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Addressing corruption through sector approaches:

Exploring lessons from the Moroccan anti-corruption strategy for the health sector

Sector-specific anti-corruption efforts are widely recommended but rarely implemented at the country level. The Moroccan Central Authority for Corruption Prevention opted for a sector approach, identifying the health sector as a priority. This analysis of the process and challenges offers valuable lessons for anyone considering similar approaches in any sector.

Sector-specific approaches require the involvement of key stakeholders already at the design stage, and an awareness of potential resistance from affected actors. Roles and responsibilities must be clearly defined, including for overseeing the implementation throughout the process

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1. Background

1.1. Sector approaches

Sector approaches for assessing and addressing corruption have primarily gained momentum among donor agencies in recent years for three reasons (U4, 2007 and 2010): 1) Research and practical experience have shown that corruption manifests itself differently in different sectors. Anti-corruption strategies need to take these sector specifics into consideration in order to adequately address the problem; 2) Sector approaches allow for the prioritizing of efforts in areas that suffer from acute problems (e.g. due to recent scandals), are particularly vulnerable, offer potential quick wins (e.g. taxes, customs) or that are of strategic importance. A special focus is often put on sectors essential for the achievement of the UN Millennium Development Goals (health, education and water) or which are crucial for the national economy (extractive industries); and 3) They can be targeted and may be easier to steer, as the respective actors, usually the Ministry and sector-related agencies, can assume ownership of the process and the results. In sum, well-designed approaches in priority sectors allow for the generation of tangible results for citizens by grounding cross-cutting or general good governance measures in concrete service delivery and the corresponding line ministries. However, it should be noted that sector approaches should draw on and be coordinated with countrywide strategies to combat corruption to ensure sustainable activities.

Despite these potential advantages, the strategic prioritization of sector anti-corruption initiatives is still the exception rather than the rule. Corruption prevention agencies and anti-corruption policies often aim at involving ministries and public agencies at different levels and sectors at the same time. This course of action does not allow for learning through pilot experiences, nor does it take into account resource constraints of specialized corruption prevention agencies. The latter is particularly relevant for the technical guidance needed to orient, accompany and monitor sector approaches. The challenge lies in designing strategies and action plans that help embedding anti-corruption initiatives into sector policies and programmes as part of the routine business of the relevant sector institutions.

Against this backdrop, the present practice insight critically explores the development of the Moroccan anti-corruption strategy for the health sector. This case was chosen because it illustrates the strategic approach taken by a national corruption prevention body. The *Instance Central de Prévention de la Corruption* (ICPC) chose to concentrate its resources and expertise on providing specific guidance in prioritized sectors, and the findings presented are the result of a desk review of available literature and 26 open-ended personal interviews with key informants in Rabat and Casablanca in September 2012. Since the issue is subject to continuous developments, there may be changes after the field research was completed.

1.2. Corruption and development challenges in Morocco

Corruption is widely recognized as a severe problem in Morocco, with available indices rating the country as rather corrupt according to international standards. In the latest Corruption Perceptions Index (TI, 2012), the country scored 37 on a scale from of 0 (highly corrupt) to 100 (very clean), while the World Governance Indicators (WBI, 2011) ranked the country at 51 for the indicator Control of Corruption (0 corresponding to the lowest- and 100 to the highest rank out of all the countries in the world). Furthermore, Global Integrity (2010) assessed Morocco's integrity indicators as "very weak" with an overall score of 56 out of 100, which was nevertheless an improvement when compared with the score of 46 in 2008.

Some available studies point out certain positive aspects such as the anti-corruption activities promoted by the ICPC (Global Integrity, 2010), although the general assessment is rather negative:

> *Morocco unfortunately boasts one of the worst scores on election integrity in the*

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> *Global Integrity Report: 2010, in part due to the lack of a formal election monitoring mechanism. There is little transparency into the financing of political parties in the country, and the budget process is opaque and inaccessible to the public. Oversight of state-owned enterprises remains poor, while whistle blower protections are non-existent.* (Global Integrity, 2010)

Similarly, the National Integrity Study highlights the following problems (TM, 2009:1):

- *The national integrity system's inability to play a decisive role in addressing corruption; [...];*
- *The intrinsic weakness of most pillars;*
- *The judiciary's inability to properly discharge its duty;*
- *The non-recognition of the right to access to information as a key factor contributing to the lack of transparency, non-accountability and corruption.*

Information concerning the levels of experienced corruption reflects a similar situation. On the one hand, petty corruption in the form of small scale bribes is widespread. According to the Global Corruption Barometer (TI, 2010), 35% of the people interviewed report having paid a bribe in the past 12 months, and public officials and the judiciary are indicated as the most corrupt institutions, with both scoring 3.5 on a scale from 1 (not at all corrupt) to 5 (extremely corrupt). On the other hand, problems of grand corruption are severe (see TM 2012 for an overview of 2011) and Morocco was added to the Grand Corruption Watch List, a group of countries at an increased risk of large-scale theft of public resources. Countries are included in this list if the results indicate that "*certain key anti-corruption safeguards were so weak that the risk of large-scale theft of public resources was greater than in most countries". The assessment is based on the following "red flags: extremely poor conflicts of interest safeguards in government, weak oversight over large state-owned enterprises, and poor or non-existent controls over the flow of money into the political process*" (Global Integrity, 2009).

Additionally, Morocco is facing challenges similar to those experienced in other developing countries (Semlali, 2010), and its society is characterized by high rates of poverty (33%) and illiteracy (43%). The population growth has led to a challenging demographic situation, which has been exacerbated by a dependence on agricultural activities and unequal urban and rural living conditions: Only 43% of rural households have access to a source of safe drinking water, while 95% of them are disposing waste into nature. The geographical conditions are yet another challenge, with Morocco featuring the highest mountains in Africa and an unpredictable climate with floods and droughts.

1.3 The Moroccan health sector and its vulnerabilities to corruption

The Moroccan health system is split into both a public and private sector. This study focuses on the public sector, which represents the largest part and is centrally managed by the Ministry of Health (MoH). The public health-care system is financed through both public funding and private household spending, with annual public funding amounting to approximately 5% of GDP or about 121 USD per inhabitant. Fifty-seven per cent of the total health expenditure is financed through household spending, making the above mentioned problems of inequity a serious issue for the health-care system (WHO, 2009 and 2011; BAMF, 2011), and basic treatment and emergencies are free of charge in public institutions. Under a new system launched in 2012 (RAMED), the poor are generally eligible for free care, while those in financially vulnerable situations pay 120 Moroccan Dirham (MAD) (14 USD) per household and treatment up to a maximum of 600 MAD (70 USD) per year. Patients who are not poor receive non-basic treatment at subsidized rates. Mandatory health insurance was introduced for public and private employees in 2005, which was financed through a payroll tax of 2% and 2.5%, respectively.

The health sector is facing a series of general challenges in delivering services to secure good health for all citizens: 1) Providing equitable access to health is difficult due to the country's geographical challenges and a concentration of secondary and tertiary health facilities in Rabat and Casablanca; 2) There is a notorious lack of qualified medical and support staff, as according to the WHO (2010: 7), Morocco is one of 53 countries worldwide "with critical shortage of health workers". Moreover, poor working conditions have led to an exodus of health-care personnel; 3) Poor management of public hospitals poses a problem for the efficient and transparent use of resources, and 4) Economic accessibility to medicines is noted as a major problem (WHO, 2009).

Over the past two decades, a series of reforms have brought about fundamental changes in the sector, including hospital and institutional reforms (1995), regionalization (1996), decentralization (1997) and several reforms of health-care financing introducing, e.g. mandatory

health insurance (since 2002).

Despite the shortcomings mentioned, it should be noted that health outcomes and service coverage have improved significantly over the past five decades. However, even in the judgement of the MoH (2008), health outcomes are characterized by serious shortcomings as far as infant and maternal mortality, regional differences and coverage, staffing, financing and organizational and administrative structures are concerned. This general situation, coupled with a shortage of health services to meet increasing demand, fosters corruption in the sector in addition to other structural, political and social factors.

There is an ample public awareness about the significance of corruption in the Moroccan health-care sector. According to Transparency Maroc (2001), 80% of the heads of the household see corruption among health-care staff as (very) common. The scarcity of resources, distortions in their allocation and irregularities and corruption in health-care expenditures all heavily compromise the functioning of the sector and its public image. Under these circumstances, access to treatment, as well as the timely and adequate delivery of services, is the main activity for the extraction of small-scale bribes (petty corruption). Additionally, interviewees pointed out that cases of grand corruption, involving actors such as the pharmaceutical industry and political elites, illustrate the aforementioned severe weaknesses of health sector governance and their impact on service delivery (see TM, 2012: 13f for cases in the health sector in 2011).

2 Health sector anti-corruption strategy

2.1 Framework: National anti-corruption strategy and sector approach

Recent anti-corruption efforts in Morocco started in 1999 with the initiation of a national anti-corruption system. After the signature of the UNCAC in 2003 and its ratification in 2007, the ICPC was established as the national anti-corruption agency, which is composed of three organs: a General Assembly with 45 members from all different sectors of society (including the public sector, the private sector and civil society), an Executive Commission and a General Secretariat. According to its mandate of implementing a global approach for the prevention of corruption, the ICPC follows the long-term mission of developing a strategy to strengthen the pillars of a National Integrity System.

In this endeavour, the ICPC opted for a sector approach. As a first step, it identified priority sectors by assessing the following criteria (ICPC, 2011c: 5):

- Disposition and availability of key institutions in the sector;
- Level of awareness of corruption risks in the institutions identified;
- Sectors most affected according to the global corruption barometer (2010).

As a result of this assessment, the sectors of health, transportation, real estate and education were selected as the highest priorities.

The development of the sector strategies was then divided into four phases (ICPC, 2011b):

- Evaluation of policies and practices in place;
- Diagnosis of frequency, causes and consequences of corruption;
- Mapping of risks according to priority;
- Developing a sector strategy, including an action plan.

The action plans are to be implemented and monitored in cooperation with the respective sector authorities, e.g. the MoH in the case of the health sector. This approach coincides with the general framework provided in Figure 1, which reflects the Moroccan experience to date.

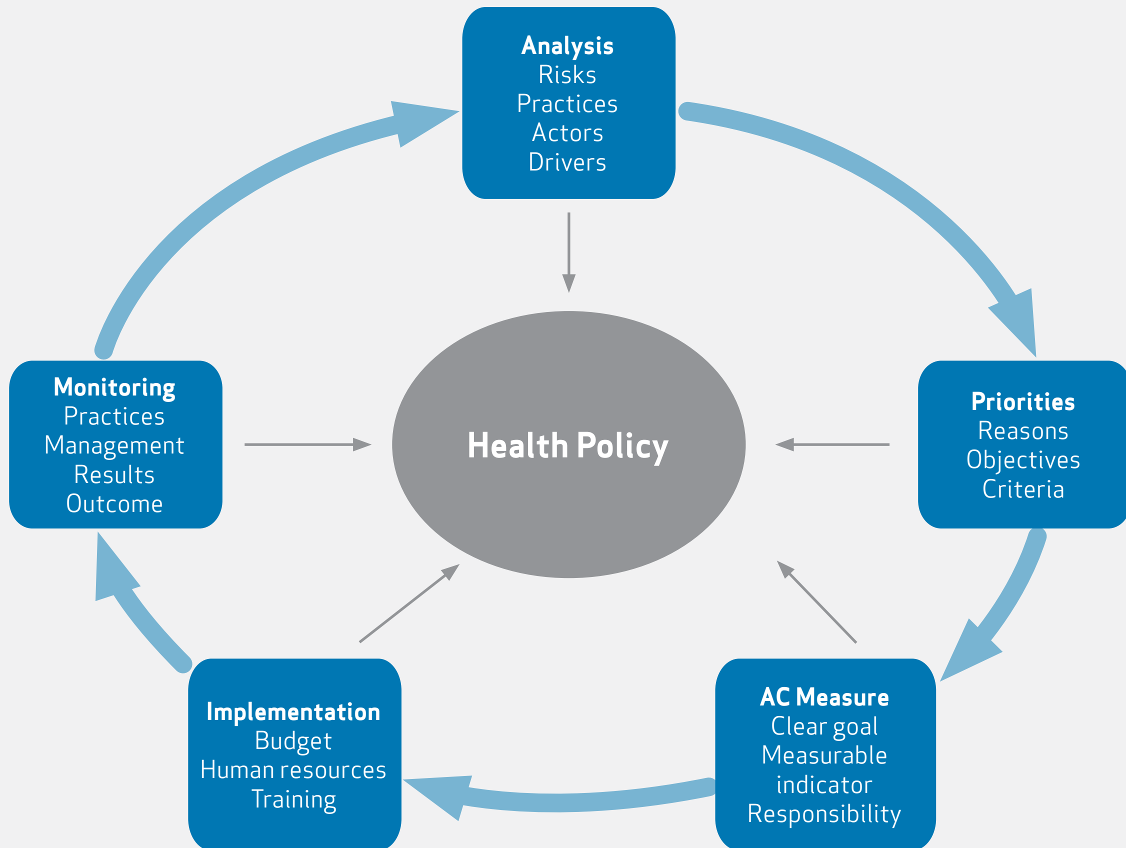
2.2 The Moroccan experience in the health sector

2.2.1 Developing a strategy

The ICPC commissioned a private consultancy for developing an action plan for the sector strategy as described above. In a first step, existing public policies and preventive measures, including laws and regulations for corruption prevention, were evaluated (ICPC, 2010a). In a second step, corruption risks and experiences were identified in all service and administrative areas of public health institutions. To this end, data was collected in five different regions, 3,500 patients were interviewed and 87 staff members of public hospitals (both medical and nonmedical) participated in interviews and focus group discussions (ICPC, 2010b). Figure 2 provides an overview of the different activities and processes analysed.

The findings revealed a high incidence of corruption, with 30% of people having been involved in corrupt transactions and 75% of these cases involving payments of 75 MAD (9 USD) or less.

Figure 1: Main steps to integrate anti-corruption efforts into a health policy



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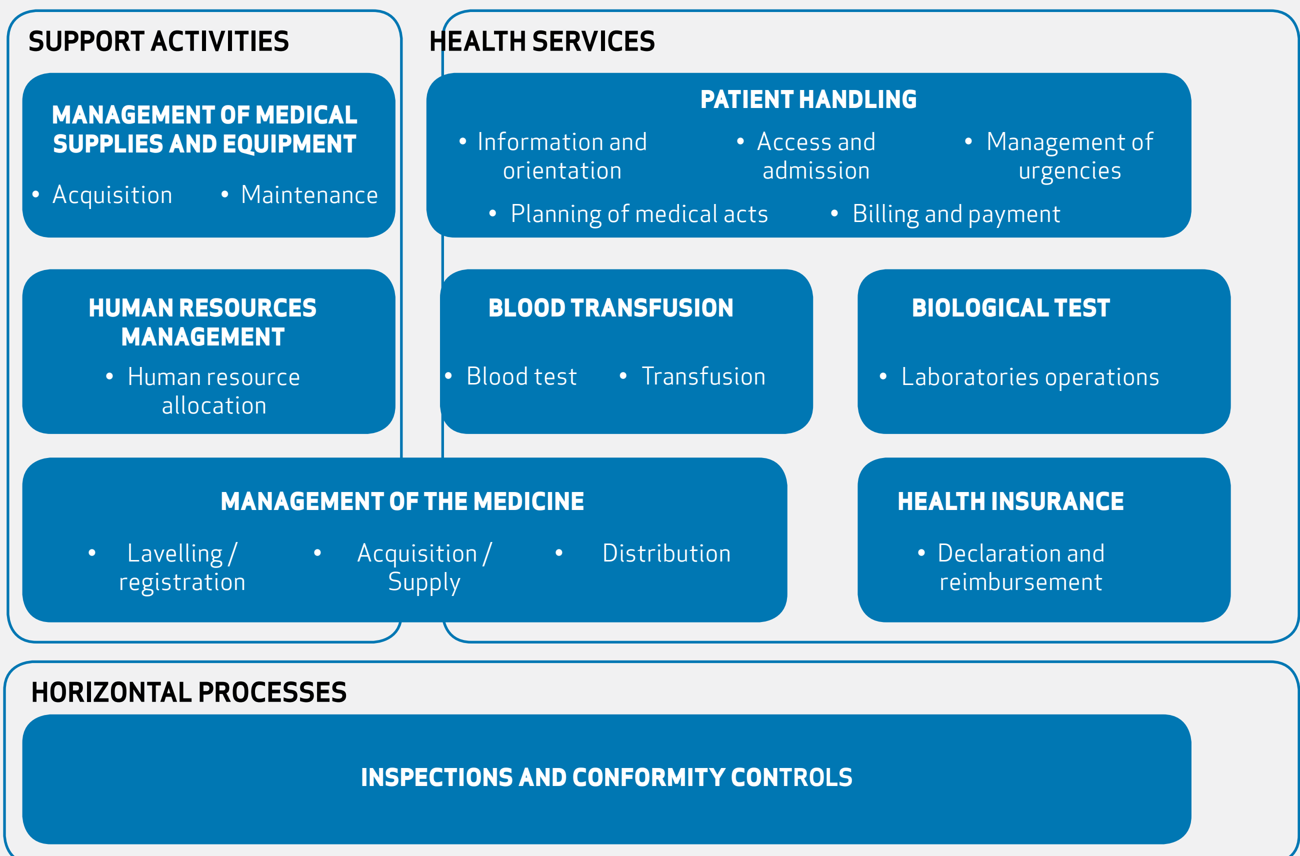

The following typologies of corruption were analysed (ICPC, 2010b: 26f):

- Under the table payments, bribes, gifts;
- Favouritism, nepotism;
- Incorrect treatment and billing (over provision of services or provision of services not medically indicated);
- Fraudulent billing (for services not provided or fictitious bills for ghost patients);
- Beneficiary fraud (bribes to receive services that the patient is not entitled to);
- Abuse of public equipment for private purposes;
- Stealing of medications from public institutions and sale for private gain;
- Irregularities in the processes of recruitment, promotions and transfers.

Under these terms, corruption can primarily manifest itself in three forms in the health sector (ICPC, 2010b: 28):

- Bribing medical staff to receive public services without being entitled.
- Under the table payments for provisions of health services or management of public goods (procurement, allocation);
- Exchange of services based on favouritism (often external actors).

Within this framework, a total of 87 corruption risks were identified, which are distributed as follows across public health institutions: hospitals (42), health centres (15), central administration of the MoH (14), clinics (12), regional centres for blood transfusion (2) and private laboratories (2).

While this analysis covers some aspects of the interaction between providers and suppliers (the purchase and administration of drugs and medical equipment), in addition to payers (billing), the focus lies on corruption in the delivery of services in the forms described, see Figure 3.

In a third step, these risks were prioritized in two further steps: 1) The criticality of each risk was and calculated by multiplying the likelihood of its occurrence with its potential impact (economic, social and cultural), which subdivided the risks into 30 low-, 17 medium- and 40 high-priority risks; and 2) The effectiveness of existing anti-corruption measures and practices for controlling the risks was assessed on a scale ranging from failing/nonexistent, to little efficient to being in need of improvement and efficient.

In a fourth step, a targeted anti-corruption sector strategy was developed based on these results, and at its core is an

action plan composed of seven axes:

1. Anchoring values of citizenship;
2. Renewing confidence in health services;
3. Evolution of HR management in institutions;
4. Adaption of the work environment;
5. Optimizing the management of equipment and supplies;
6. Management and control of activities;
7. Implementation of fundamentals.

A total of 55 projects are to be implemented over the course of five years, including provisions for monitoring and follow-up.

Additionally, the strategic health plan of the MoH (2008-2012) also contained the specific goal of implementing measures to address corruption in the sector institutions (Ministère de la Santé, 2008: 4)[1]. The core goal of the plan is to "reconcile the citizen with his health system". Therefore, one of the strategic goals was to counter corruption in health facilities, with the activities recommended aimed specifically at increasing access to care and information. Some of the key measures were:

- Toll-free hotline, as well as special desks for complaints;
- Open-door days;
- Local committees;
- Public posting of price lists and people in charge at the facility;
- Awareness raising campaigns;
- Establishment of performance indicators and inspections.

2.2.2 Implementation

As far as responsibilities are concerned, the ICPC and MoH supervised the first phase up to the formulation of the action plan in the form of a joint committee. In September 2011, they signed a partnership agreement, and in November 2011 the ICPC delivered the results of the process described above to the MoH. It is difficult to assess the current status of implementation since only a small amount of data is available, though some measures with anti-corruption relevance have been implemented, e.g. a toll-free hotline for complaints, including corruption-related incidents, information campaigns and the booking of appointments via the Internet or telephone. However, it cannot be judged how far this reflects an implementation of the anti-corruption action plan or of the MoH's strategic health-care plan because as of September 2012, details including measurable indicators of activities were not available.

The process of implementation was on hold for a period of about 10 months, with the MoH not actively pursuing a rigorous implementation or a systematic follow-up, both of which would help to identify potential obstacles or bottlenecks for implementation. Meanwhile, the ICPC made bilateral agreements with the Ibn Sina General Hospital in Rabat to start implementing the strategy in its 10 hospitals as pilot projects. To further enhance the process, there is a plan to set up a new joint committee between the ICPC and the MoH, as such an institutionalized joint oversight is expected to enable the ICPC to provide technical guidance to help ensure a proper implementation of the strategy.

3 Discussion of the approach to date

3.1 General framework

To better understand the Moroccan case and to draw the lessons learned, the approach will be examined using a framework of issues critical for this type of approach (Chêne, 2010). The following discussion takes into consideration the strategic focus, as well as the implementation factors concerning political will, institutional capacity and operational challenges. The assessment and the lessons learned are focussed on the phases undertaken by September 2012.

3.2 Focus on corruption in the delivery of services: An adequate design?

As described above, the strategy focuses on the corruption that mainly takes place in health service delivery. Several arguments were brought forward by the ICPC to explain and justify this decision. First, the prevalence of petty corruption in the Moroccan health-care system

stands at an alarming rate, and has a serious impact by restricting access to care. Poor patients who cannot afford to pay a bribe receive worse-, slower- or no treatment at all. This is illustrated by the account of one informant who related the personal experience of a colleague whose son had died in the weeks before the interview. After rushing to the hospital, the father first had to pay a bribe before his son was examined, even though the condition was so serious that he ended up dying in the hospital. In addition to negative individual incidents of this kind, widespread petty corruption exacerbates inequality and erodes general trust in the system. Second, a concentration on feasible goals can be a reasonable decision, as the "soft" approach chosen allows for addressing processes and preventing future acts of corruption, rather than investigating and sanctioning past misconduct. If adequate measures were implemented, this was expected to lead to quick wins without the need for major political decisions or cooperation with other sectors, ministries, etc. Third, based on the assessment that under the current conditions reforms for addressing grand corruption would have little chance of success, the ICPC considered it difficult to force major changes on the health sector. Thus, the decision for a strategic focus on small-scale corruption in the delivery of services to generate quick wins and tangible results is expected to be a way of making advances in tackling the issue.

On the other hand, this approach and focus gives rise to criticism, because with a high rate of impunity and considerable problems with grand corruption, critics dismiss the strategy as incomplete or even ill conceived. The concentration on corrupt acts by health-care staff or suppliers, rather than on "frying the big fish", can cause discontent among the public, in addition to the fact that those affected by anti-corruption efforts may be resistant to reforms. This is especially significant in an environment that informants characterized as follows: a high sensitivity towards doctors and medical staff for becoming stigmatized as corruptors, non-medical staff dissatisfied with the compensation and prestige of their work and the security of their jobs and a civil society demanding change and accountability, particularly for those involved in grand-scale rent seeking and corruption.

In addition to this situation in the health sector, it is worth noting that there has been a general criticism that the investigation and prosecution of corruption cases has been limited to acts of petty corruption (Global Advice Network, 2011), with the aforementioned review in 2011 by Transparence Maroc is meaningfully entitled: "Fight against corruption in 2011: Between the promising discourse of the authorities and the reality of endemic corruption."

Independently of how justified this criticism may be, discontent on behalf of the general public, civil society and stakeholders in the sector is an important factor that must be taken into account.

3.3 Strong leadership: Prerequisite for the fight against corruption

A credible commitment and strong highest-level leadership are fundamental requirements for any reform process leading to sustained changes. The low public budget of the health sector, a lack of sanctions imposed for corrupt offenses, a failure to implement measures recommended in prior studies and the delay to implement the action plan proposed in the current health sector anti-corruption strategy are the main arguments brought forward by critics to stress an apparent lack of political will for thoroughly addressing corruption in the health sector. Conversely, the reported importance attributed to the topic by the current Health Minister, who came to office in 2012 (one of his first visits after taking office was to the ICPC), the fact that the MoH signed an cooperation agreement with the ICPC, the fact that it started introducing measures and that it now intends to implement the action plan are all arguments brought forth by the interviewees to stress the determination of public health authorities to tackle the problem.

In sum, the Moroccan experience highlights the importance of a clear commitment and proactive management of the process by political leaders. Irrespective of whether delays in implementation and the obstacles encountered are caused by a lack of political will or by other impeding factors, such as a lack of resources, political pressure or resistance to change, the point to be made here is that it is essential to constantly and credibly convey signals of strong leadership to get and keep all stakeholders aboard in support of reform plans, particularly medical staff and the public.

3.4 Institutional capacity and control over the process: basics for implementation

The drivers of the reform process need to have the institutional capacity, including human and financial resources, and assume ownership. With constrained political powers,

little funding and consequently a lack of staff, the ICPC has limited means to create a significant impact. Therefore, and in view of the fact that the responsibility of generating tangible results in preventing corruption falls into the realm of line ministries, it is important to stimulate other institutions such as the MoH to address corruption. In this endeavour, the ICPC relies on a cooperative approach, which includes focussing on corruption risks and preventive action, as well as emphasizing transparency and good governance as targets rather than detecting and investigating actual corrupt incidents. Since the ICPC delivered the results of the problem analysis and priority setting process in 2011, the responsibility for implementation has been with the MoH.

The Arab Spring, the parliamentary elections at the end of 2011, a new constitution and a new government, including a new Health Minister, all had a significant impact on the management of the health sector in general and consequently on the conditions for the strategy implementation. As mentioned above, the MoH has started to implement some measures, and the ICPC has started a pilot project. However, the structured implementation process that had been proposed has not yet been initiated. It remains to be seen how this process will be advanced with the new Health Minister and a joint MoH-ICPC committee that would institutionalize the role of the ICPC for providing technical guidance and assistance in monitoring the implementation.

3.5 Ensuring ownership: Inclusion of relevant stakeholders

Including all relevant stakeholders at an early stage greatly increases the chances of designing an adequate anti-corruption approach for a given sector and implementing it to create a sustained impact. The composition of the ICPC's General Assembly reflects this intention, given that its members are drawn from all sectors of society. However, the research for this paper uncovered a general lack of awareness by the interviewees about the sector approach, thereby indicating that the approach can be strengthened through complementary activities, e.g. sector-specific sub-committees, workshops and other initiatives to explicitly include and inform stakeholders from the sector. A communication plan for the various phases of the project is a fundamental tool to foster this objective by managing expectations. Bringing all the relevant actors, namely unions, NGOs, the suppliers of medical equipment, the pharmaceutical industry, public and private insurers and development partners to the table at an early stage is beneficial in two ways in terms of providing additional technical expertise and practical experience for the design of measures, and decreasing resistance to their implementation. The ICPC is planning to increase stakeholder participation by inviting them to a workshop to present and discuss the action plan and responsibilities for implementation. In particular, the ownership of those affected is vital. Interviewees expressed great concern about the risk that medical staff, especially doctors, who may oppose reforms.

3.6 Integrating the strategy: Linkage with other policy reforms and sectors

In order to avoid the risk of a silo approach, it is important that a sector anti-corruption approach be integrated horizontally and vertically to other existing sector- and government policies. As mentioned above, since 1995 a number of reforms have been implemented that have had a great impact on the health sector in terms of its organization, financing, infrastructure and the results of health outcomes.

Additionally, efforts to implicitly address corruption through reducing opportunities for corruption are at the core of policy reforms in Morocco, several of which have been or are being implemented, including:

- Redefinition, de-concentration, simplification, electronic data processing in the administration;
- Transparency and moralization of public life;
- Modernization of public function, human resource management and budgeting.

In sum, major changes have reformed the sector and significant achievements have been accomplished concerning infrastructure and the quality of services available to the public, as well as health outcomes in the recent past (Health Affairs, 2007; WHO, 2010a).

It remains to be seen as to how issues of horizontal and vertical integration of the sector approach will be accomplished. Because its design is based on a review of the current anti-corruption policy framework and sector specific plans by the MoH, sector-internal (vertical) integration appears feasible. The bigger challenge may be to (horizontally) integrate the approach with reforms and processes that address the general challenges of governance mentioned above (impunity, poor budgetary oversight, etc.) – with a special focus on rather small-scale corruption in health service delivery.

Coordinating and integrating the (sector) specific activities has been identified as a major task for the combatting of corruption in Morocco (ICPC, 2012), and it will be interesting to observe how it is being met during implementation.

3.7 Challenges and pending issues: Lessons for future approaches

It is difficult to draw clear conclusions because the full implementation of the strategy is still pending. Individual measures taken by the MoH, a bilateral pilot project between the ICPC and a group of 10 hospitals in Rabat do not reflect what the strategy is aiming for, namely a systematic approach to address corruption. To this end, the action plan foresees a strategic course of action with prioritized activities, including projects to set up project management, follow-up indicators, etc. in the initial stage. As in many efforts to address corruption effectively, the real challenge is the implementation. A particularly challenging task of putting such a strategic plan into practice would limit the power of certain individuals or groups, who in turn might resist change. As described above, doctors and health staff may be an issue in this respect.

To put this discussion into a broader context, it can be said that corruption is a well-observed topic in Morocco, as the media are covering corruption scandals, several NGOs are dedicated to combating corruption and Morocco ratified the UNCAC and hosted its Conference of the States Parties in 2011. The Arab Spring and the Mouvement 20 février , as well as the new constitution, have reportedly increased the rights of the citizens and given rise to a civil society that demands its rights and calls for action against corruption. Speaking in general terms, change appears to be happening.

4 Lessons learned and recommendations

Analysing and understanding the process of intended reforms offers the chance for other countries to participate in the learning experience, and this section summarizes the lessons to be drawn from the process to date. Since Morocco is now facing the crucial phase of implementing the health sector anti-corruption strategy, the evolution of this process will offer more lessons to be learned in the future, including from the monitoring and follow-up approach. This will provide data for assessing this project more thoroughly and help gain an improved understanding of sector approaches. Hence, Morocco is a case to keep watching as this process unfolds.

4.1 Analysis and priorities: Devising a strategic anti-corruption approach for the health sector

Issue in Morocco

As elaborated in the discussion, the current strategy needs to be understood for what it is: a systematic method for addressing corruption in the delivery of health-care services based on an extensive analysis and comprehensive action plan. Due to the reasons described above, prioritizing service delivery may well be a valid option to initiate the process of addressing corruption in the Moroccan health sector. However, important actors and corruption risks known to be of importance have not been covered yet, so to tackle the issue on a sector-wide basis, the current approach could be complemented by an adequate strategy to include all relevant actors and corruption risks, particularly grand corruption.

Lessons learned

When devising a strategic sector approach, one course of action is to start with feasible goals and measures such as addressing petty corruption. The (more difficult) part of the problem, grand corruption, can be addressed in a second step. Nevertheless, it is recommended for several reasons to cover both types of problems, at least in the analysis, from the beginning. First, explicitly acknowledging the problem and its complexities could be expected to increase the credibility of the strategy, strengthen the confidence of citizens and lower resistance from those affected by the reforms. An explicit communication strategy explaining a phased approach to stakeholders, citizens and the media is a crucial component to help create the necessary support. Otherwise, it will be difficult to counter arguments that the approach resembles window dressing and fails to address important aspects the problem. Second, understanding the entire problem allows for strategic action when and where possible. Fundamental health sector reforms, such as those of the recent past, could be designed in a way that considers their implications for corruption risks. This is especially true for the issue of integrating sector approaches with the broader governance reforms that have been previously mentioned. For instance, it was noted that the penal and judicial system should be attuned to the needs of the fight against corruption to properly fulfil its function (ICPC, 2012). Moreover, an analysis of the incentive structures and corruption risks of all actors – including a specific focus on grand corruption – can help determine the needs for broader reforms of the justice system from the health sector perspective. In this way, sector approaches can be a helpful step for ensuring that general governance reforms are appropriately designed to best achieve their goals. Third, given that petty and grand corruption tend to reinforce each other, measures for addressing corruption at the interface with patients may require a more encompassing approach, e.g. to address nepotism in appointments, corruption in drug procurement and the purchasing and management of equipment and supplies.

4.2 Anti-corruption measures: Integrating measures with sector goals

Issue in Morocco

The results of the discussion indicate that two items are currently pending. First, the implementation could benefit from a systematic way of integrating the anti-corruption measures into the main sector goals. The sector anti-corruption approach is intended to complement the MoH's strategic health plan, and outcomes have been specified for each of the 55 projects. How they are being quantified, measured, followed up and integrated into the overall sector goals is an important factor for success that remains to be determined in the implementation. Second, ownership of the process and the active pursuit of change by staff are key elements for success, thus the planned workshop and other measures to increase stakeholder participation are of great importance.

Lessons learned

Integrating a sector anti-corruption strategy into health policies and plans requires careful planning on different levels and the consideration of various actors. Generally speaking, it may be helpful to include key stakeholders at an early stage, as they tend to be an important resource for the design of the strategy and an essential component for its smooth implementation. Furthermore, aligning measures and their evaluation criteria with the sector goals at the implementation level is expected to be helpful. Among other things, this can increase support from stakeholders since it draws attention away from misconduct of staff and avoids risks of stigmatization. Integrating the anti-corruption projects with the indicators for following up on the implementation of the MoH's strategic health plan (Ministère de la Santé, 2008: 92ff) could be beneficial. In combination with keeping an eye on measuring experienced corruption levels, an indicator used for measuring productivity, namely the ratio of admissions per doctor, could be applied in the follow-up on projects that address topics of admissions (axis 6, management and control of activities). Potentially, similar recommendations for the quantification and follow-up that facilitate the integration of the anti-corruption projects with the sector strategy could be made as early as in the design phase.

4.3 Implementation: Ensuring follow through by means of leadership and ownership

Issue in Morocco

The reform process became delayed after the delivery of the action plan, so to ensure a proper implementation, follow-up and oversight need to be institutionalized, including the capacity for the timely identification of potential

obstacles or bottlenecks. The creation of a new committee between the MoH and the ICPC may lead to a strategic implementation that adequately addresses the political and institutional challenges. More importantly, the MoH is responsible for moving things forward, taking active responsibility for the implementation, sending credible signals (tone from the top), informing key stakeholders and driving the implementation of the action plan as proposed, including quantified monitoring and evaluation.

Lessons learned

Ensuring institutional leadership and ownership for all of the main stakeholders is crucial throughout the process. In particular, the involvement of multiple actors and changes in terms of institutional responsibilities at different stages of the reform cycle bears foreseeable risks. The implementation of a sector anti-corruption strategy should be integrated into the daily routine of sector agencies and linked with other sectors and reform strategies. As in the Moroccan example, appropriate performance indicators to gauge performance and achievements should be included to help enable policy makers to evaluate the impact. If these reveal that the strategy was not implemented accurately or that the impact of the measures taken is not satisfactory, changes can be made.

4.4 Potential implications for donors

Lastly, it is worth noting that donor agencies have not played any role in the development and initial implementation of this health sector anti-corruption approach. However, the lessons discussed above illustrate how donor agencies, in accordance with their greater focus on promoting sector anti-corruption approaches, might be helpful in four ways: 1) They can provide punctual support. Working with host-country counterparts, donors can contribute examples and experiences of international good practices on diagnosing the problem and developing appropriate counter-measures, including an adequate system for monitoring and evaluation; 2) Donors can help to facilitate a dialogue and buy-in with relevant institutions. Experiences of social witnesses have shown in several settings that external monitoring can increase pressure on institutions to live up to their commitments and to follow through with reforms as planned; 3) Donors can provide material support, both financially and with qualified staff, to promote systematic sector approaches that specifically require a strong technical anti-corruption support in their design and initial implementation phase to help in complementing the skills and capacities of sector specialists, and 4) Donors are well placed to provide support for rigorous and regular monitoring and follow-up mechanisms within the public sector institutions themselves, but also, and perhaps more importantly, for those conducted by external actors, including civil society organizations, community-based organizations, universities, professional organizations, etc.

Given their potential and objectives, donors can and should play an active role in sector anti-corruption approaches – particularly in light of the fact that many of them have recommend this practice for some time.

Reference list

BAMF (Bundesamt für Migration und Flüchtlinge) (2012). Country Fact Sheet: Morocco. www.bamf.de/SharedDocs/MILo-DB/EN/Rueckkehrfoerderung/Laenderinformationen/Informationsblaetter/cfs-marokko-download-englisch.pdf;jsessionid=A6BE59AD8061FB8DF3760D490BB4D8F0.1_cid294?__blob=publicationFile

Chêne, M. (2010). Mainstreaming Anti-Corruption within Donor Agencies. U4 Expert Answer. Bergen, Norway. www.u4.no/publications/mainstreaming-anti-corruption-within-donor-agencies/

Global Advice Network (2011). Business anti-corruption portal: Morocco Country Profile. www.business-anti-corruption.com/en/country-profiles/middle-east-north-africa/morocco/

Global Integrity (2009). Global Integrity Report 2009: Key Findings. http://report.globalintegrity.org/globalindex/findings.cfm

Global Integrity (2010). Global Report Morocco 2010. www.globalintegrity.org/report/Morocco/2010

Hussmann, K. (2007). Anti-corruption policy making in practice: What can be learned for implementing Article 5 of UNCAC? Report of six country case studies: Georgia, Indonesia, Nicaragua, Pakistan, Tanzania and Zambia. U4 report 2007:1 (1st part). Bergen, Norway. www.u4.no/publications/anti-corruption-policy-making-in-practice-what-can-be-learned-for-implementing-article-5-of-uncac/downloadasset/177

Hussmann, K. (2011). Addressing corruption in the health sector: Securing equitable access to health care for everyone. U4 Issue 2011:1. Bergen, Norway. www.cmi.no/publications/file/3934-addressing-corruption-in-the-health-sector.pdf

ICPC (2010[a]). ETUDE SUR LE PHENOMENE DE LA CORRUPTION DANS LE SECTEUR DE LA SANTE : EVALUATION ET DIAGNOSTIC. Phase 1: Rapport sur l'évaluation des politiques et pratiques concernant la prévention et la lutte contre la corruption dans le secteur de la Santé. Version Provisoire.

ICPC (2010b). ETUDE SUR LE PHENOMENE DE LA CORRUPTION DANS LE SECTEUR DE LA SANTE : EVALUATION ET DIAGNOSTIC. Phase 2: Etude des manifestations, de la fréquence et de l'intensité ainsi que des causes et des implications de la corruption dans le secteur de la Santé. Version Provisoire.

ICPC (2011a). ICPC's sector approach to the analysis of corruption and the design of specific sector strategies. Brief description of the study about corruption in the health and transportation sectors in Morocco.

ICPC (2011b). Etude sur le phénomène de la Corruption dans le secteur de la Santé: Evaluation et Diagnostic. Rapport de synthèse. Rabat. www.icpc.ma/wps/wcm/connect/9696e280487ecd89be94be45f50d2bf5/ICPCS_Note+de+Synth%C3%A8se+Sant%C3%A9_20110623_AE_TEF.pdf?MOD=AJPERES&CACHEID=9696e280487ecd89be94be45f50d2bf5

ICPC (2011c9. Le rôle de la coopération dans la lutte contre la corruption. http://www.icpc.ma/wps/wcm/connect/95fb240048ffaa5b94dbf742071e6776/Le+r%C3%B4le+de+la+coop%C3%A9ration+dans+la+lutte+contre+la+corruption.pdf?MOD=AJPERES&CACHEID=95fb240048ffaa5b94dbf742071e6776

ICPC (2012). Résumé du rapport 2010-2012: Instance Centrale de Prévention de la Corruption. http://www.icpc.ma/wps/wcm/connect/48f467804d4dfb528987af3f624bc886/+R%C3%A9sum%C3%A9+fr.pdf?MOD=AJPERES&CACHEID=48f467804d4dfb528987af3f624bc886

Ministère de la Santé (2008). Plan d'action santé, 2008-2012: 'Réconciller le citoyen avec son système de santé'. Rabat. http://www.sante.gov.ma/INAS/pdf/Plan-action-08-12.pdf

Savedoff, W., & Hussmann, K. (2006). "Why are health systems prone to corruption"? In Global Corruption Report 2006, edited by Transparency International, 4-16. http://archive.transparency.org/content/download/4816/28503/file/Part%201_1_causes%20of%20corruption.pdf

Semlali, H. (2010). Positive Practice Environments Campaign. The Morocco Country Case Study. WHO, International Council of Nurses. http://www.who.int/workforcealliance/knowledge/resources/ppemorocco/en/index.html

TI (Transparency International) (2010). Global Corruption Barometer 2010. http://www.transparency.de/fileadmin/pdfs/Wissen/Korruptionsindices/GCB_2010.pdf

TI (Transparency International) (2012). Corruption Perceptions Index 2012. http://cpi.transparency.org/cpi2012/

TM (Transparency Maroc) (2001). La corruption au Maroc: Synthèse des résultats des enquêtes d'intégrité. www.transparencymaroc.ma/uploads/communiques1/19.pdf

TM (Transparency Maroc) (2009). National Integrity System Study Overview Morocco 2009. http://files.transparency.org/content/download/272/1092/file/2009_MoroccoNISSummary_EN.pdf

TM (Transparency Maroc) (2012). Lutte contre la corruption en 2011: Entre le discours prometteur des pouvoirs publics et la réalité d'une corruption endémique. Observatoire de la Corruption et du Développement de la Transparence au Maroc. Revue de presse 2011. http://www.transparencymaroc.ma/uploads/projets/Fr/5065_1.pdf

WBI (World Bank Institute) (2011). Worldwide Governance Indicators. http://info.worldbank.org/governance/wgi/index.asp

WHO (2010). Every Woman Every Child: Access for all to skilled, motivated, and supported health workers. www.who.int/pmnch/activities/jointactionplan/20101007_4_skilledworkers.pdf

may be, discontent on behalf of the general public, civil society and stakeholders in the sector is an important factor that must be taken into account.

3.3 Strong leadership: Prerequisite for the fight against corruption

A credible commitment and strong highest-level leadership are fundamental requirements for any reform process leading to sustained changes. The low public budget of the health sector, a lack of sanctions imposed for corrupt offenses, a failure to implement measures recommended in prior studies and the delay to implement the action plan proposed in the current health sector anti-corruption strategy are the main arguments brought forward by critics to stress an apparent lack of political will for thoroughly addressing corruption in the health sector. Conversely, the reported importance attributed to the topic by the current Health Minister, who came to office in 2012 (one of his first visits after taking office was to the ICPC), the fact that the MoH signed an cooperation agreement with the ICPC, the fact that it started introducing measures and that it now intends to implement the action plan are all arguments brought forth by the interviewees to stress the determination of public health authorities to tackle the problem.

In sum, the Moroccan experience highlights the importance of a clear commitment and proactive management of the process by political leaders. Irrespective of whether delays in implementation and the obstacles encountered are caused by a lack of political will or by other impeding factors, such as a lack of resources, political pressure or resistance to change, the point to be made here is that it is essential to constantly and credibly convey signals of strong leadership to get and keep all stakeholders aboard in support of reform plans, particularly medical staff and the public.

3.4 Institutional capacity and control over the process: basics for implementation

The drivers of the reform process need to have the institutional capacity, including human and financial resources, and assume ownership. With constrained political powers, little funding and consequently a lack of staff, the ICPC has limited means to create a significant impact. Therefore, and in view of the fact that the responsibility of generating tangible results in preventing corruption falls into the realm of line ministries, it is important to stimulate other institutions such as the MoH to address corruption. In this endeavour, the ICPC relies on a cooperative approach, which includes focussing on corruption risks and preventive action, as well as emphasizing transparency and good governance as targets rather than detecting and investigating actual corrupt incidents. Since the ICPC delivered the results of the problem analysis and priority setting process in 2011, the responsibility for implementation has been with the MoH.

The Arab Spring, the parliamentary elections at the end of 2011, a new constitution and a new government, including a new Health Minister, all had a significant impact on the management of the health sector in general and consequently on the conditions for the strategy implementation. As mentioned above, the MoH has started to implement some measures, and the ICPC has started a pilot project. However, the structured implementation process that had been proposed has not yet been initiated. It remains to be seen how this process will be advanced with the new Health Minister

Notes

1. All foreign quotations are translations by the authors. For ease of reading they are not marked as such in each case.
2. In the wake of manifestations in other Arab countries, on February 20 of 2011, thousands of Moroccans demonstrated demanding political reforms. In the aftermath, several reforms were passed, including a new constitution.

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