"It Keeps Us from Putting Drugs in Pockets": How a Public-Private Partnership for Hospital Management May Help Curb Corruption

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Perm J 2017;21:16-113

E-pub: 07/05/2017

https://doi.org/10.7812/TPP/16-113

ABSTRACT

Introduction: Health care sector corruption diverts resources that could otherwise be used to improve access to health services. Use of private-sector practices such as a public-private partnership (PPP) model for hospital governance and management may reduce corruption. In 2011, a government-run hospital in Lesotho was replaced by a PPP hospital, offering an opportunity to compare hospital systems and practices.

Objective: To assess whether a PPP model in a hospital can help curb corruption.

Methods: We conducted 36 semistructured interviews with key informants between February 2013 and April 2013. We asked about hospital operations and practices at the government-run and PPP hospitals. We performed content analysis of interview data using a priori codes derived from the Corruption in the Health Sector framework and compared themes related with corruption between the hospitals.

Results: Corrupt practices that were described at the government-run hospital (theft, absenteeism, and shirking) were absent in the PPP hospital. In the PPP hospital, anticorruption mechanisms (controls on discretion, transparency, accountability, and detection and enforcement) were described in four management subsystems: human resources, facility and equipment management, drug supply, and security.

Conclusion: The PPP hospital appeared to reduce corruption by controlling discretion and increasing accountability, transparency, and detection and enforcement. Changes imposed new norms that supported personal responsibility and minimized opportunities, incentives, and pressures to engage in corrupt practices. By implementing private-sector management practices, a PPP model for hospital governance and management may curb corruption. To assess the feasibility of a PPP, administrators should account for cost savings resulting from reduced corruption.

INTRODUCTION

Corruption is a serious challenge to achieving the goals of population health and sustainable development. In 42 of 109 countries surveyed by Transparency International, more than 50% of respondents said that the health care sector was corrupt or very corrupt.[1] The World Health Organization estimated that of the $5.7 trillion in worldwide health care expenditures in 2008, 7.3% or $415 billion was lost to health care fraud and abuse, including practices ranging from theft of medicines to organized crime rackets billing insurance funds for services that were never provided.[2] Beyond the financial costs are the social and human costs of corruption, especially in low-income settings. A study of 20 African countries showed that higher perceived national corruption was negatively associated with health outcomes, with more detrimental impact among lower social classes.[3] Other studies support these findings.[4-7] Researchers believe that the immediate and delayed effect of corruption on health outcomes, including mortality, is caused by disrupting access to and the quality of health care systems, and distorting the amount and allocation of national health care investments.[7]

Types of corruption that occur at point of service may include informal payments (a direct contribution, made in addition to any contribution determined by terms of entitlement, to health care practitioners for services to which patients are entitled),[8-11] embezzlement of medicines and supplies,[12,13] shirking (ie, avoiding or neglecting assigned work duties and responsibilities, or conducting private practice instead of the assigned task during public work hours),[14] and absenteeism (ie, habitual nonpresence of an employee at his/her job when the employee is capable of working).[15,16] Sometimes called "quiet corruption,"[17] these types of abuses siphon scarce resources away from health care facilities, increase costs, and undermine the functioning of the health sector.[18] Strategies for combating corruption include strengthening oversight of clinicians,[19-21] introducing fraud control measures or civil service reforms (eg, meritocratic recruitment, improved salaries, and decentralization), and changing health care financing systems.[22] However, these initiatives take time; are politically sensitive; require resources, expertise, and leadership; and have not always been successful.[23]

Public-private partnerships (PPPs) promote greater private-sector participation in the financing, delivery, and operation of government-initiated infrastructure projects and public services. In Europe, PPPs may provide a means to meet the challenge of how to pay for necessary health care infrastructure, especially in new member states.[24] Yet, although the European Commission's plan for investment encourages private financing of public infrastructure,[25] reliable evidence on PPP performance is scarce.[26] Value-for-money, transparency, and accountability are important factors to consider when contracting for facility management and clinical service delivery.

PPPs can involve different kinds of governance, financing, management, and risk-sharing arrangements,[27-29] and they provide an opportunity for public sector partners

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to benefit from private financing and management. In addition, there is some evidence that health sector PPPs improve the quality of care provided.[30-32] However, the context in which PPPs are implemented is critical in determining whether the investment is worthwhile.[28,29] Internal enablers (perceived need and intention to collaborate) and external enablers (the operating environment and market conditions) affect PPP success.[33] Governance of complex PPP relationships may use contractual or relational mechanisms that complement each other.[34] For example, contracts are often used to mitigate opportunistic behavior by the private partner through formal control systems, whereas relational mechanisms such as informal meetings can help build trust and enhance informal control and information sharing.[35] In health care settings where rampant corruption limits access to and decreases the quality of care, it is possible that the PPP model, through its private partner governance and management, might help curb corruption, creating a more favorable operating environment. Our overarching research question, therefore, is whether the use of health sector PPPs can reduce "quiet" forms of corruption during service delivery, such as employee shirking, absenteeism, and embezzlement.

In Maseru, Lesotho, a newly built PPP hospital replaced an aging, government-run hospital.[36,37] The private partner in this project, Ts'epong Ltd, a consortium made up of a private South African health care provider and several Lesotho-owned businesses, was responsible for designing, building, partially financing, equipping, and fully operating the new hospital.[37] The relationship between Ts'epong and the government was primarily contractual rather than relational.[38] The interests of the two entities were aligned by the agreement stipulating benchmarks related to the operation of the hospital (eg, types of services offered, numbers of patients seen, and standards of care quality), with fines being imposed if certain benchmarks were not met, and additional monies paid if some benchmarks were exceeded.[37] Ts'epong was then autonomous in how it managed hospital operations, with relationships in the Ts'epong consortium governed both contractually and relationally.

The PPP hospital, like its predecessor, provided publicly funded health care services in the capital district, the largest urban area in the country with approximately 20% of the population,[39] and referral services for the rest of the country. The PPP hospital opened in October 2011 just as the government-run hospital closed, and many staff from the old hospital were employed to work under the management of the private partner at the new hospital. The replacement of the government-run hospital with a PPP hospital provided an opportunity to assess changes stemming from the PPP via a quantitative study comparing measures of capacity, utilization, clinical quality, and patient outcomes[30] as well as a qualitative study assessing differences in roles and functions between the 2 hospitals.[40] Those studies showed that the PPP had better clinical outcomes and had changed many managerial practices compared with the government-run hospital. Differences between the 2 hospitals raised questions about whether changes put into place by the PPP might influence the scope of corrupt practices. To our knowledge, there have been no studies examining the association between PPP management systems and their effects on corruption. Therefore, the purpose of this article was to compare hospital systems and practices that related to corruption between the government-run hospital and the PPP hospital that replaced it using interview data that were previously collected. Our findings add to our understanding of value creation in hospital PPPs[41] and the role of autonomous governance in addressing corruption.

METHODS

Semistructured Interviews

We used a qualitative study design. In February 2013 to April 2013, about 1.5 years after the PPP hospital opened, an interview team consisting of 2 of the coauthors (NM and AG) conducted semistructured interviews with a purposeful sample of hospital leadership, subcontractors, consultants, and government officials, as well as a convenience sample of hospital technicians and support staff. These interviews were done as a part of a previous study to document perceptions and mechanisms by which the PPP may have altered innovation, technical knowledge and skills, and organizational culture, and how these changes may influence clinical outcomes.[40] Key informants were purposefully chosen to include members of the hospital executive team, service chiefs, and contractors who would have knowledge of how management systems operated under the PPP (eg, the hospital Director and Heads of the Nursing, Pharmacy, Finance, and Administration Services, clinical managers of each ambulatory clinic, and the subcontractors responsible for laboratory and maintenance services). We also selected government key informants who would have knowledge of the PPP and the hospital it replaced, including the Ministry of Health Head of Clinical Services, all staff of the PPP oversight unit, the financial controller, and the district statistician. To understand the perceptions of lower-level hospital employees, we interviewed a convenience sample of hospital physicians, nurses, technicians, and support staff.

Each interview lasted between 30 minutes and 60 minutes. Informants were first asked, "How do PPP hospital systems differ from the systems in place at the government-run hospital?" The functioning of each service (eg, pharmacy, laboratory) was then probed through questions such as "How does the hospital manage this function now? How does this affect performance? Is this different from how the function was managed previously?" We asked key informants to describe the most important factors driving performance, and what they thought were possible reasons for changes in performance between how the government hospital used to perform, and how the PPP hospital performs now. We did not directly ask participants about practices of occupational fraud or corruption. The interview team compared and consolidated notes after each interview to create a final written transcript.

Data Analysis

We used a modified Corruption in the Health Sector framework to guide the analysis of our interview data.[22] This framework is based on prior work by one of the authors[18] and has been used in corruption vulnerability assessments in

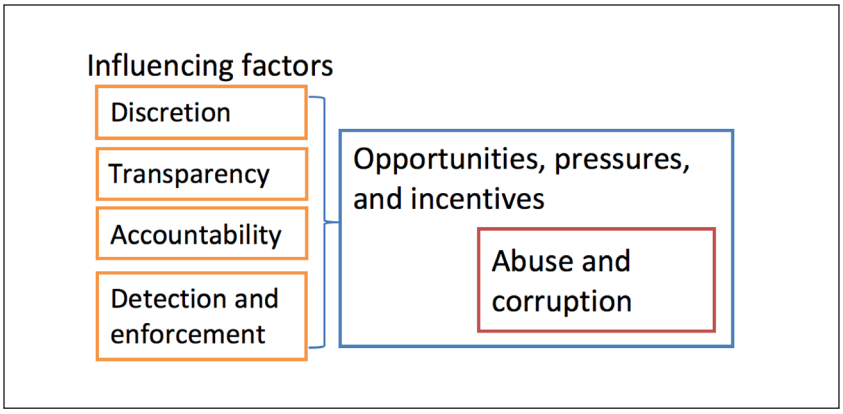

Figure 1. Corruption in the health sector framework

Albania,[42] Azerbaijan,[43] and Vietnam.[44] In this framework the five concepts of discretion, transparency, accountability, detection, and enforcement are associated with opportunities for abuse and/or pressures or incentives for abuse (Figure 1). We did content analysis of interview transcripts using these concepts as our a priori codes. We examined text describing management practices at the PPP or government-managed hospital and identified where these practices illustrated some aspect of the five concepts and/or where the informants mentioned abusive practices. Data were organized using spreadsheets (Microsoft Excel, Microsoft Corp, Redmond, WA).[45] The lead analyst (NM) performed initial coding, with review by a second member of the team (TV). We reached consensus on differences in coding through team discussions. We then grouped codes by management subsystems and made comparisons between the government-run hospital and the PPP hospital. The study was approved by the Boston University Medical Campus institutional review board and the Ethics Committee of the Lesotho Ministry of Health.

RESULTS

We interviewed 36 key informants, including 24 hospital executives, Chiefs of services, clinicians, technicians, and support staff; 8 government personnel from the Ministries of Health and Social Welfare; and 4 subcontractors/consultants. Fifteen informants were men (42%); 26 were citizens of Lesotho (72%; other nationalities included South Africa and 5 other countries). Twenty-three (64%) key informants had worked at both the government-run and the PPP hospitals.

The most common corrupt practices described at the government-run hospital were theft of medicines and equipment by clinical staff, absenteeism, and shirking. Participants stated that although the aforementioned problems had occurred in the government-run hospital, they were less frequent or had been eliminated in the PPP hospital. None described informal payments in either hospital.

Interviewees described anticorruption mechanisms that reduced opportunities for corruption or altered incentives, making corruption less likely. These were present in four management subsystems: human resources, facility and equipment management, drug supply, and security. The mechanisms are listed in Table 1 along with sample quotations showing how practices differed between the government-run and PPP hospitals.

Here we discuss the types of anticorruption mechanisms identified (ie, discretion, transparency, accountability, and detection and enforcement) and give evidence for each.

Discretion

Discretion is defined as the freedom or autonomy to use one's own authority and judgment to make decisions.[46] Through the PPP, discretion was limited by clear rules and consistent oversight. A major control on discretion was the implementation of a medication management system that tracked medicines by individual patient. At the government-run hospital, medications were stored and controlled at the ward level, and were dispensed without individual patient prescriptions. At the PPP hospital, when a physician ordered a medication, pharmacy staff entered the prescription into an electronic system. The staff member affixed a sticker with the patient's information to the back of the prescription and sent it to the appropriate ward, where a ward clerk received and accounted for it. This reduced the discretion of ward nurses regarding medications and limited opportunities for theft of medicines. One participant described the process: "Inpatient medication is [ordered] per person now, not for the entire ward. When it was for the entire ward [at the government-run hospital], that was why a lot of people were selling drugs on the outside. Now that is not easy to do. Everything that goes to the ward is recorded [in the electronic system]."

At the same time, discretion was increased at the PPP hospital by giving some staff greater authority to make decisions. For example, a pharmacy manager described how she could reorder medicines without having to get extra permissions. Her ability to make these decisions in a timely manner allowed her to keep lower amounts of stock on hand, thus reducing the opportunity for theft. The ability to get a fast decision was seen as driving performance in the PPP. "In government, it might take a long time to get a decision. There is so much red tape ... but here we know the decision will get made. You can trust that you'll get feedback, an answer." Participants also described how service heads were empowered to resolve issues: "If there is a problem you go to that department team leader. This results in more accountability because people are responsibly solely for their department."

Transparency

Transparency is defined as the active public disclosure of information on roles, policies, process, objectives, and results.[47] The PPP influenced transparency by disseminating written policies and procedures, improving electronic and paper data systems, and encouraging data-based decision making. Hiring and promotion procedures

Table 1. Public-private partnership (PPP) anticorruption practices by management systems

PPP practice	Anticorruption mechanism	Sample quotes comparing government-run hospital with PPP hospital
Human resources		
Written policies are disseminated	Transparency	*It is not that there were no policies and procedures [at the government-run hospital]. But [at the PPP hospital] we have access to them in how we do work … the policies are clear. I make sure staff have read them and understand them. Everything now, you write it down.*
Explicit work expectations	Accountability	*Back then [at the government-run hospital] we were civil servants, and we worked like civil servants. You only do something if someone is pushing.* *People had small businesses that they were running outside before [at the government-run hospital], because they didn't have to be here completely.* *Here [at the PPP hospital] you have a role. You know what to do. You can't just sit.*
Performance evaluations tied to rewards for good performance	Accountability, reducing pressure for corruption	*From when people join [the PPP hospital], they know that the 13th check [annual bonus] will be performance-based.* *Before [at the government-run hospital], some people … did good nursing, but they weren't appreciated. No one ever said "thank you." Now [at the PPP hospital] they are appreciated and rewarded. You might get the "best ward" award and all staff will get a voucher to buy things in shops.*
Explicit disciplinary processes	Transparency, discretion, accountability	*[At the government-run hospital] if there was a breakdown in discipline, and you wanted to do something about it, with civil service rules our hands were tied … [in the PPP hospital] you can immediately take care of problems with disciplinary action.* *A lot of discipline has taken place, disciplinary inquiry [at the PPP hospital]. [People are told] "If you do this, it is not tolerated here and we will follow disciplinary procedures." It is a tight knit community, so when that is done a few times, people hear about it and are deterred.*
Facility and equipment management		
Electronic tracking system for equipment (bar codes)	Accountability	*At [the government-run hospital] you heard about large equipment disappearing overnight, stolen … . It seems like there aren't so many security incidents at [the PPP hospital]. There are more controls [ie, an electronic tracking system].*
Inventory tracked by room of hospital where equipment is assigned	Discretion	*We are supposed to declare things [equipment] we move in and out of their assigned spaces [at the PPP hospital].*
Drug supply		
Weekly or monthly drug orders, rather than quarterly, via simplified direct order system, to reduce stock on hand	Accountability, reducing temptation or incentives to steal	*Here [at the PPP hospital], the pharmacy is not ordering large boxes but ordering very often, regularly.* *Purchasing [drugs] more often [at the PPP hospital] means less stock losses. The shelves are not stocked with a lot of drugs.*
Checking drugs received to ensure that the amount and quality of medicines received matches invoice	Accountability, detection (of possible collusion with supplier)	*[At the PPP hospital] when stock is delivered from a supplier, every box is opened and checked before it is put on the shelf. This way, the supplier can't short us.*
Integrated electronic pharmacy system allows query of stock levels in any location in real time, tracking individual medicines	Transparency, detection	*We had huge loss of medications at [at the government-run hospital]. Now [at the PPP hospital], you charge whatever [medicines] you are using for the patient. The pharmacy can see when stocks are low and reorder. That has really reduced theft.* *This [electronic pharmacy system] allows [us at the PPP hospital] to monitor systems so if one patient has a drug for too long there is an alarm [alert], so if one doctor prescribes and then another, it will be alerted. This is a big change [from the government-run hospital].*
Full inventory of stocks every 6 months, plus ad hoc inventories of in-house supplies	Detection, enforcement	*We do stock-take, a physical check compared to what is recorded in the system [at the PPP hospital]. If they don't add up, then we figure out who is accountable.*
Restrict supplies to wards; medicines are identified by patient name before being sent to the ward	Discretion	*At [the government-run hospital] when patients were admitted, we used to just get medicines in bulk, and the medication was used for multiple patients. Here [at the PPP hospital] prescriptions are ordered for patients directly, ordering per person, for 24 hours. [There was a] huge loss of medications at [the government-run hospital].*
Tracking and investigation of anomalous drug use	Transparency, detection	*There is a stock count [at the PPP hospital]: when they come in, the drugs are recorded. And then as they are distributed, it is recorded too. And if they don't match, we have to figure out [what happened].* *We can see if record-keeping is lacking [at the PPP hospital]. We might say to ward staff, "Seems like for bandages, you are using 12, but you recorded less." At first people would use medicines and not record the usage. They'd say "I have nothing," and I would say, "You are supposed to have 200!"*
Security		
24/7 security with trained guards, checkpoints, and security cameras	Detection	*We [at the PPP hospital] also have surveillance cameras in storerooms and in other areas. In [the government-run hospital there was] no surveillance. I see security here.* *Security is very disciplined here [at the PPP hospital], and you are sure they are patrolling around, maybe every 30 minutes. That helps them to be available most of the time. There is a sort of link between security and us now [compared with at the government-run hospital]. They [security] aren't just at the gate ... . [At the government-run hospital] they were just at the gate.*

were made more transparent, and communications were improved through frequent meetings and the creation of team structures and committees. One participant explained, "[In the PPP hospital] we have clear guidance on what you are supposed to do: standard operating procedures (SOPs). An SOP is like a recipe. It tells you, for example, this is how you admit a patient. These are the steps." Another participant described transparency in supply chain management: "Drugs used to be stocked out [out-of-stock in the government-run hospital], but now we use a control system. Every time I take the drug out, it says how many are left so we can order before you get to zero. This also helps because it keeps us from putting drugs in pockets." Transparent measures of performance were also available; several participants mentioned regular testing of competencies, and, at the unit level, balanced scorecards were used for performance management.

Accountability

Accountability refers to the obligation of those in authority to demonstrate effectiveness in carrying out goals and achieving results.[20] Participants described hierarchical accountability, that is, the answerability of individual agents to authorities above them.[19] To hold someone accountable requires that there are clear accountability relationships (ie, who is accountable to whom) and performance standards and procedures. It also requires tracking that standards are being upheld and mandates consequences for poor performance. Accountability is thus linked to transparency and enforcement.

The PPP influenced accountability by creating clear job descriptions and performance plans, tools to monitor individual compliance with standards, and methods to measure results. Information management systems were key to this process, but communication systems that conveyed expectations and facilitated discussions about performance were also important. This was especially noted in the human resources management systems in which participants described changes in performance expectations in the PPP hospital compared with the government-run hospital. One participant observed, "In government, people do whatever they want, whenever they want. … You can come 30 minutes late and be considered early." This was contrasted with the system under the PPP: "Time management has also changed [at the PPP hospital]. … There are clock machines. You put your hand in it, and key in your employment number. It reflects this. And when you clock out, it will show how many hours you worked." Participants described the use of regular team meetings to discuss progress toward performance goals as well as the presence of rewards for good performance (team and individual).

Not everyone, however, was able to adapt to the new expectations of accountability at the PPP hospital. Speaking of colleagues at the PPP hospital who had worked previously at the government-run hospital, one participant surmised, "People are not used to being disciplined; they are used to doing as they wish. There are some [who] have gone back to government, because they can open clinic at 7 [am] and close at 3 [pm], and nobody cares." The participant concluded that at the PPP hospital *"you either walk or run, no in-between,"* meaning either commit to working hard ("run") or get out ("walk"), but don't try to engage in occupational fraud or shirking ("no in-between").

Detection and Enforcement

Detection refers to the steps used to identify abuses of power, including investigation and audit, whereas *enforcement* refers to the process of defining and carrying out punishment of those who are caught abusing their authority or role for private gain.[48] The PPP has a biometric time attendance system that helps to detect unjustified absences from work, and it implemented bar codes on equipment and security checks at exit points to detect theft. Strong inventory control systems for medicines and equipment also included regular audits, both scheduled and unscheduled.

The PPP put into place disciplinary systems that allowed managers to impose consequences when employees were caught engaging in wrongdoing. If an employee committed a transgression, that worker was notified in writing of the reasons for the disciplinary notice, and the notice outlined a date and time of a disciplinary hearing, at which both parties had the opportunity to state their cases. The hearing resulted in decisions about disciplinary action or actions that were informed by guidelines regarding appropriate actions for different offenses. An interviewee described how at the PPP hospital there were about four cases per month that reached the level of having a disciplinary hearing, with one dismissal per month. Similarly, there was a process for employees to report grievances. Unit managers described how they appreciated the support from Human Resources that allowed them to discipline staff: "At [the government-run hospital] if you discussed with a person a problem, they would give you the 'eyes of fire.' Now [Human Resources] gives you support on what to do, and you don't have to fear that the [employee] will sue you." In addition, security systems put in place at the PPP hospital contributed to the sense that wrongdoing would be detected and punished. "It seems like there aren't so many security incidents at [the PPP hospital]. There are more controls. … They search the bags of staff when we leave. We want to promote a secure environment for the company, for patients, for staff. Everyone benefits."

DISCUSSION

Participants described how the PPP organizational structure and management systems reduced the incidence of theft of medicines and equipment, absenteeism, and shirking. Our findings suggest that this was done through changes in discretion and increased transparency, accountability, detection, and enforcement.

Anticorruption experts suggest that limiting discretion is an important control measure.[49,50] The PPP did this by creating clear guidelines and decision-making processes and by disseminating policies and procedures. Yet other research shows that giving individual managers more discretion—especially as it relates to disciplining employees—may also help control corruption.[51] We found evidence that the management of the PPP hospital used this mechanism as well, ensuring that individual unit leaders had discretion to impose sanctions on staff, while backing up unit leaders with guidance and support.

In an essay collection on transparency and accountability commissioned by the

Carnegie Endowment for International Peace, Lant Pritchett[52] argued that effective accountability requires a change in how agents perceive their role, and that problems such as absenteeism or poor performance cannot be solved by just providing additional funding for inputs and then monitoring indicators. According to Pritchett,[52] this "thin" approach to accountability ignores a core problem, that dysfunctional organizations do not enable accountable workers:

> *Once organizations have declined into dysfunction, a key problem is that formal mechanisms of accountability have ceased to have traction on the normal account of the frontline providers' behavior. Attacking that problem through "accounting" and "transparency" assumes one can beat a turtle into moving—that is, penetrate the hard defensive shell from external pressures that dysfunctional organizations have created.*[52]

Pritchett proposes replacing "accounting-based accountability" with a "thick" approach, a broader focus on high-performing systems and normative guidance.

The PPP hospital appeared to create accountability in this "thick" sense. The private partner in the PPP implemented processes and systems that enabled frontline workers—clinicians, support staff, and unit leaders—to do their work well, thereby reinforcing pride in their work and a commitment to the hospital's mission. As one PPP hospital staff said, "[Staff] are becoming interested in the business and [becoming] problem solvers. A culture of accountability in the staff has been created. [They take] pride in their job." Accountability was also facilitated and reinforced by these systems factors: standard operating procedures, trainings, and recognition awards that gave explicit guidance as to what was expected of staff, setting norms and standards. Without these external messages and rules, it is up to the individual alone to rely on his/her integrity when confronting temptations to abuse. In the government-run hospital, staff lacked support for doing good work. Although some staff persevered, many were unable to resist the pressures and opportunities to engage in corrupt practices. It is much easier to do good work when operating in a wholly accountable system.

The PPP hospital created several levels of accountability, combining more technical fixes associated with detection and enforcement (eg, regular audits, attendance monitoring) with an empowerment and incentives approach that helped workers to clearly understand their role and expectations for performance, and gave line managers the power to discipline wrongdoing while strengthening their ability to do their work well. This, in effect, created a change in organizational culture, from one in which opportunities, incentives, and pressures for abuse were common to one in which corrupt practices were not tolerated. This two-tiered approach to accountability mirrors deep "double-loop" organizational learning, in which organizations do not simply detect and correct individual issues but also attempt to change higher-order incentives, processes, and practices (ie, culture) that shift the way problems are framed and addressed.[53,54] For example, rather than simply instituting security checks at the exit of the hospital to catch equipment thieves, the PPP hospital worked to create a culture that nurtured employees' innate desire to do good work, so that it would be less likely for staff to even consider stealing hospital equipment. As a PPP hospital executive put it: "We took people out of [the government-run hospital], but the challenge is to take [the government run-hospital] out of the people. We have made strides, but there is more to do around work ethic and culture."

Creating a "thick" sense of accountability or engaging in double-loop organizational learning is difficult and generally takes time, but it may result in a deeper and more long-lasting accountability, with anticorruption practices embedded into the organization's institutional fabric. The PPP's contractual requirements to meet cost and quality standards create strong incentives for the private partner to implement management practices that expedite change in anticorruption culture. This may be further facilitated by the private partner in its ability to manage operations autonomously, without government involvement. The speed and level of change, without the impetus of the PPP contract or the expertise, resources, and leadership of the private partner, may be difficult to achieve otherwise.[55]

Despite evidence of gains in quality of services,[30-32] PPP hospitals have been criticized for being unaffordable.[56] The true cost of a PPP, however, may be lower than expected if benefits associated with reduced corruption are taken into account.[41] Organizations with high levels of abuse are unwittingly paying the cost of corruption as part of their operating expenses, like a "secret tax."[48] Although it is difficult to quantify benefits from corrupt practices averted, some studies have documented the potential savings from prevention efforts.[57-59] In estimating the economic viability of a PPP initiative, policy makers should likewise consider potential cost savings. It could be useful if future evaluations of PPP models measured perceived corruption and corruption risk factors to better understand how corruption manifests, how corruption is controlled, and the potential savings of implementing anticorruption practices. Researchers in Lesotho could build further evidence by comparing stockout rates, absenteeism, and other performance measures in the PPP hospital compared with government-managed hospitals over time.

European policy researchers have hypothesized that in the future, governments may try to separate facilities management contracts from PPP infrastructure contracts to allow more frequent repeated competition, thus encouraging redesign to reduce waste and improve efficiencies.[24] Our findings suggest that controlling corruption is another aspect of contract performance that should be considered in evaluating the productive efficiencies possible through PPP contracts.

CONCLUSION

Our findings show that corruption can be curbed in a hospital setting and that a PPP model for hospital governance is one positive mechanism in that it leverages the management expertise of the private sector. The PPP hospital implemented rules, policies, and practices across a number of management systems that changed levels of discretion; increased transparency, accountability, detection, and enforcement; and decreased opportunities, pressures, and incentives to engage in corrupt practices. The PPP approach of implementing, en masse, private-sector management

rules, systems, and structures may succeed in creating a culture that limits losses and waste in a facility with entrenched corrupt practices. ❖

Disclosure Statement

The author(s) have no conflicts of interest to disclose.

Acknowledgment

Kathleen Louden, ELS, of Louden Health Communications provided editorial assistance.

How to Cite this Article

Vian T, McIntosh N, Grabowski A. "It keeps us from putting drugs in pockets": How a public-private partnership for hospital management may help curb corruption. Perm J 2017;21:16-113. DOI: https://doi.org/10.7812/TPP/16-113.

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Awesome Citadels

Few institutions have undergone as radical a metamorphosis as have hospitals in their modern history. In developing from places of dreaded impurity and exiled human wreckage into awesome citadels of science and bureaucratic order, they acquired a new moral identity, as well as new purposes and patients of higher status.

— Paul Starr, PhD, Pulitzer Prize-winning professor of sociology and public affairs