



## Bribery in health care in Uganda

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### ABSTRACT

I examine the role of household permanent income in determining who bribes and how much they bribe in health care in Uganda. I find that rich patients are more likely than other patients to bribe in public health care: doubling household expenditure increases the bribery probability by 1.2 percentage points compared to a bribery rate of 17%. The income elasticity of the bribe amount is about 0.37. Bribes in the Ugandan public sector appear to be fees-for-service extorted from the richer patients amongst those exempted by government policy from paying the official fees. Bribes in the private sector appear to be flat-rate fees paid by patients who do not pay official fees. I do not find evidence that the public health care sector is able to price discriminate less effectively than public institutions with less competition from the private sector.

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The empirical literature on corruption has identified consequences of corruption for countries, such as lower growth and foreign direct investment,<sup>1</sup> and causes of corruption across countries, such as the legal, political and fiscal systems.<sup>2</sup> It has made progress in suggesting remedies for corruption: some papers infer corrupt practices in particular industries, and examine how rule changes or audits affect business practices.<sup>3</sup> In this paper, I contribute to a nascent empirical literature that seeks to understand bilateral interactions between public officials and clients as a stepping stone to devising policy.<sup>4</sup> I do so by studying bribery in health care in Uganda, with particular emphasis on the role of household permanent income in determining who bribes and how much. Uganda is a low-income country (GNI per capita of US\$1500) classified as one of the most corrupt countries in Transparency International's Corruption Perceptions Index, with an excellent

source of data on bribes by individuals in the 2002 Second National Integrity Survey.<sup>5</sup>

In earlier work, [Hunt and Laszlo \(2009\)](#) analyzed bribery mechanisms for samples pooling all institutions in Uganda and Peru. The health sector is worthy of separate study for several reasons. First, mechanisms could differ across institutions, and different mechanisms may require different solutions. Unlike many public institutions, the public health care system has competition from the private sector, which could influence bribery mechanisms. Second, the health sector is one where equitable access, and hence the link between permanent income and bribery, is of particular concern. Third, my data show that 37% of Ugandan bribes are paid in the health sector, due to widespread use of the health system. Fourth, a comparison between bribery in the public and private health care systems may be made for Uganda.<sup>6</sup> Finally, the Ugandan data allow a richer set of covariates to be used in the study of health care than could be used with other institutions.

Theory suggests that richer clients should be more likely to bribe a public official, due to a higher valuation of their time and

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<sup>1</sup> Mauro (1995) and Wei (2000).

<sup>2</sup> Fisman and Gatti (2002) and Treisman (2000).

<sup>3</sup> Di Tella and Schargrodsky (2003), Ferraz and Finan (2008a,b), Olken (2006, 2007) and Yang (2008a,b).

<sup>4</sup> See also Kaufmann and Wei (1999) and Svensson (2003) for firms, and Deininger and Mpuga (2004) and Thompson and Xavier (2002) for individuals.

<sup>5</sup> Perceptions from Transparency International (2004). Purchasing power parity and Gross National Income from [siteresources.worldbank.org/DATASTATISTICS/Resources/GNIPC.pdf](http://siteresources.worldbank.org/DATASTATISTICS/Resources/GNIPC.pdf).

<sup>6</sup> Corruption is not by definition confined to the public sector: see [Gambetta \(2002\)](#). A payment in the private sector is a bribe if it is paid to an agent to induce behavior contrary to the interest of the principal.

higher demand for services. Richer clients should also pay more conditional on bribing. This stems from the official's possessing a degree of monopoly power, and hence the ability to price discriminate amongst customers. If such discrimination is observed, it could reflect first-degree price discrimination, or, if the exact service being paid for by the client cannot be observed, third-degree price discrimination (the rich pay more and get more).<sup>7</sup> Greater competition between service providers, whether private or public, should reduce the ability of officials to price discriminate, and indeed, under perfect competition bribe amounts should be bid down to zero. Lewis (2006) has proposed that infrequent bribery in health care in certain countries is explained by the presence of private-sector competition in those countries. Clarke and Xu (2004) find that in countries with competition amongst utilities there is less utility bribery than in countries with monopolies.

As expected, I find that rich patients are more likely than other patients to bribe in public health care: doubling household expenditure in Uganda increases the bribery probability by 1.2 percentage points compared to a bribery rate of 17%. The income (expenditure) elasticity of the bribe amount is about 0.37 in the public sector: the rich pay more, but pay a smaller share of their expenditure. This elasticity is the same as that for official payments in both the public and the private sector. This could indicate that in all three cases the elasticity is determined by the same combination of fee-for-service, with the rich demanding more expensive services, and price discrimination. I also find that bribes in the public sector are disproportionately paid by the richer patients amongst those not paying official fees. The results, combined with anecdotal evidence, suggest that much public sector bribery represents a facility-level extortion policy to raise revenue from patients exempted from payment by government policy. This suggests that well-intentioned policies to reduce health care fees for the poor may be thwarted by health workers seeking to supplement their own incomes. In addition to undermining the goal of increased access to health care, the effect could be to contribute to a culture of bribery which helps bribery flourish in other institutions.

The private-sector results provide an intriguing contrast. The probability of bribing is unrelated to household expenditure, and the income (expenditure) elasticity at 0.15 is much lower than for the public sector. Bribes in the private sector are therefore close to flat-rate fees, and as in the public sector are paid almost exclusively by patients not paying official fees. Bribes paid in the private sector are more effective than those paid in the public sector, with some bribers successfully raising the quality of the facilities and the level of service from good to very good. This suggests that bribes may not represent revenue-raising extortion as they do in the public sector.

Although bribery rates and amounts are lower in public health care than in other public institutions, I do not find evidence that the public health care system in Uganda is able to price discriminate less effectively than other public institutions. The results therefore fail to support the hypothesis that competition reduces bribery.

## 1. Health, health care and corruption in Uganda

### 1.1. Health and health care

I present in Table 1 statistics documenting the poor health outcomes and health care quality in Uganda. Life expectancy at birth is only 48 for men and 51 for women, and there are only 0.08 doctors per thousand population. Private provision of health care is significant, as government health spending represents only 30% of total

**Table 1**  
Health and health care in Uganda.

	Year	Value
Life expectancy at birth – males	2004	48
Life expectancy at birth – females	2004	51
Percent of population 15–49 HIV positive	2003	4.1
Percent of births attended by skilled personnel	2000	39.0
Doctors per 1000 population	2004	0.08
Nurses per 1000 population	2004	0.61
Health spending as % GDP	2003	7.3
Government spending as % total health spending	2003	30.4

Source: WHO, <http://www3.who.int/whosis/core/core.select.cfm>.

health spending. In 2000 there were 1226 public, 465 NGO and 49 private (non-NGO) health facilities in Uganda.<sup>8</sup> Health insurance is essentially non-existent. During the period relevant for my data, health care at public facilities below the hospital level was free, while in public hospitals fees were based on the patient's ability to pay.<sup>9</sup> Although NGO and mission hospitals also make provision for fee exemptions for the poor, Amone et al. (2005) observe that in their sample of Catholic hospitals, only a minority of exempted patients were poor (the others were predominantly hospital and church staff, and teachers and pupils of the Catholic school). Most of these hospitals charged on a fee-for-service basis (each service had an associated fee), with the exception of treatment for tuberculosis and sexually transmitted diseases including HIV/AIDS, which was funded by the government.<sup>10</sup>

### 1.2. Corruption in health care

As part of the collection of the data, described below, the consulting company commissioned by the government ran focus groups on bribery and availability of public services in 180 villages and towns. Almost every focus group notes that medical attention at public hospitals and health units can only be obtained in exchange for payment despite the official abolition of user fees at health units. They state that patients have to bribe to attract the attention of medical staff and pay for all medical supplies, no matter how small.<sup>11</sup> The impression conveyed by the focus groups is less one of individual bad apples within a particular facility than of facility-wide policies to extort bribes.

Focus group participants complain that the only drug available at Ugandan health facilities is Panadol (Tylenol). Other drugs must be purchased at pharmacies, drug shops or private practices with connections to the doctor recommending the drug, despite the fact that they should be available free in the public health units.<sup>12</sup> Some groups note that the corruption and poor service in the public health sector lead people to use private clinics, despite their cost.

Accounts of the health care system in periods when user fees existed describe widespread corruption similar to that deplored by the 2002 focus groups.<sup>13</sup> McPake et al. (1999) estimate that 68–77% of revenues from official fees were misappropriated and that 76% of drugs at the facilities they studied disappeared before reaching patients. Given this, it seems highly unlikely that any bribe revenue

<sup>8</sup> Uganda Investment Authority: <http://www.ugandainvest.com/health.htm>. Reinikka and Svensson (forthcoming) outline the post-colonial history of private and public health care in Uganda.

<sup>9</sup> Nabyonga et al. (2005).

<sup>10</sup> See also Uganda Ministry of Health Online (2000) at <http://www.health.go.ug/budget.htm>.

<sup>11</sup> Jitta et al. (2003) observe that patients routinely bring their own syringes and must pay for the liquids used to mix the injection fluid.

<sup>12</sup> The respondents in Jitta et al. (2003) make the same observation.

<sup>13</sup> For example, Konde-Lule and Okello (1998).

<sup>7</sup> See Hunt and Laszlo (2009) and Olken and Barron (2009).

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