support for reform from within the healthcare system.<sup>19</sup> Recommended anticorruption reforms include increasing patient awareness of free services and the budget process, and getting community action groups to undertake watchdog functions.

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<sup>19</sup> Pereira, 2005, p. 3.

### III. FINDINGS

Five areas of vulnerability to corruption are discussed in this report and shown in Table 1, including 1) human resources management, 2) service delivery and informal payments, 3) pharmaceutical policy and management, 4) financial management, and 5) the new Global Fund grant mechanism, under which Azerbaijan has been awarded two grants for HIV/AIDS and TB. People described corruption as being present in the medical education system, e.g. bribes paid for exam grades and over-production of doctors which leads to bribes paid to obtain positions in medical facilities; however, we did not have enough information to analyze these issues in detail.

The USAID Primary Health Care Strengthening Project, which started in September 2005, will review laws and policies that regulate health care financing. Of special interest to the anti-corruption project will be laws and regulations pertaining to private practice of medicine. Annex A highlights components of health law on private practice of medicine which should be considered during the Project's legal review.

**TABLE 1: FUNCTIONS WITH VULNERABILITIES TO CORRUPTION IN AZERBAIJAN'S PUBLIC HEALTH SYSTEM**

Function	Vulnerabilities	Possible Results
Human resources management	<ul style="list-style-type: none"> <li>▪ Excessive discretion and lack of transparency in hiring, promotion, and dismissal or disciplinary decisions</li> <li>▪ Oversupply of medical professionals, creating rent-seeking opportunities</li> <li>▪ Poor government pensions, creating disincentives to retirement and further imbalance in labor supply and demand</li> </ul>	<ul style="list-style-type: none"> <li>▪ Jobs are "bought": medical personnel pay to keep job or to obtain promotion</li> <li>▪ To obtain money to pay for or retain job, government medical personnel charge patients informally and/or hold second jobs or see private patients, possibly using government resources</li> <li>▪ Government medical personnel are accountable to the person who hired them and has power to fire them, rather than to the public or to the MOH's mission</li> </ul>
Service delivery	<ul style="list-style-type: none"> <li>▪ Very low salaries for medical personnel, combined with excessive discretion and lack of transparency mentioned above</li> <li>▪ Budgeting based on inputs rather than in relation to activity</li> <li>▪ Provider payment that is unrelated to performance</li> <li>▪ Weak routine data systems</li> <li>▪ Medical staff are punished for poor health outcomes of population</li> </ul>	<ul style="list-style-type: none"> <li>▪ Informal payments required for treatment that is supposed to be free</li> <li>▪ Medical personnel exaggerate diagnoses, favor more expensive treatment options (such as abortion rather than contraceptives), or require medically unnecessary diagnostic tests and treatments to increase informal payments</li> <li>▪ No accountability for performance of medical personnel or facilities: medical personnel could be absent or not perform their functions</li> <li>▪ Falsification of health outcome data to avoid disciplinary action</li> </ul>
Pharmaceutical policy and management	<ul style="list-style-type: none"> <li>▪ Inadequate enforcement of drug and pharmacy licensing policies, inadequate staffing, and lack of administrative mandate to impose fines</li> <li>▪ Conflict of interest: physician ownership of pharmacies and ancillary facilities</li> <li>▪ Lack of objective drug information or controls on physician-pharmaceutical company interactions</li> </ul>	<ul style="list-style-type: none"> <li>▪ Bribes by private companies or pharmacies to bring drugs into the country without licensing and registration</li> <li>▪ Government doctors and administrators with ownership in private pharmacies have little incentive to make sure drugs are available free in government facilities</li> <li>▪ Irrational prescribing</li> <li>▪ High drug costs</li> <li>▪ Fake and sub-therapeutic drugs on the market</li> </ul>

Function	Vulnerabilities	Possible Results
Financial management	<ul style="list-style-type: none"> <li>▪ Bifurcation of funding sources without true provider-payer split</li> <li>▪ Lack of common understanding of rules for official fees and systems for collection</li> </ul>	<ul style="list-style-type: none"> <li>▪ Lack of accountability for efficient and effective use of resources to achieve objectives</li> <li>▪ Diversion of budgeted funds or official fee revenue</li> </ul>
Global Fund program management	<ul style="list-style-type: none"> <li>▪ Newly created management structure lacking experience (Country Coordinating Mechanism [CCM] and Project Implementation Unit)</li> <li>▪ Pressure to complete budget within short timeframe</li> <li>▪ Large number of subgrantees</li> <li>▪ Conflicts of interest affecting participation in meetings to allocate grant funds, monitor implementation, and supervise subordinates</li> </ul>	<ul style="list-style-type: none"> <li>▪ Decisions favoring the interests of the organization represented by the person with a conflict of interest, with direct financial benefit to the organization or individual</li> <li>▪ Loss of reputation, integrity of the Global Fund program, and trust in activities and reported results</li> <li>▪ Procurement fraud</li> </ul>

## A. HUMAN RESOURCES MANAGEMENT

We found excessive discretion and a lack of transparency in decisions related to hiring and disciplinary actions for government health workers. Job vacancies are not widely publicized, and criteria for selecting candidates are not standardized or made public. Similarly, supervisors have a great deal of discretion in procedures to discipline employees.<sup>20</sup> Table 2 outlines the current lines of hiring authority, as described by MOH personnel.

**TABLE 2: ADMINISTRATIVE DISCRETION IN HIRING**

Staff Level	Appointment Procedures
Minister, Deputy Minister	Appointed by presidential decree
Staff employees of MOH (currently 68)	Appointed by the minister with approval of the Collegium (board composed of senior health officials)
Young specialists, just graduated	Cannot apply to jobs in the public sector without approval of the MOH human resources department
Chief doctor of MOH-financed medical facilities	Appointed by the minister with approval of the Collegium
Other staff working in MOH-financed medical facilities	Appointed by the chief doctor
District chief doctor/chief of health department	Appointed by the minister with approval of the Collegium and “with advice” of the district Executive Committee
Other staff in district facilities	Appointed by the chief doctor/chief of health department

<sup>20</sup> It is possible that checks on discretion and properly documented personnel selection, promotion, and disciplinary processes do exist at the regional or district level. However, the fact that few people can describe these procedures, and most believe they do not exist, is in itself a problem.

Weaknesses in human resources management, extremely low salaries, and the opportunity to collect informal fees for service in government health facilities may lead people to pay bribes to obtain government jobs.<sup>21</sup> Another factor increasing the risk of bribes for jobs is the current imbalance in supply of and demand for health workers; many more medical professionals enter the job market each year than are needed. The MOH estimates that Azerbaijan graduates 2.5 times as many doctors per year than are needed, and the World Bank (2005) estimates that there is a 30 percent oversupply of physicians at the national level.<sup>22</sup> The World Bank report also noted imbalances in distribution of medical personnel by location (favoring urban) and function (favoring hospitals), possibly exacerbated by the better opportunities to obtain informal revenue in urban hospitals.<sup>23</sup>

In addition, pension policies provide a disincentive to retirement. It appears that government workers who are at the mandatory age for retirement may opt to continue working at full salary if they agree to receive only half of their pension. According to the MOH personnel director, most people of retirement age opt to continue working, presumably receiving full salary and half pension. The retention of these older workers keeps new places from opening up in public service and creates more pressure for employment bribes.

Interviews suggest that a doctor might be asked to pay \$10,000–\$30,000 for a position as a hospital-based government medical care provider, while a higher-level official—such as an administrator who is also a provider of medical services—might pay much more. Once having paid to obtain a position, government medical personnel may be asked to continue making payments to maintain their positions or to obtain promotions. Reportedly, the expected payment is calibrated to the informal earning capacity of the medical staff member. Personnel who do not make such payments could risk dismissal, demotion, or transfer to an undesirable posting, although if a person does not have high earning capacity he might not be asked to make regular payments.

The costs of this type of corruption are that medical personnel have great incentive to charge patients informally for care and to prescribe unnecessary treatment to increase their revenue. These issues are described further in the next section. Another effect of corruption is that medical personnel who wish to retain their positions but do not want to charge patients in public facilities for care that is supposed to be free must find a way to afford the maintenance payments. This can be an incentive to take on another job (resulting in occasional absenteeism from the government job), maintain a private practice on the side after hours, or work in a private clinic on government time.

Lack of control systems for decisions to fire employees creates two types of situations. First, an official with hiring discretion can fire an employee who does not make the necessary maintenance payments to keep his or her job, then extort payment from the employee to be reinstated. Second, a poorly performing employee who was rightfully dismissed may be able to bribe his or her way back into the government health system.

Too much discretion also may be a cause of kickback situations involving externally funded projects. For example, staff who are entitled to travel reimbursement are reportedly forced to share a portion of this reimbursement with government supervisors. The employee may be denied further opportunities to work with externally funded projects unless the kickback is made. This practice was described by many people interviewed, and one donor representative even reported having frank discussions with officials about the payments, suggesting that the practice is considered acceptable and is not hidden.

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<sup>21</sup> This issue is also mentioned during a discussion of salaries for medical personnel in World Bank, 2005, Vol. II, p. 99.

<sup>22</sup> Interview with MOH Director of Personnel, October 20, 2005; World Bank, Vol. II, p. 72.

<sup>23</sup> World Bank, Vol. II, p. 120.

Excessive discretion may be due to lack of proper control systems for human resources management functions, resulting in a form of administrative corruption; however, many people perceive that corruption in human resources management in the MOH is organized vertically: very high officials are involved in a pyramid of payments to retain positions. This type of organization would make the problem less amenable to bureaucratic solutions such as revision of staff responsibilities, development of personnel manuals, or new hiring procedures.

One MOH official suggested that information system improvements could reduce vulnerability to corruption by putting in place a database of job listings for all health positions (including regional as well as Baku-based postings). This is a step in the right direction.

We did not explore supply of nurses or their motivations to accept informal payments. The World Bank reported low levels of nursing resources devoted to clinical care because of the excess of doctors.<sup>24</sup> It appears that informal payments are made to nurses and nurse-midwives, but they may be lower amounts. Future surveys might try to gather more information on informal payments to nurses.

## **B. SERVICE DELIVERY**

Problems related to corruption in service delivery include the practice of requiring informal payments for drugs and services that are supposed to be provided by government personnel free of charge; inducing demand, where medical providers prescribe unnecessary or more expensive tests, procedures, and drugs in order to increase informal or formal revenue; and using government resources for private practice without authorization.

It is important to note that many health researchers do not agree that the first two problems, informal payments or induced demand, are necessarily corruption.<sup>25</sup> For example, it can be difficult to distinguish under-the-table payments, which are coping mechanisms undertaken by grossly underpaid workers as a survival strategy, from payments used by medical workers for personal enrichment and given by fearful patients who believe they cannot get care any other way. Likewise, it is hard to tell when smaller informal payments are being offered freely to express respect (“making hermat”) or are given because patients feel obliged to give. Gratitude payments are rooted in tradition in some Commonwealth of Independent States/Central and Eastern European countries, as documented in Hungary, Armenia, and Albania.<sup>26</sup> In terms of induced demand, it can be hard to tell when a procedure is outside what is considered the range of allowable discretion in medical decision making. Induced demand is sometimes seen as a predictable economic effect of the structure of provider payment systems, rather than as corruption. Nevertheless, these practices should be controlled.

The systemic roots of these problems are similar. Vulnerabilities include very low salary levels for public employees, lack of incentives, and weak management tools such as information systems.

### **LOW PAY**

Medical personnel in the government health system are very poorly paid. In 2003, medical personnel earned AZM 108,900 per month, on average (\$22).<sup>27</sup> Salaries were increased by 50 percent in June

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<sup>24</sup> World Bank, 2005, Vol. II, p. 130.

<sup>25</sup> Van Lerberghe, et al., 2002; Ensor, 2004.

<sup>26</sup> Gaal and McKee, 2005; Vian, Gryboski, Hall, and Sinoimeri, 2005; Pereira, 2005; and Balabanova, McKee, Pomerleau, Rose, and Haerpfer, 2004.

<sup>27</sup> World Bank, 2005, Vol. II, p. 98.

2003, but are still less than half the national average.<sup>28</sup> This creates an incentive to charge patients informally for services that are supposed to be provided free of charge.

Evidence from out-of-pocket expenditure surveys in Azerbaijan suggests that gratitude payments represent a small fraction of informal payments and that most payments were not made willingly to show satisfaction.<sup>29</sup> In addition, the strong incentive of health workers to collect informal payments in order to keep their jobs, as discussed in the previous section, suggests that the informal payments go beyond what is normally considered an “institutional survival strategy.” The argument for informal payments as institutional survival strategy goes something like this: in the post-Soviet era, because of collapsed economic performance and subsequent low government revenues, medical personnel have had to ask patients for informal payments as a coping mechanism. Government officials ignore or overlook these payments because the practice is seen as a necessary price to ensure government staff will continue service.<sup>30</sup> This argument assumes that government workers are collecting only enough revenue to “cope” or earn a living wage, and that government administrative officials are not colluding in the capture of informal revenue. Many people believe that, contrary to this argument, government officials are colluding and sharing in the informal revenue streams in Azerbaijan.

### **LACK OF INCENTIVES AND MANAGEMENT TOOLS**

One effect of informal payments is reduction in demand for health services. People simply do not come. There is evidence that this is happening in Azerbaijan: for example, a household survey of healthcare-seeking behaviors found that while 94 percent of respondents reported experiencing an illness that was serious enough to treat, only 48 percent actually used health services.<sup>31</sup> Both poor and better-off respondents cited lack of money as the main reason why they did not seek treatment.<sup>32</sup>

In addition, patients who can afford to pay or have the opportunity to borrow funds may be shifting to private facilities. This may be because the quality is perceived to be better (as suggested in World Bank, 2005), although the quality of private clinics has not been measured. In fact, it is possible that price is a driver for utilization: one person interviewed for this study hypothesized that when informal payments are included, a normal birth delivery in a public hospital may actually cost more than in a private hospital.

Although it is clear that informal payments are a cause of low utilization, there are few incentives for medical personnel to increase utilization. As a result, there is no pressure to stop the informal payments. The financing model for health services is input-driven (that is, based on numbers of beds and staff), rather than activity-based (driven by population served, service utilization, or outcomes), and providers are paid a salary that is unrelated to performance. Under such a system, there are few incentives for facilities or providers to increase access or utilization by decreasing informal payments.

In addition, management tools to measure performance—including management information systems that report on utilization of services in comparison with resources used in producing those services, and quality assurance measurement systems—are weak. Tools like these, in conjunction with independent “performance audits” (to verify reporting accuracy) could help detect abuses in utilization of unnecessary procedures, or physician discretion for treatment decisions that is used to

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<sup>28</sup> World Bank, 2005, Vol. I, p. 34.

<sup>29</sup> World Bank, 2005, Vol. II, p. 103.

<sup>30</sup> World Bank, 2005, Vol. II, p. 139.

<sup>31</sup> World Bank, 2005, Vol. II, p. 55.

<sup>32</sup> World Bank, 2005, Vol. II, p. 55.

increase revenue rather than implement best-practice protocols. One person interviewed described how utilization analysis helped to detect a neonatal condition (intercranial hypertension) that was being overdiagnosed, possibly to increase informal revenue sources for providers. Strategies to reduce excess utilization will need to include revisions to approved curriculum.

Some progress is being made in information systems. The MOH is investing in a new National System for Health and Environmental Monitoring, which will improve the registration of deaths and births, and USAID and UNICEF are assisting the MOH in supporting a Demographic and Health Survey that will provide population-based measures of utilization and outcomes. However, facility-based reporting systems for utilization and use of resources in producing health outputs also must be improved and linked to financing and provider payment decisions.

### **C. PHARMACEUTICAL POLICY AND MANAGEMENT**

Vulnerabilities in pharmaceutical policy and management to corruption include heavy reliance on a largely unregulated private sector for procurement and distribution, lack of management and regulatory capacity, conflict of interest in pharmacy ownership, strong promotion of pharmaceutical products to physicians by industry representatives, and poor management control systems for stock management. Specific types of corruption that can result from these vulnerabilities include bribes to register and license drugs and operate pharmacies (or to avoid penalties for operating without a license); corruption in public procurement, resulting in higher prices and lower quality; diversions of supply from the public to the private sector in order to charge for drugs that should have been provided for free; and prescribing decisions that are based on financial incentives and commercial interests rather than clinical need.

Low public spending on pharmaceuticals limits access to safe, effective, reasonably priced drugs. Per capita expenditure on medicines in Azerbaijan is \$2, the lowest in the region. Public spending on pharmaceuticals as a percentage of total public spending on health is thought to be around 10 percent, lower than most other countries in the Caucasus and Central Asia regions.<sup>33</sup> Finally, pharmaceutical expenditures as a percentage of total out-of-pocket healthcare spending is among the highest in the region; studies report 61–71 percent, showing that the burden falls mostly on patients.<sup>34</sup>

An important structural consideration in Azerbaijan is that pharmaceutical distribution is almost completely privatized, increasing the need for the government to play a strong role in pharmaceutical policy and regulations. Most drugs are privately imported (98 percent) and expensive, domestic production is limited, and there is a large unregulated informal market for drugs.<sup>35</sup> There is an approved essential medicines list, but it does not appear to be disseminated and is of limited use given the nearly total reliance on private distribution systems. While precise estimates are difficult to obtain, many drugs in Azerbaijan do not pass customs and may not be inspected. The central drug warehouse system managed by the MOH procures and supplies a very limited range of drugs, mainly for TB, diabetes, and cancer.<sup>36</sup>

In addition to lack of public investment in medicines and gaps in policy and regulation, pharmaceuticals management in the public sector is weak. The MOH and regional facilities do not have adequate management control systems and lack training in management of drug supply.

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<sup>33</sup> World Bank, 2005, Vol. II, p. 165, and Table 7.1, p. 161.

<sup>34</sup> World Bank, 2005, Vol. II, p. 160.

<sup>35</sup> World Bank, 2005, Vol. II, pp. 162–3. The figure of 98 percent is from the MOH Director of Pharmacy Services.

<sup>36</sup> Interview with the MOH Director of Pharmacy Services, October 20, 2005.

Vulnerability in pharmaceutical supply systems puts at risk the financial investments in antiretroviral drugs made through the Global Fund. In addition to potential procurement fraud, which can result in higher prices and lower-quality drugs, corruption in pharmaceutical management increases the risk for stock-outs that could lead to disrupted treatment, causing treatment failure and antiretroviral resistance, which has profound effects on worldwide access to effective treatment.

The MOH lacks resources to enforce regulations on licensing and registration of drugs and pharmacies. The Laboratory for Drug Expertise and Registration has only 10 inspectors, and a presidential directive that would allow the MOH to apply administrative measures such as fines has not yet been approved by the Council of Ministers.<sup>37</sup>

Another potential factor leading to corruption is the lack of statutes to limit conflict of interest in ownership of private pharmacies. According to MOH officials, health laws allow any legal entity to own a pharmacy, including legal entities with public-sector employees (doctors and health administrators) as principals. The risk for corruption is that if the hospital director (or sibling or other relative) is the owner of a private pharmacy, he or she has less incentive to ensure that free drugs are available through the public system. Some private pharmacies actually operate on hospital grounds. This is not a bad thing from the viewpoint of patient convenience, but there must be adequate controls to ensure that profit sharing goes back into the hospital budget and benefits the institution.

Finally, several people interviewed mentioned that pharmaceutical promotion is pervasive; drug representatives contact doctors frequently and offer gifts and hospitality in return for the doctors prescribing their proprietary drugs. There is strong evidence in the literature that physician interaction with pharmaceutical representatives does influence medical practice patterns, resulting in decisions that place commercial objectives above client needs.<sup>38</sup> As far as we could determine, Azerbaijan does not have regulations or guidelines in place to control potential conflict of interest or regulate interactions between doctors and industry, nor are there many independent sources of drug information.

#### **D. FINANCING AND FINANCIAL MANAGEMENT**

The health financing situation in Azerbaijan has been documented in several key reports.<sup>39</sup> Other than informal payments, discussed earlier, the most important aspects to consider from an anti-corruption viewpoint include the following:

- **There is no social insurance or public contracting for service delivery.** This does not promote efficiency, but it also means that reimbursement fraud is not (yet) an issue. Although a public health insurance law passed in 1999, it has not been implemented.
- **Funding is bifurcated in a way that does not support accountability for performance.** The Ministry of Finance channels 75 percent of government health funds directly to districts, while 25 percent is allocated to the MOH (see Annex B).<sup>40</sup> This sounds like devolution—which can in theory bring government closer to the people and enhance accountability—except that the MOH is still responsible for overall government health services performance and consolidates the local

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<sup>37</sup> Interview with the MOH Director of Pharmacy Services, October 20, 2005.

<sup>38</sup> Komesaroff and Kerridge, 2002; and Wazana, 2000.

<sup>39</sup> See, for example, G&G, 2003; Holly, Akhundov, and Nolte, 2004; and World Bank, 2005.

<sup>40</sup> World Bank, 2005, Vol. II, p. 93.

budget requests to submit to the Ministry of Finance.<sup>41</sup> Medical personnel in district hospitals and lower-level health facilities are paid by local budgets; however, the chief district doctor is appointed by the Minister of Health (see Section A). This division of responsibilities makes lines of authority unclear, especially related to budget monitoring, supervision, and local discretion in setting priorities for spending.

- **Managers lack understanding of financial issues and budget information is not transparent.** Even at the level of deputy chief of a district hospital we visited, there was little understanding of different sources of financing, requirements for accountability, or financial management functions. Budget information is also not easily available to managers, and it is certainly not available to citizens for oversight.
- **The budgeting process is based on inputs rather than needs, which provides few incentives for efficiency and may create incentives for “ghost workers” and “ghost beds.”** When budgeting is input-based, a risk for corruption is that people will lie and say that more beds exist in a facility, or that there are more staff than actually exist. Some people interviewed reported instances of such falsification of data. Staff may also exist and be paid, but not have to show up for work. Interviewees noted that with this practice, a person could hold more than one full-time equivalent government job (that is, be employed 125 percent or 150 percent). While there should be controls on this practice, the bifurcated funding system may make it difficult to detect. Short of corruption, input-based budgeting creates resistance to decreases in staffing, beds, and facilities, even if these decreases are justified based on low utilization and staff productivity or changes in medical practice standards (a move toward more outpatient surgery, for example). An earlier World Bank primary healthcare project tried to promote policy change in the way health budgets are created. The project proposed the use of detailed district-level plans following a needs-based methodology and stakeholder participation.<sup>42</sup> Proposed reforms also included a decrease in inpatient facilities, beds, and personnel; an increase in primary care clinics; and reorientation of personnel toward primary care, general practice, and prevention. According to interviewees, none of these proposed policy changes was implemented by the government.
- **Policy on official user fees for government services is unclear, leading to the risk that official revenue is being pocketed or that patients are being deceived regarding informal payments.** Some government medical personnel at local levels reported that user charges are permitted for surgical procedures, while other officials claimed that official user charges had been phased out. Official policy documents have reported that user fees were to be phased out starting in 2003. Confusion in policy makes it difficult to control official user fee collections and compare them with utilization, the most common method of detecting when employees are pocketing funds. Confusion may also mean that patients think they are making formal payments, when actually the payments are informal. It is important to distinguish formal from informal payments if the government wants to make insurance systems work at a later date.<sup>43</sup>

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<sup>41</sup> G&G, 2003, p. 16.

<sup>42</sup> G&G, 2003, p. 14.

<sup>43</sup> See discussion of how informal payments can reduce citizens' willingness to pay for health insurance in Vian, et al., 2005; also Hotchkiss, et al., 2004.

## E. GLOBAL FUND

The Global Fund is an international funding mechanism created in 2001 to support public-private collaborations to fight HIV-AIDS, TB, and malaria. In its first two years of operation, the Global Fund awarded \$3.1 billion to 128 countries. Azerbaijan participated in the fourth round of proposals in 2004, and won a grant for \$11.7 million for HIV/AIDS program activities that is just now starting to be disbursed. Azerbaijan recently learned that it has won a grant for TB control as well.

### COUNTRY COORDINATING MECHANISM

The Global Fund Country Coordinating Mechanism (CCM) is a key governance structure. The CCM's role is to facilitate public-private collaboration in the development of grant proposals and monitoring of implementation. While the Global Fund's guidelines for CCM structure and operation are fairly general, other countries' experience with CCMs has been analyzed to draw lessons learned on how to improve CCM governance in Azerbaijan.<sup>44</sup> Box 1 summarizes some of the problems that CCMs have faced in other countries and may face in Azerbaijan. Table 3 summarizes common characteristics of advanced and well-functioning CCMs, which may contribute to better governance, and compares them to Azerbaijan's CCM.

### LOCAL FUND AGENT

The Local Fund Agent (LFA) is another key governance structure for the Global Fund. The LFA is, literally, an agent of the Global Fund with principal oversight authority at the country level. In Azerbaijan, the Fund has chosen the UN Office for Project Services (UNOPS) as its agent.<sup>45</sup> UNOPS is responsible for ensuring that the MOH, as Principal Recipient of the grant, is accountable for progress achieved and how the money is spent. The LFA can make spot-checks of records and grant activity, inspect goods received, and call for special audits if needed. The LFA ensures that the Principal Recipient follows generally accepted accounting standards, maintains adequate internal controls, adheres to Fund guidelines for procurement, and adheres to external audit requirements.

The CCM and LFA, working together, can ensure accountability and transparency in governance of Global Fund resources. Each needs to understand the other's role and scope of work to create a well-functioning system of checks and balances.

#### Box 1: CCM Problems

1. The CCM's role and operating methods are not defined/understood by CCM members and outsiders.
2. The CCM chair serves as Principal Recipient and has a conflict of interest.
3. The CCM chair is very powerful and members are reluctant to disagree.
4. There is no genuine involvement in CCM decision making; decisions are made in advance by the chair and a few others.
5. CCM officers do not share information within/outside CCM.
6. CCM members do not know whether the project funded by the Global Fund is being effectively implemented (the Principal Recipient does not report to the CCM).
7. Subrecipients are actually units of the Principal Recipient and are not legally allowed to receive funds.
8. The administration of the bidding process to select third-party procurement agents is not transparent.
9. The third-party procurement agent is not held accountable for contracted deliverables.

Source: Problems 1–6 are based on experiences of other countries, as described in Garmaise and Rivers, 2004, p. 17. Other problems are specific potential risks in Azerbaijan, given current structure and arrangements.

<sup>44</sup> See, for example, Garmaise and Rivers, 2004. Also of interest are Global Fund, 2004a and 2004b.

<sup>45</sup> According to its website, UNOPS is also the designated LFA for China, Mongolia, India, Serbia and Montenegro, Macedonia, and Kosovo. <http://www.unops.org/UNOPS/Services/LoanSupervisionandAdministration/>, accessed November 3, 2005.

**TABLE 3: CCM CHARACTERISTICS**

Characteristic of Well-Functioning CCMs	Azerbaijan's CCM*
Use of terms of reference and other tools to formalize governance, including bylaws and operating procedures	Few tools have been developed as yet
Establishment of subgroups as part of the CCM	Ad hoc committees perform tasks such as development of conflict of interest policy; there are plans to create an Organizational Development Subcommittee
Rules of procedure to formalize decision making by vote	Decisions require consensus
Democratic selection of officers, selective use of secret ballot, rotation of officers	Not stated in proposal; current vice chair has agreed to serve for 6 months only
Secretariat established with adequate administrative support	Secretariat has been established and staff assigned (from the Principal Recipient); not clear if support will be adequate
Innovation and continuous improvement (examples: selection of subgrantees through competitive tender, new subcommittees for coordination with health sector in general, etc.)	Too soon to evaluate
Government committed to partnership with international agencies and civil society (sometimes measured by satisfaction of CCM members)	Too soon to evaluate

Source: Global Fund, 2004b, p. 2.

### CONFLICT OF INTEREST

Conflict of interest is a key concern with CCMs. Conflict of interest can occur when a member of the CCM must consider matters that have a direct impact on the interests of the government or organization represented by the member. There is a need to safeguard against the perception that the participation by the member is in any way conferring an unfair advantage for the organization in decision making. Perceptions of conflict of interest can damage the reputation and integrity of the CCM and of the Global Fund program in Azerbaijan.

CCMs in all countries are exposed to conflict of interest by their very nature: the CCM is a gathering of stakeholders who benefit from the allocation of grant funds. A particular conflict of concern to many in Azerbaijan is the participation of the Minister of Health as the chair of the CCM, given that the MOH is the Principal Recipient of the Global Fund grant. This situation has arisen in other countries as well; for example, in Round 3 of Global Fund financing, 28 of 47 (60 percent) MOH Principal Recipients were also chairs of the CCM; in Round 4, 89 percent of MOH Principal Recipients were also CCM chairs.<sup>46</sup> Cambodia has specified that Principal Recipients cannot be chairs or vice chairs and created a policy that specifies that Principal Recipient representatives are excluded from decision making where they might have a conflict of interest.<sup>47</sup> In Kenya, an analysis of the CCM noted that having the Minister of Health as the chair can inhibit open discussion.<sup>48</sup>

<sup>46</sup> [www.theglobalfund.org/en/about/structures/ccm\\_analysis/](http://www.theglobalfund.org/en/about/structures/ccm_analysis/), accessed October 16, 2005.

<sup>47</sup> Global Fund, 2004b, p. 9.

<sup>48</sup> Global Fund, 2004b, p. 14.

In addition to the risk of having the Principal Recipient act as chair of the CCM in Azerbaijan, there is also conflict of interest in at least one subrecipient of the HIV/AIDS grant funds. The National Reproductive Health Office (NRHO) appears to be a unit of the MOH without official legal existence outside the MOH. Although the proposed principal recipient and subrecipient relationships were analyzed by UNOPS before the grant was approved, it appears that this arrangement does not comply with Azeri law. Specifically, the director of the NRHO maintains a separate bank account that is likely being used to transfer Global Fund funds from the Principal Recipient to the subrecipient. Yet, the Budget System Law requires that all government funds be budgeted in the Consolidated Budget; capital investments must be prepared, analyzed, and prioritized in the Public Investment Program (prepared by the Ministry of Economic Development) and all public expenditures for both recurrent and capital spending must pass through the Treasury System.

Azerbaijan's CCM has created a draft policy to mitigate conflict of interest. The policy seems appropriate and has adequate components, including a requirement that the chair recuse himself from certain decisions, such as the reprogramming of grant funds, and a mandate for the creation of a subcommittee to deal with potential conflicts as they arise in the future. The effective implementation of this policy and the functioning of the subcommittee will need to be monitored.



## IV. ACTIONS

### HUMAN RESOURCES

1. **Vertical Corruption.** USAID should provide technical support to Government of Azerbaijan legal agencies in government-initiated efforts to root out vertical corruption in the MOH, including the purchasing of MOH and district jobs and maintenance payments to keep jobs. Such an investigation would need to be carried out by appropriate government authorities and may require the assistance of whistle-blowers. USAID could provide technical assistance in the design of protections for whistle-blowers in general, and other necessary legal advice.

In addition to legal investigation and prosecution, the other anti-corruption strategy that can help to curb vertical corruption in the health sector is the elimination or drastic reduction of government-run healthcare delivery structures. Instead, allow small, private medical practices to develop, and ensure that they are properly regulated. Given the extensive reliance on out-of-pocket payments and privately purchased medicines in government-run service delivery now, this change would not entail a huge shift in behavior on the part of the general public. Moreover, downsizing the government's healthcare delivery role will allow more of the current informal revenue to be channeled to actual service delivery, instead of being captured by senior administrators in the form of kickbacks from government providers. It would make financing transactions more transparent and increase accountability. The MOH could concentrate on developing a small, clean operation focused on policy development, regulatory control (including regulation of a national insurance fund and essential benefits package, once implemented), and research. (See also the recommendations under the heading of Financial Management and Health Reform.)

2. **Transparency in Hiring.** Support the design of the computerized system for the MOH personnel office to collect information on available job vacancies in all districts and MOH functions, and advertise vacancies to the public. This is a government-initiated idea and a first step in increasing transparency. Based on this experience, advocate for further changes that improve transparency and limit discretion in hiring, including, for example, transparent hiring protocols, an electronic system for people to apply for jobs online, hiring reports that justify decisions made based on criteria, and so on. In a similarly phased approach, USAID could support electronic systems for tracking other personnel-related functions such as payroll, and human resources decisions such as promotions and dismissals, via the USAID project in the Ministry of Finance, Treasury Management Information System.
3. **Professional Networking.** Help Azeri health professionals strengthen their international public health professional networks by sponsoring professional meetings and cross-visits and by supporting local professional associations. Networking can help to connect Azeris with other regional professionals with whom they can share best practices in health system organization, management, and medical practice. A strong professional association can also become an advocate for change, a more active stakeholder in health reforms, and a civil society voice. It can pressure for more accountable governance in the health sector.

### SERVICE DELIVERY

1. **Citizen Voice.** Continue building on the early USAID successes in empowering communities to solve problems and provide input to governance. The Primary Health Care Strengthening Project and the Azerbaijan Access, Quality, and Use in Reproductive Health project (ACQUIRE) are already working or planning to work in local communities on initiatives such as health boards to

manage community-based financing schemes, or problem solving for better health. Other new projects such as Community Development and Strengthening Civil Society are planning to launch similar public education or advocacy activities. These initiatives promote government accountability through community oversight and management tools such as accounting and information systems. Working with receptive local government officials, these projects should consider ways to expand health boards to include other development activities or local governance issues.

2. **Informal Payments.** Through the Primary Health Care Strengthening Project, USAID will support the development of health financing policies and service delivery reform, and baseline data on the extent and nature of informal payments already exist. Yet, this information is mainly quantitative and motivations behind the informal payments are not clearly understood. Many people believe that informal payments and corruption in general have become accepted, ingrained practices in Azerbaijan. These beliefs about the “inevitability” or cultural acceptance of corruption threaten the success of policy reform.

Reform efforts should look specifically at how policies and behavior-change strategies can work together to reduce informal payments. USAID should support research on attitudes and beliefs about informal payments and corruption. The results should be used to design complementary behavior change strategies to support proposed reforms.<sup>49</sup>

Another aspect of informal payment reform that USAID efforts could support is citizen education on health law and patient rights—what is supposed to be covered by official fees, and what is supposed to be available for free. This would ensure that patients at least make informal payments with full knowledge, and with facility boards, could help detect and curb the practice of collection agents pocketing official fees. (In larger facilities with official charges, the implementation of networked point-of-service cash registers can also help reduce the diversion of revenue, but few MOH facilities have this much discretion in charging fees for service.)

## PHARMACEUTICAL POLICY AND MANAGEMENT

1. **Drug Price Monitoring.** Implement a drug price monitoring study such as the *Medicine Prices* manual designed by WHO and Health Action International (HAI).<sup>50</sup> Studies that document the problems of access and cost of pharmaceutical supply can be a tool in advocating for policy change. A preferred option is to collaborate with government in the design of such a study to avoid later rejection of findings due to questions on data reliability. As USAID has found with the ongoing Demographic and Health Survey (a nationally representative household survey on a wide range of health topics, jointly implemented by Macro International, Inc. and the State Statistics Committee), time spent up front in clarifying methods and incorporating government suggestions regarding design will make for a stronger study and may pay off in terms of acceptance of results. The WHO/HAI methodology includes trend analysis of drug prices and availability, using comparative data on prices of common drugs by sector (public facilities, private for-profit facilities, private for-profit pharmacies, and private not-for-profit facilities). Local prices are shown in relation to international reference prices. The Armenian study showed that prices in Armenian private pharmacies ranged from 1.8 to 95 times higher than international reference prices. The pricing methodology detects and analyzes reasons for price variation, such as local

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<sup>49</sup> See Vian and Burak, 2005, for an example of how an understanding of beliefs can help inform informational campaigns about informal payments.

<sup>50</sup> See website at <http://www.haiweb.org/medicineprices/>.

costs (transportation, duties, taxes, and mark-ups). It can also help raise questions about irrational drug use and patterns of high sales of drugs unexplained by local cost factors.

2. **Action Plan for Anti-Corruption in the Pharmaceuticals Sector.** Consider sponsoring an in-depth study by pharmaceutical experts to analyze some of the areas of vulnerability for corruption identified in this study and develop plans to address them. A World Bank study on the pharmaceutical sector that may have already covered this issue was not available during this consultancy. Once it is released, the World Bank report should be reviewed and USAID should tailor the next study to plan interventions in areas such as:
  - Improving the process of registering drugs and licensing pharmacies, including procedures to remove from lists drugs or pharmacies that companies fail to re-register, and to enforce sanctions for violations.
  - Increasing online, public access to lists of registered drugs and pharmacies (this idea was suggested by the MOH).
  - Cleansing the market of fake or sub-therapeutic drugs.
  - Creating/revising pharmaceutical legislation to reduce conflict of interest in ownership of pharmacies by physicians. (The Primary Health Care Strengthening project is supporting a legislative review that could be expanded to include this topic.)
  - Introducing legislation to regulate procurement practices used by wholesalers providing drugs to private pharmacies.
  - Implementing a system of drug problem reporting.
  - Implementing an essential drugs list and enforcing its use.
3. **Education and Information.** Anti-corruption strategies in the area of education include the integration of modules on ethics education into the regular training curriculum, especially discussion of ethics of physician-pharmaceutical industry interactions and patient rights. Ethics education may also include development or revision of codes of ethics for professionals. Education on patient rights will empower patients in the long run, helping to reinforce accountability and, if coupled with methods for lodging complaints, providing checks on excess discretion and abuse of power. Finally, more objective drug information aimed at both providers and consumers can help to counteract the powerful influence of pharmaceutical companies on physician prescribing practices.

## **FINANCIAL MANAGEMENT AND HEALTH REFORM**

1. **Support for Health Reforms.** Corruption in the health sector will never be reduced as long as funding provided for government services or risk-pooling is less than 1 percent and there are so many staff. The inherent risks of corruption in such an environment are so great that controls cannot help. The Ministry of Finance and the MOH must understand that in order to reduce corruption, there must be adequate funding for a more limited public system that provides defined benefits to citizens and pays a living wage to staff. The new Minister of Health has stated that more funding is being allocated to the health sector, which could help to ameliorate the situation, but more must be done to define limited public benefits, reduce the pressure from the excess supply of doctors, and increase compensation of medical personnel.

USAID should continue to support the health reform process and specific reforms identified in USAID project design documents and the World Bank Health Sector Review Note of 2005.

These include moving to a needs-based funding formula, revising the financing flows to enhance full management control over inputs and outputs used to produce government services (either public contracting model or full devolution), and rationalizing the hospital sector by reducing beds and staff. There is wide scope for collaborative efforts with USAID's Public Investment Policy and Efficiency project, which seeks to improve the identification, appraisal, and budgeting of capital investments in the consolidated state budget, working with the Ministries of Finance and Economic Development.

2. **Develop Measures of Performance.** Health reforms should include measures of government performance in the health sector, especially measures that combine inputs and outputs (such as cost per outpatient clinic visit, per delivery, or per inpatient-day). Appropriate dissemination and use of these types of measures can provide positive incentives and change the "economic equation" favoring corruption. Within their existing scopes of work, USAID projects should explore ways to evaluate performance using external "performance audits" to provide a check on falsified data. Projects should also experiment with how best to disseminate performance data to enhance accountability and transparency in government.

## GLOBAL FUND

Specific recommendations for increasing good governance of the CCM and transparency and accountability in Global Fund grant management include the following.

1. **Translate key portions of Global Fund guideline documents** into Azeri and make sure that all stakeholders receive and read them. Such documents include *Guide to GF Policies on Procurement & Supply*, *Revised Guidelines on the Purpose, Structure and Composition of CCMs*, *Fiduciary Arrangements for Grant Recipients*, and the *Monitoring & Evaluation Toolkit* (available at: [http://www.theglobalfund.org/en/about/policies\\_guidelines/](http://www.theglobalfund.org/en/about/policies_guidelines/), accessed November 2, 2005).
2. **Insist that the CCM create terms of reference and bylaws for operation.** Use guidance from the Global Fund and AIDSPAN websites to help create terms and reference and bylaws. Consider including policies on voting that will allow individuals to register disapproval while not necessarily impeding progress on important issues (that is, use majority rule or require only two-thirds approval on some issues). Consider rotating officers and using secret ballots to vote for chair if this will help people feel they can vote honestly without endangering ongoing relationships. Create specific requirements for reporting by Principal and Secondary Recipients to the CCM.<sup>51</sup> Clarify and strengthen the relationship between the CCM and the LFA, including procedures for lodging questions or complaints about potential abuse of funds (see also point 4, below).
3. Given the size of the full CCM—35–40 members and still growing—**recommend the creation of an executive committee or some kind of steering body** to ensure that detailed questions are dealt with in a timely manner without having to wait for the full committee to convene. An executive committee with one representative of each sector or major stakeholder group (NGOs, donors, government, people living with AIDS, the private sector) should meet at least once per month to ensure adequate oversight of decision making by the CCM Secretariat (also called the Project Implementation Unit and housed in the MOH).

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<sup>51</sup> Plans for reporting are already described in Azerbaijan's Global Fund proposal, but it is essential for governance by CCM to have these requirements codified.

4. **Develop a compliance program.** USAID should propose that the CCM create a Compliance Subcommittee and adopt a formal compliance program to minimize chances of fraud or abuse, whether intentional or unintentional, that could result in cancellation or suspension of the grant. This type of approach has been used successfully in U.S. hospitals to reduce vulnerability to fraud and abuse.<sup>52</sup> Compliance programs include the following key elements: written standards, policies, and procedures addressing specific problem areas; designated responsibility structures; education and training of staff; an internal reporting system (for lodging complaints or concerns about abuses); disciplinary procedures; an audit function; and an evaluation system.<sup>53</sup> Work with the LFA (UNOPS) to help create the compliance program. The LFA is knowledgeable about the institutional capacity of the Principal Recipient and is responsible for ongoing reviews to ensure continual compliance with financial and procurement regulations. The Compliance Subcommittee may also take responsibility for monitoring selection of the third-party procurement agent to ensure that the process is conducted with transparency and competition, and monitoring the implementation of the conflict of interest policy and revising it based on specific issues that arise.
5. **Investigate the legal standing of the NRHO** and the basis on which it is acting outside of the Budget System Law, maintaining a bank account as a unit of MOH. Discuss at the CCM whether the NRHO should be allowed to continue as a subrecipient of Global Fund funds and, if so, create adequate safeguards against conflict of interest.
6. **Review the organizational development of the CCM.** CCMs develop and mature with experience. USAID should support governance structure development by providing technical assistance,<sup>54</sup> supporting team-building activities, and funding the translation and dissemination of manuals or web-based initiatives for knowledge management.

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<sup>52</sup> Office of Inspector General, 1998.

<sup>53</sup> Office of Inspector General, 1998.

<sup>54</sup> Some consultants specialize in supporting CCMs. The GTZ has funded technical assistance in this area in many countries, and Management Sciences for Health ([www.msh.org](http://www.msh.org)) also has experience.



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## ANNEX A: ELEMENTS OF LAWS TO REGULATE PRIVATE PRACTICE OF MEDICINE\*

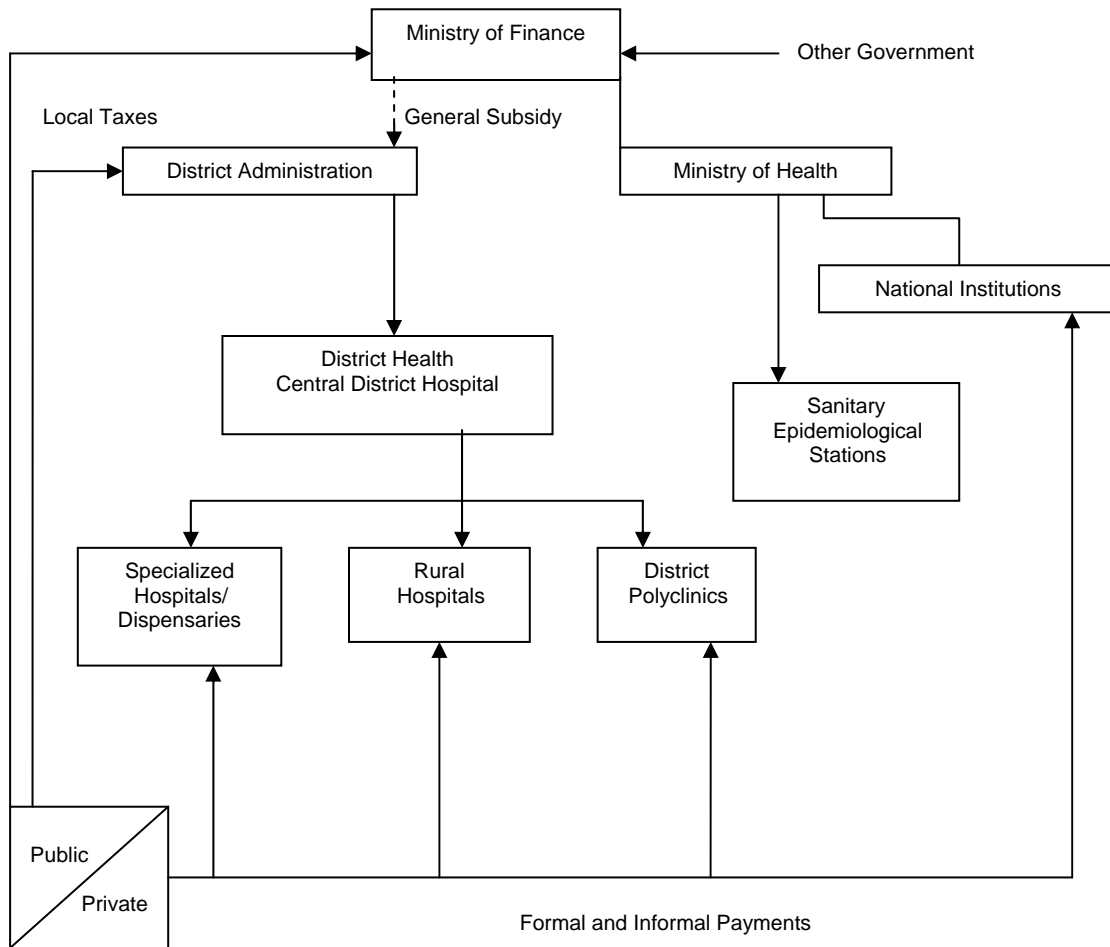
Items in *italics* have special relevance for increasing accountability and transparency and reducing conflict of interest

Area of Law	Requirements or Main Elements of Law
State licensing of physicians	Law must state it is illegal to practice medicine without a license; specify what is "practice of medicine"; if licensing by specialty, then specify categories, definitions
Minimum qualifications for eligibility to practice medicine	Approved training, competency testing, character, and criminal record
<i>Ownership of facilities</i>	Disclosure of ownership; limits on types of ownership allowed and locations; restriction on ownership of affiliated facilities such as pharmacies, laboratories, or radiology facilities; and required financial standing for ownership
Physical facility requirements	Minimum floor space and structural requirements, utilities, hygiene, equipment, other approvals, and inspection and enforcement requirements (how violations will be detected and corrected, what will happen if corrections are not made)
Staffing	Minimum levels, levels in relation to volume, training, or experience
<i>Controlling diversion from the public healthcare system</i>	Options/issues: 1) require approval by the employer for private practice (specify hours, limitations on actions to divert patients) 2) pay by contract in public service (this may be preferable to keeping doctors in civil service and requiring special permission for private practice) 3) make public employment conditional on compliance (loss of license for private practice)
<i>Use of public facilities in private practice</i>	Options/issues: 1) allow private practice, specify hours, types of procedures, quality assurance mechanisms 2) charge for rent or services in the public clinic 3) admitting privileges (criteria for granting, barring)
Price regulation	Price controls (are they desirable, how to set); balance billing (billing in excess of insurance payment); posted charges (requirements to list); nondiscrimination (barring differential pricing)
Capacity regulation	Permission to practice in a geographic area, limits on investment and equipment (required certificates of need)
<i>Professional liability</i>	Defining physician's liability for professional negligence; define standard of care; measure of damages; dispute resolution procedures; financial guarantees
<i>Patient rights</i>	Disclosure and information; informed consent; right to refuse treatment; right to medical records; obligation to treat; nondiscrimination; complaints about violations
Establishment/termination of physician-patient relationship	Defining point at which relationship is established; defining obligations for continuity of care or referral
<i>Public health reporting requirements</i>	Reportable diseases and vital statistics, case finding, abuse reports, immunization

Area of Law	Requirements or Main Elements of Law
Advertising	Bans or limits; requirements on content; system for adjudicating disputes; sanctions
Maintenance of medical records	Positive obligation to maintain; privilege requirements (limits to confidentiality)
<i>Prescribing authority</i>	Links between pharmaceutical law and physician licensing law; special authority for highly dangerous substances; specialty regulations, if desired; written prescriptions (requirements); generic prescribing; permission to sell drugs
Physician extenders	Process for qualifying physician extenders (nurse-practitioners, physician assistants)
<i>Registration and re-registration: license renewal</i>	Continuing medical education rules; competency testing; availability of licensing data (public release)
<i>What body sets the rules?</i>	MOH or independent body (if MOH, need to control for possible MOH abuse of power over private licenses in order to punish doctors who are critical of MOH action); inclusion of public members on independent board (to balance physician interests); national or regional
Suspension and revocation of license	Procedures for revoking or suspending license; action in emergencies; cause for license action; drug/alcohol abuse (impaired physicians); poor-quality medical care (method of proof)

\*Source: USAID, 1996.

## ANNEX B: FLOW OF FUNDS FROM THE MINISTRY OF FINANCE



Source: G&G, 2003, Figure 35, p. 37, citing WHO, 1996.