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# **How do Patients and Providers Navigate the “Corruption Complex” in Mixed Health Systems? The Case of Abuja, Nigeria**

**By**

**Sabastine Stephen Wakdok**

**This thesis is submitted in fulfilment of the degree of  
Doctor of Philosophy (PhD) in Global Health Policy**

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# Abstract

## Introduction

Over the last decades, scholars have sought to investigate the causes, manifestations, and impacts of corruption in healthcare. Most of this scholarship has focused on corruption as it occurs in public health facilities. However, in Nigeria, in which most residents attend private health facilities for at least some of their care needs, this focus is incomplete. In such contexts, it is important to understand corruption as it occurs across both public and private settings, and in the interactions between them. This study seeks to address this gap. It aims to examine how corruption is experienced by, and impacts upon, patients and providers as they navigate the “corruption complex” in the mixed health system of Abuja, Nigeria.

## Objectives

This over-arching aim is addressed via three interrelated objectives, as follows:

1. To investigate the experiences of patients and providers concerning the causes, manifestations, and impacts of corruption in public health facilities, in Abuja, Nigeria.
2. To investigate patients / provider experiences of corruption as they relate to private health facilities in Abuja, Nigeria.
3. To investigate how, and the extent to which, corruption is enabled by the co-existence of and interactions between public and private health facilities in the context of the mixed health system of Nigeria – and of Abuja in particular.

## Methods

All three objectives are addressed via a qualitative exploratory study. Data was collected in Abuja, Nigeria’s Federal Capital Territory (between October 2021 to May 2022) through: (i) in-depth interviews with 53 key informants, representing a range of patient and provider types, and policymakers; and (ii) participant observation over eight months of fieldwork. The research took place in three secondary-level public health facilities (Gwarinpa, Kubwa, and Wuse General hospital) and three equivalent-sized private health facilities (Nissa, Garki, and King's Care Hospital) in Abuja. The empirical data was analysed using Braun and Clarke's (2006) reflexive thematic analysis approach and presented in a narrative form. Abuja was selected as the research setting, as the city is representative of the mixed health system structures that exist in Nigeria, especially in the country’s larger urban areas.

## **Results**

**Objective 1:** Corruption in public health facilities is driven by a shortage of resources, low salaries, commercialisation of health and relationships between patients and providers, and weak accountability structures. Corruption takes various forms which include: bribery, informal payments, theft, influence- activities associated with nepotism, and pressure from informal rules. Impacts include erosion of the right to health care and patient dignity, alongside increased barriers to access, including financial barriers, especially for poorer patients.

**Objective 2:** Corruption in private health facilities is driven by incentives aimed at profit maximisation, poor regulation, and lack of oversight. Corruption takes various forms which include: inappropriate or unnecessary prescriptions (often driven by the potential for kickbacks), forging of medical reports, over-invoicing, and other related types of fraud, and under/over-treatment of patients. Impacts include reductions to the quality of care provided and exacerbation of financial risks to patients.

**Objective 3:** The nature of public-private sector interactions creates scope for several forms of corruption. For example, these interactions contribute to the causes of corruption in the public sector - especially the problem of scarcity of resources. Related manifestations include dual practice, absenteeism, and theft (e.g., diversion of patients, medical supplies, and equipment from public to private facilities). The impacts of such practices include inequities of access, for example, due to delays in and denials of needed services and additional financial barriers encountered in public facilities, alongside reductions to quality of care, pricing transparency and financial protection in private facilities.

## **Conclusion**

Patients experience corruption in both public and private health facilities in Abuja, Nigeria. The causes, manifestations and impacts of corruption differ across these settings. In the public sector, corruption creates financial and non-financial barriers to care – aggravating inequities of access. In the private health sector, corruption undermines quality of care and exacerbates financial risks. The public-private mix is itself implicated in the problem – giving rise to new opportunities for corruption, to the detriment of patients’ health and welfare. For policymakers in Nigeria to address the problem of corruption, a cross-sectoral approach - inclusive of the full range of providers within the mixed health system – will be required.

## Lay Summary

The lay summary is a brief summary intended to facilitate knowledge transfer and enhance accessibility, therefore the language used should be non-technical and suitable for a general audience. [Guidance on the lay summary in a thesis](#). (See the Degree Regulations and Programmes of Study, General Postgraduate Degree Programme Regulations. These regulations are available via: [www.drps.ed.ac.uk](http://www.drps.ed.ac.uk).)

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Insert the lay summary text here - the space will expand as you type.

1. Scholars have sought to investigate the causes, manifestations, and impacts of corruption in healthcare. Most of this scholarship has focused on corruption as it occurs in public health facilities. However, in Nigeria, in which most residents attend private health facilities for some or all of their healthcare needs, this focus is incomplete. In countries such as Nigeria, it is important to understand corruption as it occurs in all sectors (public and private), and also understand how the interactions between these sectors affects the nature and effects of corruption. This study seeks to address this gap. It aims to examine how corruption is experienced by, and impacts upon, patients and providers as they navigate the “corruption complex” in mixed health systems. This over-arching aim is addressed via three interrelated objectives, as follows: (i) To investigate the experiences of patients and providers concerning the causes, manifestations, and impacts of corruption in public health facilities, in Abuja, Nigeria, (ii) To investigate patients / provider experiences of corruption as they relate to private health facilities, and (iii) To investigate how, and the extent to which, corruption is enabled by the co-existence of and interactions between public and private health facilities in the context of the mixed health system of Nigeria – and of Abuja in particular.

As this study is concerned with individuals’ experiences (and individuals’ perceptions of those experiences), the three objectives are addressed through qualitative exploratory research. Data was collected in Abuja, Nigeria’s Federal Capital Territory (between October 2021 to May 2022) through:

in-depth interviews with 53 key informants, including patients, providers, and policymakers; alongside participant observation over eight months of fieldwork. The research took place in three secondary-level public health facilities (Gwarinpa, Kubwa, and Wuse General hospital) and three equivalent-sized private health facilities (Nissa, Garki, and King's Care Hospital) in Abuja. The data thereby generated was analysed using Braun and Clarke's (2006) reflexive thematic analysis approach and is presented in the study in narrative form. Abuja was selected as the research setting, as the city is representative of the mixed health system structures that exist in Nigeria, especially in its large urban centres.

The study reveals that:

1. In public health facilities, corruption is driven by a shortage of resources, low salaries, commercialisation of relationships between patients and providers, weak accountability structures. Corruption takes various forms in these facilities, including: bribery, informal payments, theft, and influence-activities associated with nepotism, and pressure from informal rules. Impacts include erosion of the right to access health care, and undermining of patient dignity, alongside increased barriers to access, including financial barriers, with adverse consequences for those individuals (especially poorer individuals) who do choose to seek care.
2. In private health facilities, corruption is driven by incentives related to profit maximisation, in a context defined by inadequate regulation, and an absence of transparency. Corruption takes various forms, including: inappropriate or unnecessary prescriptions (often driven by the potential for kickbacks), forging of medical reports, over-invoicing, and other related types of fraud, and under/over-treatment of patients. Impacts include reductions to the quality of care provided and exacerbation of financial risks to patients.
3. Furthermore, the nature of public-private sector interactions in Abuja, Nigeria, generate additional drivers for corruption. Related manifestations include: dual practice, absenteeism, and theft (e.g., diversion of patients, medical supplies, and equipment from public to private facilities). The impacts of such practices include: inequities of access, for example, due to delays in and denials of access to needed services; additional financial barriers to those encountered in public facilities; and reductions to quality of care, transparency of pricing, and the amounts charged in private facilities.

This study shows that, while patients experience corruption in both public and private health facilities in Abuja, Nigeria, the causes, manifestations, and impacts of this differ across sectors. In the public sector, corruption creates financial and non-financial barriers to care – aggravating inequities of access. In the private health sector, corruption undermines quality of care and exacerbates financial risks. The public-private mix itself can be a driver of corruption, to the detriment of patients’ health and welfare. For policymakers in Nigeria to address the problem of corruption, a cross-sectoral approach – one that includes the full range of providers in the mixed health system – will be required.

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**Sabastine Stephen Wakdok**

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## Abbreviations

<b>ACE</b>	Anti-Corruption Evidence Network
<b>AGPMPN</b>	Association of General and Private Medical Practitioners of Nigeria
<b>CMI</b>	Chr. Michelsen Institute
<b>CSOs</b>	Civil Society Organisations
<b>CPI</b>	Corruption Perception Index
<b>DFID</b>	Department for International Development
<b>EU</b>	European Union
<b>FCT</b>	Federal Capital Territory
<b>FCTHA</b>	Federal Capital Territory Health Administration
<b>FMOH</b>	Federal Ministry of Health
<b>FGN</b>	Federal Government of Nigeria
<b>HCPP</b>	Healthcare Provider Perspective
<b>HICs</b>	High income Countries
<b>IDIs</b>	In-depth Interviews
<b>LMICs</b>	Low-and-middle-income countries
<b>LSHTM</b>	London School of Hygiene and Tropical Medicine
<b>MDCN</b>	Medical and Dental Council of Nigeria
<b>NBS</b>	National Bureau of Statistics
<b>NHIS</b>	National Health Insurance Scheme

<b>NMA</b>	Nigerian Medical Association
<b>NYSC</b>	National Youth Service Corp
<b>OECD</b>	Organisation for Economic Co-operation and Development
<b>PHC</b>	Primary Health Centre
<b>PPA</b>	Patient Pathway Analysis
<b>POS</b>	Point of Sale
<b>SERVICOM</b>	Service Compact with All Nigerians
<b>SHC</b>	Secondary Health Centre
<b>SMOH</b>	State Ministry of Health
<b>SOAS</b>	School of Oriental and African Studies
<b>THC</b>	Tertiary Health Centre
<b>TI</b>	Transparency International
<b>UNCAC</b>	United Nations Convention Against Corruption
<b>UNDP</b>	United Nations Development Programme
<b>WHO</b>	World Health Organisation



# Chapter One

## Introduction

### 1.0. Research Problem

Corruption in health service delivery has been demonstrated to be a major barrier to the achievement of universal health coverage, especially in low and-middle-income countries (LMICs) (Vian, 2008a; García, 2019; Kirya, 2020; Koller, Clarke and Vian, 2020; Naher *et al.*, 2020). In many LMICs, health systems are “mixed” – incorporating a large (and often largely unregulated) private sector across multiple service domains, including primary care, secondary care and pharmacy retail, alongside the public sector - and are plagued by performance challenges with respect to key universal health coverage (UHC) objectives, including: equity of access; safety, efficacy and quality of care; and financial protection (Nishtar, 2010a; Mackintosh *et al.*, 2016; Naher *et al.*, 2020). Many challenges can be attributed in part to an “unholy triad” comprised of: (a) chronic underfunding of the public health sector (Nishtar, 2007; Mackey and Liang, 2012), (b) poor regulation of the private health sector (Das *et al.*, 2016; Naher *et al.*, 2020), and (c) lack of transparency and accountability in health service delivery (Koller, Clarke and Vian, 2020; Vian, 2020) – a combination labelled the “*mixed health system syndrome*” (Nishtar, 2010b).

This assessment well-describes the situation in Nigeria, in which the private sector occupies a dominant role in healthcare provision at all levels and for people across all income quantiles; while the public health sector is underfunded, under-staffed, and revenue-driven, with both formal and informal user fees presenting additional barriers to care (Akokuwebe and Damilare, 2015; Aregbeshola, 2016; Mackintosh *et al.*, 2016; Hafez, 2018b; Onwujekwe *et al.*, 2019; Onwujekwe *et al.*, 2020).

In addition, corruption in Nigeria is pervasive, affecting all sectors of the country, including the healthcare sector (Abiodun, 2013; Tormusa and Mogom Idom, 2016; Namadi, 2020; Onwujekwe *et al.*, 2020). The most recent report by Transparency International ranks Nigeria 150 out of 180 countries in its global corruption perception index, with a score of 24 out of 100 (Transparency International, 2023). Nigeria is also ranked 187 out of 191 in health service delivery by the World Health Organisation when measured along several key dimensions of health system performance, including equity of access, quality of care, and financial protection (WHO, 2020). Multiple factors have been put forth as reasons for this poor performance, including underfunding, inadequate health resources, and lack of transparency and accountability, all creating an enabling environment for inefficiency and corruption that undermine the goal of the government's health reforms to improve population health in Nigeria's mixed health system (Adeyemo, 2005; Aigbiremolen *et al.*, 2014).

In the context of a highly inequitable health system, with variable quality and limited financial protection, corruption poses a significant additional threat to Nigeria's UHC progress (Akokuwebe and Damilare, 2015; Saka *et al.*, 2016; Tormusa and Mogom Idom, 2016); and the last two decades have seen considerable attention from scholars and policymakers on the causes, manifestations and impacts of this phenomenon (Kamorudeen and Bidemi, 2012; Abiodun, 2013; Aregbeshola, 2016; Onwujekwe and Odii, 2018; Onwujekwe *et al.*, 2019; Abba-Aji *et al.*, 2020). However, the vast majority of these studies focus on corruption as it manifests in *public health facilities* (Azuh, 2012; Saka *et al.*, 2016; Tormusa and Idom, 2016; Akokuwebe and Adekanbi, 2017; Onwujekwe and Odii, 2018; Onwujekwe *et al.*, 2020), except for a limited study on a specific form of corruption – informal payments in Enugu, southeast Nigeria, which comparatively looked at informal payments for malaria care in public and private primary health facilities (Onwujekwe *et al.*, 2010). Similarly, attempts to tackle corruption in health facilities have targeted public facilities (Garuba, Kohler and Huisman,

2009; Anaemene, 2016; Aregbeshola, 2016, 2021) - which represents a partial policy response given the dominant role played by private facilities, which 60 per cent of residents receive some form of health care in an average year.<sup>1</sup> (Hafez, 2018a).

Regarding Abuja, the capital of Nigeria and the focus of this study, evidence on the causes, manifestations and impacts of corruption is limited. In relation to the public health sector, the causes, manifestations and impacts of corruption are still poorly understood (partly, perhaps, because practices that should be considered corrupt, such as offering bribes and diversion of patients to private facilities by clinicians, are considered normal (Onwujekwe and Odii, 2018; Abba-Aji *et al.*, 2020). In relation to private health sector facilities in Abuja, no empirical evidence on corruption is readily available. This is despite the fact that a recent study by Ofoli and colleagues found that 77 per cent of patients in Abuja receive care in private facilities compared to 13 per cent in public facilities, 10 per cent in local drug stores/pharmacies, and 1 per cent were classified as others including traditional healers (Ofoli *et al.*, 2020, p. 5). As a result, we know less than we need to if our aim as scholars is to fully inform related policy interventions about how patients experience corruption as they seek care from the diverse range of public and private sector facilities available to them - encountering different incentive structures and behaviours as they do so.

This study will fill the gap mentioned above by providing an empirical analysis of the causes, manifestations, and impacts of corruption in Abuja, Nigeria through two distinct but interlinked and complementary perspectives; the patient and the healthcare provider perspective, in order to provide a nuanced view and more comprehensive understanding of how corruption influence healthcare encounters in public and private health facilities in the city. For example, an issue that has generated attention relates to the commercialisation reform drive by the government

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<sup>1</sup> This figure is likely to be an underestimate for the urban population.

in public health facilities which the government introduced formal co-payments (user fees) intending to eliminate informal payments and to increase revenue for funding health facilities (Onwujekwe *et al.*, 2010; Akwataghibe *et al.*, 2013). However, the effect of such policies on patients' experiences and provider behaviours is poorly understood, and this study will capture some of these dynamics.

Therefore, the present study will examine how patients and providers experience and perceive the problem of corruption in the mixed health system of Abuja. In doing so, the study aims to provide evidence and insights on how the causes, manifestations, and impacts of corruption problems in the public sector and the private sector, and the interconnections between them, create or exacerbate barriers to access, including financial barriers, and risks to household finances of impoverishment or other catastrophic financial impacts. It is useful to understand patients' experiences of corruption and to capture healthcare providers' perspectives as well. The perspectives of providers are particularly valuable in understanding the causes of corruption. At the same time, that of patients is valuable for understanding manifestations and impacts, such as the ability of patients to access quality services in a timely way and at an affordable cost. As it is, we have little evidence on this in relation to private sector settings, nor has there been an adequate focus on public-private interactions in creating additional corruption vulnerabilities in Abuja, Nigeria. It is intended that the findings from this research will contribute to a richer understanding of how informal practices, institutional structures, incentives, norms, and social relationships in public and private health facilities impact on health service delivery, thereby informing future policy action - both for Abuja and the country in general.

## 1.1 Aim and Objectives of the Study

Based on the research problem presented above, the aim of this study is to examine **how corruption is experienced by, and impacts upon, patients and providers as they navigate the mixed health system of Abuja, Nigeria**. This over-arching aim is addressed through three interrelated objectives.

1. To investigate the experiences of patients and providers concerning the causes, manifestations, and impacts of corruption in public health facilities in Abuja, Nigeria.
2. To investigate the experiences of patients and providers concerning the causes, manifestations, and impacts of corruption in private health facilities in Abuja, Nigeria.
3. To investigate how, and the extent to which corruption is enabled by the co-existence of and interactions between public and private health facilities in the context of the “mixed” health system of Nigeria – and of Abuja in particular.

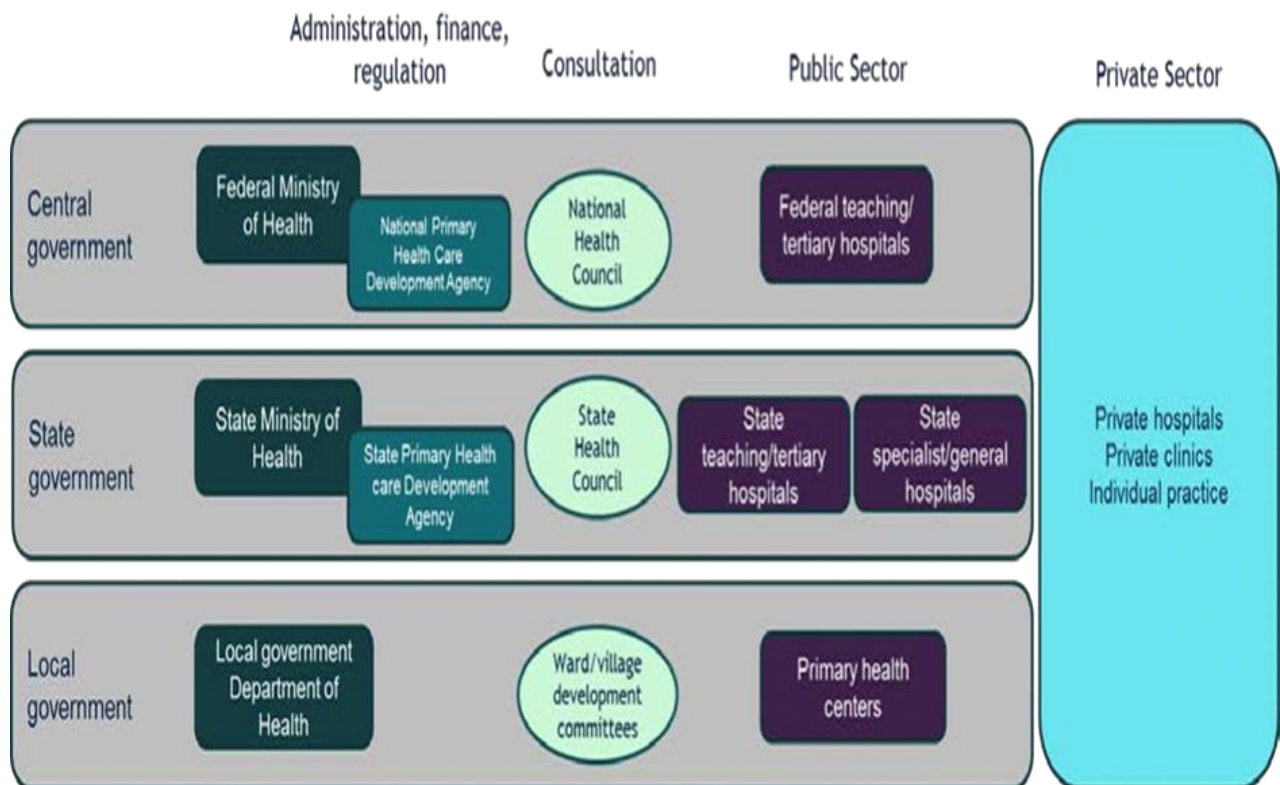
## 1.2. Contextual Background of the Study

Nigeria has a pluralistic healthcare system with public and private sectors (including pharmacy retail shops, private laboratories and diagnostic centres), orthodox and traditional healthcare providers (FGON, 2018). The formal healthcare system, which is the focus of this study, comprises the private and the public health sectors – *a mixed health system* (Hafez, 2018b). The private health system operates as a free-market entity responsible for about 60% of health care service delivery in the country which is far higher in urban cities (Hafez, 2018b; Ofoli *et al.*, 2020). In contrast, the public health system operates as a government establishment, paying health workers and owning the health infrastructure, including buildings and equipment. The public health sector accounts for 40% of health service delivery in Nigeria (FGON, 2018).

Nigeria's mixed health care delivery system is three-tiered, through primary, secondary, and tertiary health facilities coordinated by the local, state, and federal ministries of health,

respectively (FMOH, 2016). However, the arrangement, in reality, across both the public and private health systems is fluid and often allows one level of the health system to provide services at any of the other two levels despite holding a primary responsibility (Hafez, 2018b). The three tiers of government share the responsibility of health system functions, stewardship, financing, and service provision (Nworuh, 2018). The local government is responsible for the primary-level health facilities, which are saddled with providing primary health care. The state government is responsible for the secondary level and the regulation of the local government health activities, sometimes providing primary care as well. The federal government oversees tertiary care, developing national health policy, and providing technical assistance to state and local government health authorities. It is also statutorily responsible for all levels of health care in Abuja, the federal capital territory, which is the focus of this study (FMOH, 2009, 2016).

In Abuja, the federal capital of Nigeria, the private health sector is even a far greater dominant form of healthcare provider compared to the rest of the country (Ofoli *et al.*, 2020; FCT HHS, 2021). There are 656 health facilities across the six area councils in Abuja, with 85 per cent (559) primary health facilities, 14% (90) secondary health facilities and 1% (7) tertiary health facilities. Of the 559 PHC facilities, 28% (179) are publicly owned. The remaining 72% (380), are private providers. However, at the secondary healthcare level which are the research sites where this study was conducted (details provided in chapter 3) 85% (76) are privately owned and only 15% (14) of the 90 health facilities are publicly owned (FCT HHS, 2021).



**Figure 1.1: Organisational structure of the Nigerian healthcare delivery system (source: (Hafez, 2018b))**

This study is focused on the causes, manifestations, and impacts of corruption at the *health service delivery level*, where patients and providers interact daily at the facility level. This level of service delivery is important because it is that level of the health system where "everyday" corruption occurs, directly impacting patients as they seek care in public and private health facilities in Abuja and the rest of Nigeria. Furthermore, increasing evidence suggests that several corruption problems in the health sector emanate from the provider-patient interaction at the health service delivery level (Akokuwebe and Damilare, 2015). These corrupt practices can potentially impact patients' access to healthcare services. At the same time, these practices occur within Nigeria's dysfunctional healthcare facilities, where healthcare workers have to navigate in practical terms to deliver services to patients. Hence, focusing on the health service delivery level represents the interphase and conceptual lens through which this study's analysis

occurs. Similarly, it is that level of the health system (last mile) where reforms can be particularly challenging to implement.

Furthermore, the principal function of a health system is to improve population health (Manyazewal, 2017). How good a country's health system is, is usually in the accompanying testimonies from patients on the accessibility, quality, and effectiveness of its healthcare services at the facility level. However, there has been increasing evidence to suggest that many corruption-related performance problems have their origins in mixed health systems (Aigbiremolen *et al.*, 2014; Tormusa and Mogom Idom, 2016; Hafez, 2018b; Uzochnikwu *et al.*, 2018). For example, in Nigeria, there have been reports of the absence of healthcare providers at duty posts in public facilities because they engage in dual practice (usually at a private facility), providing an avenue for health workers to engage in corrupt practices (Akinbajo, 2012; Abba-Aji *et al.*, 2020). There have also been reports of empty drug shelves at public hospital pharmacies, complaints of sub-standard hospital equipment, and reports of patients having to pay unofficial fees to secure health services.

By many measures, the Nigerian mixed health system is considered weak across several dimensions of care, including equity of access, quality of care, efficiency and financial protection (Aregbeshola, 2017, 2021; Hafez, 2018b). Compared to its counterparts in lower-middle-income countries, Nigeria spends abysmally low on health care, with a public health expenditure as a percentage of GDP of 0.9%. In comparison, total tax revenue was less than 3.5% of GDP. It also scores terribly on several human development indicators relative to low-income countries, whereas it is a low-middle-income country (World Bank, 2022).

Since Nigeria's independence over six decades ago, several reforms and development initiatives have been repeatedly put in place to improve the patient experience and quality of healthcare delivery, including addressing the challenges of corruption (Adeyi, 2016). However,



most of these reforms, starting with the first (1962-1968), second (1970-1975), third (1975-1980), and fourth (1981- 1985) National Development Plans, have been said to be devoid of realities regarding the actual challenges of healthcare delivery including corruption problems which impacts on patients at the facility level. The story was not different with the 2004 Health Sector Reform (2004- 2008) as well as the National Strategic Health Development Plan (2010 – 2015) (Aregbeshola, 2021).

These plans, from the oldest to the latter, had several challenges relating to chronic underfunding of the public health sector, including inadequate supply and allocation of essential health resources, workforce, drugs, and equipment to the hospitals. The long-term underfunding of the public health sector has led to rapid development and growth of the private health sector without a proper regulatory framework (Adeyi, 2016). In addition, both sectors are heavily commercialised due to the drive for revenue by both the public and private health sectors. However, the potential to create a fertile environment for corruption cannot be overruled at varying proportions and in the context of poor regulation and oversight in Nigeria's mixed health system.

The context in which the Nigerian health system has evolved needs mutual accountabilities in a framework of principals, agents, and citizens. That context does not work for the average Nigerian patient, especially the poor and vulnerable (World Bank, 2003). This situation occurs due to several problems, chiefly entrenched nepotism, patronage, rent-seeking, and weak public financial management, entailing corruption in the health system, especially at the service delivery level (Okonjo-Iweala, 2012). Therefore, it has been suggested that a fundamental flaw of these reforms is their inability to address the problem of corruption at the level of health service delivery based on the barriers each of these two health sectors pose (Fatusi, 2015; Aregbeshola, 2021).

These health sector reforms in Nigeria included a move away from direct government provisioning, which entails a greater reliance on voluntary and private services, as well as implementing several financial measures like the imposition of user fees and contracting out to the private sector to increase productivity and patient satisfaction. Unfortunately, they made equity problems worse and raised access barriers even more, both at private health facilities due to high treatment fees and in public hospitals due to unofficial payments in the form of informal payments and bribery (Garuba, Kohler and Huisman, 2009; Anaemene, 2016; Aregbeshola, 2021). Since public healthcare was no longer free or fully subsidised as it once was, the market for private healthcare in Nigeria proliferated due to the commercialisation policies of public hospitals. These private health facilities were poorly regulated, leaving patients with reported experiences of quackery and high payment costs (Agwu *et al.*, 2020).

Similarly, the service compact (SERVICOM), an organ of government responsible for ensuring effective and efficient service delivery through enforcing transparency and accountability and increased patient satisfaction devoid of corruption in the health sector, has failed (Daka, 2017; Odebode, 2017). Ama Pepple, a former head of the civil service, has adjudged it as failed as it has been plagued by corruption and virtually had no oversight on the private sector, including Nigeria's private health sector, which was not the intended plan when former president Obasanjo set it up in 2004 (Daka, 2017).

Despite several of these reforms involving substantial financial implications, the evidence suggests a malignment of policies and priorities, with the country laying more emphasis on health inputs rather than health outputs, contrary to the current systems design thinking by global health scholars (Hellowell, 2019; Aregbeshola, 2021). The continuous change in health policies regarding health service delivery has left little or no effect on improving healthcare delivery to patients (Anaemene, 2016; Tormusa and Mogom Idom, 2016). Instead, the

decentralisation of the Nigerian mixed health system with associated fragmentation has led to a porous system plagued by everyday corruption with a lack of accountability from healthcare providers at the implementation level of health facilities (Aregbeshola, 2021).

“Everyday” corruption arising from interactions between patients and healthcare providers has direct consequences for the provision of health services (Balabanova and McKee, 2002a; Blundo and Olivier de Sardan, 2006a; Vian *et al.*, 2006; Onwujekwe *et al.*, 2010; Tormusa and Idom, 2016). These corrupt practices are non-compliant acts that patients encounter as they traverse public and private health facilities seeking care in Nigeria's mixed health setting. Available evidence suggests that corrupt practices include bribery, informal payments, over-invoicing, health insurance and reimbursement fraud; leakage of health commodities such as test kits, syringes and hand gloves; and theft of drugs from hospital wards and pharmacies (Akokuwebe and Damilare, 2015; Onwujekwe *et al.*, 2018; Abba-Aji *et al.*, 2020). Other related practices that create an enabling environment for corruption include absenteeism related to dual practice, lack of regulation of prescribing decisions, and discretion over how patients are referred from public to private health facilities (and vice-versa) (Saka *et al.*, 2016; Onwujekwe and Odii, 2018; Odii *et al.*, 2022; Angell *et al.*, 2023; Onwujekwe *et al.*, 2023).

While the emphasis in the literature suggests that opportunities to abuse power for private gain are often organisational-level variables, there is increasing evidence that informal practices/behaviours influence these organisational or formal variables (Hussmann, 2011a; Vian, 2020). Also intricately linked to the unravelling of corruption is the influence of social norms (Olivier de Sardan, 2013a; Hahonou, 2015; Anders and Chirwa, 2018; Olivier De Sardan *et al.*, 2018). However, the academic literature in Nigeria still needs to fully explore the critical part social norms play in entrenching corrupt practices at the health facility level in Nigeria. This gap needs to be addressed, especially from the policy point of view, which has largely not

been a focus of emphasis in previous reforms targeted at improving the quality of health services resulting from corruption-related practices in Nigeria's public and private health facilities. Addressing this lacuna is vital in generating the needed empirical evidence that can draw the attention of policymakers on issues relating to societal norms that enable corrupt practices to thrive in public and private health facilities in order to develop reforms that take into consideration these social norms.

### **1.3. Conceptual Frameworks guiding the Study**

The conceptual frameworks that lay the foundation for this present study and its analysis in the substantive chapters were adapted from two existing conceptualisations of corruption, which combined a *vertical approach* (Vian, 2008b; Vian and Norberg, 2008) with a *horizontal/network approach* (Gaal and McKee, 2004; Olivier de Sardan, 2013c). These approaches have gained wide adoption by corruption studies in the health sector in LMICs and Nigeria in particular (Husmann, 2011a; Hahonou, 2015; Onwujekwe et al, 2019).

Although these two approaches are not mutually exclusive and can be complementary in analysing and addressing the problems of corruption, including in the health sector, it is essential to tease out the differences between them, such as the specific dimensions in which they differ, how these approaches suggest that analysis of corruption should be conducted, and how policy interventions should be defined. *Table 1.1* below provides these differences between the vertical and horizontal/network approaches.

**Table 1.1: summarising the differences between vertical and horizontal approaches in analysing corruption (created by author)**

<b>Dimension</b>	<b>Vertical approach</b>	<b>Horizontal/Network approach</b>
<b>Definition</b>	Corruption is seen as a vertical problem caused by individual behaviours and actions in a system	Corruption is considered a systemic challenge, rooted in a web of interactions between multiple actors in the system
<b>Focus</b>	identifying and punishing individual corrupt actors and practices	identifying and addressing the underlying systemic factors that enable corruption
<b>Perspective</b>	A top-down approach with emphasis on government/regulatory agencies' roles in curbing corruption	A bottom-up approach with emphasis on the role of non-state actors (civil societies, media) in advancing transparency and accountability
<b>Methodology</b>	Place reliance on formal investigations (e.g., audits, legal) to expose and punish corrupt acts	Uses social mobilization and citizen participation to beam light on corruption
<b>Strength(s)</b>	Rigour in identifying sector-specific issues	Holistic understanding of corruption
<b>Limitation(s)</b>	Fails to address the underlying systemic factors that give rise to corruption and may lead to scapegoating of individual actors	May not have the authority or resources to carry out effective investigations and legal actions to punish corrupt practices

In relation to these two approaches to analysing corruption in health service delivery which is the focus of this study, first, the vertical approach is presented followed by the horizontal/network approach.

The first conceptualisation- *a vertical approach* adopted from the works of Vian (2008) and Vian and Norberg (2008), contends that corruption thrives in healthcare systems due to the nature of the relationships between system stakeholders. The *vertical approach* refers to analysing corruption by focusing on the power dynamics or hierarchy of power within the health care system, i.e., top-down in nature. According to this viewpoint, corruption is a top-down problem in which individuals in positions of power, such as health officials and healthcare providers with powers relative to patients, exploit their authority for personal gains at the expense of the patients, the health system, or the public they are supposed to serve (Vian, 2008b; Hussmann, 2011a). The vertical approach underscores the need to understand the healthcare system's power structure and accountability processes and, therefore, examines the power dynamics and structural elements that contribute to corruption focusing on individual actors and specific forms of corruption (Vian and Norberg, 2008; Onwujekwe et al, 2019).

Relationships based on social norms, pragmatic objectives, or reciprocal relationships are potent drivers of corruption in the health sector (Vian and Norberg, 2008). Vian and Norberg identified three types of agents who can encourage corruption in the health sector: (i) *government agents/policymakers/health officials* who engage in corrupt practices in response to failings in the health system; (ii) *pressured clients*, i.e., patients/care-seekers who may seek to circumvent health systems for faster and better-quality health services; and (iii) *healthcare providers* seeking to augment their low salaries (Vian and Norberg, 2008, p. 25). Therefore, corruption occurs when government agents engage in inappropriate practices; clients are denied healthcare, even in cases where they have a right to such care and are thus pressured to pay

bribes or engage in other unethical practices to obtain health services. The vertical perspective implies that policy interventions to tackle corruption should focus on individual actors within the health systems, increase penalties for corrupt behaviours, and strengthen regulatory frameworks.

The second conceptualisation- the *horizontal/network* approach underpinning this present study are the works of Gaal and McKee (2004) and Olivier de Sardan (2013). The horizontal approach offers a method of analysing corruption that focuses on networks. Corruption is viewed as a systemic/collective problem involving numerous actors embedded in the complex web of interactions between various actors in the health system. This approach emphasises the significance of understanding the social and cultural frameworks in which corruption happens and the informal networks and relationships that enable corrupt practices. It also emphasises the importance of promoting openness, accountability, and ethical behaviour among all healthcare system actors (Onwujekwe *et al.*, 2018).

Olivier de Sardan (2013) propounds corruption as “*informal behaviours that contradict official norms, with primarily negative consequences for the less powerful or disadvantaged groups*” (Onwujekwe *et al.*, 2019). Olivier de Sardan theorizes that informal activities constitute rule-breaking and thus pose risks to both health providers and less powerful service consumers- *the patients*. This perspective is also reflected in Gaal and McKee's (2004) interpretation of Hirschman's postulation of consumer behaviour, where end users of health care, usually patients, take part in unofficial and sometimes illegal behaviours to achieve their objectives within a health system that is under-resourced and where legitimate claims are not respected (informal exit or “inexit”) (Gaal and McKee, 2004, pp. 165–166).

These interpretations imply that effective action would give less powerful groups a voice to transform the current system. Deviations from ethics and principles by stakeholders in the

health sector are mostly informal and frequently occur at the crossroads of "usual practice" and corruption. Rather than seeking an official route to obtain service ('voice') or seeking care outside of the public sector ("exit"), consumers and providers resort to informal means (giving an informal payment or gift) within the constraints of the existing system (informal exit or "inexit") (Onwujekwe et al, 2019). The horizontal/network perspective implies that policy interventions to tackle corruption should strengthen citizen participation (patients/providers alike), promote transparency and accountability, and establish social accountability mechanisms.

This present study is anchored on elements drawn from these two conceptual frameworks to analyse the empirical findings in the substantive chapters of the thesis. The horizontal/network perspective implies that policy interventions to tackle corruption should focus on a collaborative effort among multiple actors and that solutions must be tailored to each healthcare system's specific context and challenges. For example, in this study, interventions should be tailored to the specific context of public and private health systems and their interactions.



**Table 1.2 Corruption approaches guiding this study (adapted from Onwujekwe et al. 2019)**

Approach	Basic Assumptions	Dimensions	Policy interventions	Explanation
<b>Vertical approach</b> <ul style="list-style-type: none"> <li>- <b>Vian 2008</b></li> <li>- <b>Vian and Norberg (2008)</b></li> </ul>	Corruption is driven by key actors who are either opportunists, under pressure, or skilled at rationalising' alleged corrupt behaviours as normal.	Focuses on power dynamics/hierarchy within the health care system, i.e., top-down in nature	Institutional/system-level interventions	<p>Corruption thrives due to a poorly managed healthcare system</p> <p>Corruption occurs when providers participate in unethical behaviour; as a result, patients are under pressure to engage in the same to obtain healthcare.</p>
<b>Horizontal approach</b> <ul style="list-style-type: none"> <li>- <b>Gaal and McKee (2004)</b></li> <li>- <b>Olivier de Sardan (2013)</b></li> </ul>	Behaviours of actors that deviate from ethics and values are primarily informal and frequently occur when "the usual practice" and corruption converge.	Focuses on the relationships and networks between different actors in the healthcare system	Individual actors and context-specific interventions	Informal behaviours of key actors allow corruption to thrive, affecting end users-patients.

## 1.4. Structure of the Thesis

This thesis is arranged into eight chapters, including this introductory chapter. The remaining seven chapters are organised as follows:

**Chapter Two:** critically reviews the relevant broader literature on corruption in the health sector. The review provides the theoretical foundation and the analyses of previous empirical works within the extant literature related to corruption at the facility level from daily interaction

between providers and patients. This chapter clearly identifies the gaps within the scholarship on the limited empirical evidence regarding the influence of corruption in mixed health systems of LMICs and Nigeria in particular. It situated the corruption problems at the health facility level within the broader mixed health system problems and highlighted the areas where this empirical study contributes to the current scholarship.

**Chapter Three:** describes the research setting and the study sites in Abuja, Nigeria. The chapter also describes the methods that guided the data collection in this qualitative empirical research, the ethical process followed, and the requirements met while undertaking this research.

**Chapter Four:** presents the empirical findings and analysis addressing this study's first objective: investigating the causes, manifestations, and impacts of corruption in public health facilities as they are experienced by patients and providers in these settings. This chapter presents the various forms of corruption that are manifested and their main drivers – focusing on resource scarcity, low salaries, discretion over access, and the commercialisation of care at the organisational/individual level. This chapter also presents the empirical findings on the impacts of corruption in public facilities, focusing on the erosion of the right to health care and patient dignity alongside increased barriers to access, including financial barriers.

**Chapter Five:** presents the empirical findings and analysis addressing this study's second objective: investigating the causes, manifestations, and impacts of corruption in private health facilities as they are experienced by patients and providers in these settings. This chapter describes the various forms of corruption and their main drivers – focusing on incentives aimed at profit maximisation, poor regulation, and lack of oversight. The chapter also describes how and why forms of corruption in private facilities manifest differently from those in public health

facilities. The chapter further presents the impact of these practices on patients in private health settings, emphasising on impacts relating to the quality of care and financial protection.

**Chapter Six:** presents empirical findings and analysis addressing the third objective of this study, investigating how public-private sector interactions enable corruption – again, in the perception of patients and providers. The chapter also presents patients' perceptions of the relative levels of access, quality, affordability, and satisfaction provided in the two sectors.

**Chapter Seven:** This discussion chapter pulls together and reviews the main findings of the thesis and the significance of these in the context of existing scientific and policy understanding about the nature of corruption across the public and private health sectors in Nigeria. The chapter discusses the policy implications that emerge from these findings, describes their limitations, and outlines directions for future research.

**Chapter Eight:** This chapter concludes the thesis by providing the overall response to the study's aim and objectives.

## Chapter Two

### Literature Review

#### 2.0. Introduction

This chapter will focus on reviewing the literature concerning the theoretical perspectives and empirical studies on corruption in health service delivery with emphasis on low-and-middle income countries (LMICs), including Nigeria. Importantly, this chapter will critically review previous empirical studies regarding the causes, forms, and impacts of corruption on patients as they interact with healthcare providers in health facilities.

To recap briefly, the present study seeks to understand the causes, manifestations, and impacts of corruption as patients seek care in the mixed health system of Abuja, Nigeria. To ensure that this study builds upon existing knowledge in this area, two broad strands of empirical literature have been reviewed – namely, conceptual, and empirical studies of *corruption in health care*, and conceptual and empirical studies of *private sector operations and performance in mixed health systems*. As it will be shown in this chapter, there are major gaps in respect of how corruption is understood in mixed health systems particularly in health systems where private health sector facilities are dominant and in relation to the views of patients and healthcare providers.

This chapter is organised as follows. Section 2.1 outlines the search strategy for the literature review in relation to the two strands of the literature- “everyday” corruption in health care and the private health sector in mixed health systems. Section 2.2- *the corruption strand*, reviews the broader “corruption complex,” the theoretical constructs and underpinnings, and the common forms of corruption in healthcare facilities as they influence health service delivery.

Section 2.3 - *the private health sector operations and performance in mixed health systems strand*, focuses on the operationalisation mix of dominant private health systems occurring alongside public health systems in LMICs as it relates to health service provision, including Nigeria. The literature chapter ends with the gaps arising from the review that needs to be addressed by this study.

## **2.1 Search strategy**

As highlighted, the literature review focused on conceptual and empirical works, particularly those on “everyday” corruption in health service delivery in LMICs including mixed health systems. A focused search of the academic literature was done using key terms with Boolean operators resulting in more focused and productive results. Some words and phrases used to enhance the search include corruption, everyday corruption, petty corruption, bribery, informal payments, kickback, theft, stealing, health care, health systems, health facilities, health centres, hospitals, patients, health workers, healthcare providers, doctors, nurses. Other words and phrases that guided the search included mixed health systems, low-and-middle-income countries, sub-Saharan Africa.

The search was an iterative process with an initial broad search to identify all relevant literature which subsequently refined the search to include relevant and specific searches as familiarity with the literature increased. Several databases were searched and included PubMed, Google Scholar, Scopus, ResearchGate, Hinari, ProQuest, JSTOR, EMBASE, and websites of international development organisations such as Transparency International, World Health Organization, World Bank, U4 Anticorruption Resource Centre, and the websites of National governments including Nigeria’s ministry of Health. Peer-reviewed articles included in this review ranged from systematic reviews, surveys, empirical studies both qualitative and quantitative, case studies, expert opinion pieces, commentaries, operational research,

implementation research, historical narrative, and cross-sectional studies. Articles from the grey literature were also sourced. Studies included focused on corruption in the health sector, authored in English or having a readily available English translation.

## **2.2. Review of the Corruption Literature**

This section starts by describing how corruption is conceptualised in the literature. To understand the causes, manifestations and impacts of corruption on patients in healthcare delivery systems, we must first recognise that corruption in the health sector does not exist in isolation but often within a broader societal complex and shares similar intrinsic properties with societal/systemic corruption (Blundo and Olivier de Sardan, 2006a; Vian, 2020). Doing this, will provide a good grasp of the theoretical constructs and underpinnings from which healthcare sector corruption stems and why corruption in health systems should be understood within the broader “corruption complex”- which is described shortly in subsection 2.2.3.

### **2.2.1. Definition(s) of Corruption**

There is no universally agreed definition of corruption. Due to the complexity of corruption, the United Nations Convention Against Corruption does not prescribe a single definition (UNCAC, 2004). However, the most widely cited definition is that by Transparency International, which used to be the *"misuse of public office for private gain"* but has since changed to the *"abuse of entrusted power for private gain"* (Transparency International, 2017, para. 2). This reviewed definition has at least addressed in part the misleading concept that privatisation or private sector entities may eliminate corruption (Huss, 2020).

Furthermore, several scholars have shown that relying on this simplistic definition of corruption by Transparency International, *"the abuse of entrusted power for private gain"*, makes what corruption is, obvious at the upper end of the spectrum, i.e., “grand” corruption but at the lower end of the spectrum, the line is blurred on what constitutes a corrupt practice

and what does not (Olivier de Sardan, 1999; Kolstad, Fritz and O'Neil, 2008; Hahonou, 2015). What constitutes corruption is subjective and can be tied to prevalent norms in different societies, which relates to certain informal practices, practical norms, and non-compliant behaviours (Olivier de Sardan, 1999; Olivier de Sardan, Diarra and Moha, 2017; Anders and Chirwa, 2018; Olivier De Sardan *et al.*, 2018).

Similarly, Nye's 1967 classical definition of corruption: "*behaviour which deviates from the formal duties of a public role because of private -regarding (personal, close family, private clique) pecuniary or status gains; or violates rules against the exercise of certain types of private-regarding influence*" (Nye, 1967, p. 419) also faced criticisms. This interpretation, established from a modern, western point of view, has been criticised partly for being too limited and overly preoccupied with the illegality of such activities. Some of these "practices" can be perfectly legal in other historical and social contexts (Olivier de Sardan, 1999, p. 27). Olivier de Sardan in his book titled – *A moral economy of corruption in Africa?* suggested that what is regarded as corruption in countries in Africa and the middle East differ from that in western societies. Therefore, there have been increasing calls for a broader approach, including practices that are detrimental to the public, particularly in the health sector (Olivier de Sardan, 2013b; Hahonou, 2015; Olivier De Sardan *et al.*, 2018; Onwujekwe et al, 2019; Naher *et al.*, 2020; Vian, 2020).

Blundo and Olivier de Sardan (2006) suggest that corruption has two faces. The first one is blatantly unlawful and is widely criticised, while the second is socially acceptable and is occasionally even promoted, albeit "informally" (Blundo and Olivier de Sardan, 2006b, p. 7). They argued that most of the time, the "facts" of corruption are not proven, supported, or obvious and that, in fact, one of the traits of corruption is that it is frequently denounced without compelling evidence. As a result, when corruption is investigated, what is mostly dealt with

are claims, charges, and suspicions that are made in the media or during private talks. In this sense, we risk reducing corruption to “*what is said about it as we approach a sociology of rumour*” (Blundo and Olivier de Sardan, 2006b, p. 7).

In a wider perspective, Olivier de Sardan (2013), Vian (2008:2020) and Onwujekwe et al. (2020) all describe corruption in the health system as rule-breaking practices aided by healthcare providers and managers at the facility level, as well as policy actors at the government level that short-change patients of qualitative care or total care in some instances (Vian, 2008a, 2020; Olivier de Sardan, 2013c; Onwujekwe et al, 2019). Similarly, description of corruption in healthcare by Anders and Chirwa (2018) and Olivier de Sardan (2018) suggest that corrupt and informal practices could be initiated by patients/care-seekers as well, including its wide acceptability as part of social norms (Anders and Chirwa, 2018; Olivier De Sardan *et al.*, 2018).

Each of these definitions of corruption, including those that are narrow or broad, has its merits. For example, though simplistic yet broad in scope, Transparency International's definition captures the use of market power by providers to increase profits, hence, regarded as corruption and therefore broad in concept in its own perspective, and this review adopts the broader concept of corruption. This broader viewpoint is adopted and is critical to this literature review chapter. The rationale is presented in *section 2.2.3.1* under the broader term "corruption complex" and adopted further in *section 2.2.4.1* regarding previous empirical studies on corruption, including their drivers, motivations, and associated norms.



### 2.2.2. Healthcare Sector and its Vulnerability to Corruption

Several authors suggest that the healthcare sector is particularly vulnerable to corruption (Vian, 2002; Savedoff and Hussmann, 2006; Mathisen, 2007; Hussmann, 2011b; Martini, 2014; García, 2019; Hutchinson, Balabanova and McKee, 2019). According to the European Healthcare Fraud & Corruption Network, this is because of some inherent healthcare system characteristics listed below (European Commission, 2013, p. 25):

- (i) information asymmetry between healthcare providers and patients;
- (ii) multiple actors with complex interactions;
- (iii) the obligation placed on healthcare professionals to select services for their patients;
- (iv) the decentralised, individualised, and private nature of healthcare services makes it challenging to monitor;
- (v) healthcare is a complicated market with significantly more opaque pricing;
- (vi) determining the "correct" amount to spend on healthcare is incredibly difficult due to the ethical considerations involved in healthcare decisions; and
- (vii) the payer and the direct recipient of healthcare services are frequently different parties.

In healthcare delivery, there is often a wide disparity in terms of information asymmetry between healthcare providers (suppliers of care) and patients/care-seekers (consumers of care), which leads to a *lack of transparency*, a well-known ingredient for corruption (Kelley, 2009; Vian, 2013). Similarly, because the health sector and health delivery systems involve several actors with associated complexities in their interactions, this creates a broad avenue for corruption in health service delivery (European Commission, 2013, p. 25). Another factor relates to power dynamics. The healthcare system offers a disproportionate power and responsibility by its design to healthcare providers to choose services for patients who rely on

them, often at their most vulnerable points where they can be exploited (Vian and Norberg, 2008). Also, because healthcare services are often decentralised and individualised, standardisation of care is usually challenging, making monitoring health service provision a herculean task (Rădulescu *et al.*, 2008). Therefore, such implications increase the risk of unsafe, ineffective, or unnecessary care being provided, at a higher than justified cost, in ways that harm people as patients and consumers.

In addition, as against standard economics, consumers' and suppliers' price fixing is based on market supply and demand to arrive at the right price; however, the complexity of health service markets makes pricing quite opaque and vulnerable to corruption (Rădulescu *et al.*, 2008). Another dimension of healthcare systems' vulnerability to corruption concerns the ethical dimension surrounding healthcare decisions, making it unfeasible to ascertain the “right” cost of healthcare spending (Kelley, 2009). In some instances, such as insurance related, the payer for healthcare is usually different from the direct consumer of the service. In such instances, this arrangement makes it difficult for the payer to verify if indeed such health services were provided and challenging for the direct consumers (patients) also to ascertain if the payer, usually the health insurance provider, had been billed for services they know they did not consume (Husmann, 2011b). Hence, immediate confirmation of the actual provision of such health services is not realistic, serving as a lacuna for exploitation.

Furthermore, the unique arrangement of the health sector where governments and donor agencies sometimes entrust private health actor providers to deliver health services on their behalf for the greater public, such as in epidemics, disasters, and mass vaccinations, with its attendant colossal amount of public money allocated to such system makes even the private sector vulnerable to corruption (Savodoff and Husmann, 2006; Vian *et al.*, 2017). In summary, therefore, the volume, type, price, and mode of delivery of health services are all subject to

provider manipulation. These services are often broad scope which includes consultations, diagnosis, laboratory and radiological investigations, and treatment- including both outpatient and inpatient investigations and medications.

### **2.2.3. Theoretical/Conceptual Frameworks for Corruption in Healthcare Systems**

Several concepts, frameworks, and approaches to explain corruption in the health sector and its impact on health service delivery have yielded many distinct but interconnected typologies (Klitgaard, 1988; Savedoff, 2007; Vian, 2008b; Wells and Cressey, 2011; Jorgensen, 2013; Olivier de Sardan, 2013a; Sommersguter-Reichmann *et al.*, 2018).

In Europe, the *EHFCN Waste Typology* and *Corruption in the Health Sector Typology* have gained usage as they highlight malpractices within the context relevant to the European health system (European Commission, 2013; Medeiros and Schwierz, 2013). Two other frameworks, the *Five Key Actors in the Health System model* and *OECD Integrity Violations Framework*, which are also derived within the global north context, connect individual health actors to distinct forms of corruption or integrity violations (Savedoff, 2007). A different framework - *Typology of Individual and Institutional Corruption* has gained usage to differentiate corrupt practices at the individual abuse of power and at the institutional level and their failure to align with rules and regulations (Jorgensen, 2013; Sommersguter-Reichmann *et al.*, 2018). Another framework, Vian's 2008 framework, draws on prior works such as the fraud triangle theory (Wells and Cressey, 2011) and the heuristic model for anti-corruption (Klitgaard, 1988), to enumerate factors enabling health sector corruption, especially in the global south which is the focus of this research (Vian, 2008b).

These documented typologies and their assumptions take root in two main approaches - the vertical approach/regulation solutions and the horizontal approach/collective solutions. Vian's (2008) framework, which has relevance in LMICs in the global south and is anchored to a

vertical approach, provides a guide for policymakers in examining health sector corruption and suggesting reforms that enhance transparency and accountability as advocated in Klitgaard's (1988) heuristic model. Vian's (2008) conceptual framework suggests that the interplay of government agents with pressure clients - patients driven by norms propagates corruption in health systems (Vian, 2008b). Consequently, these government agents and patients rationalise their behaviours as acceptable norms in society and not just restricted to the health sector. This view by Vian (2008) was echoed by Gaitonde and colleagues (2016), who suggested that health-related corruption is sustained by the actions and interactions between care-seekers and healthcare providers, as well as health facilities (Gaitonde *et al.*, 2016). Vian and Norberg (2008) also argue that health sector corruption breeds because of the inter-relationships among health actors, which often involve material gains embedded within social norms (Vian and Norberg, 2008).

The second approach - *the horizontal approach*- is now gaining ground in the literature on health service delivery (Hahonou, 2015; De Herdt, 2018; Olivier De Sardan *et al.*, 2018). Horizontal frameworks, which are often complementary to vertical approaches, illuminate the complexity and overlapping relationships between the several actors in the health sector and the opportunity allowing for such behaviours to be propagated and embedded within the health sector (Transparency International, 2006). For example, a complementary theoretical framework of crucial importance is that by Olivier de Sardan (1999), which is a horizontal approach focusing on the influence of social norms and informal arrangements in health sector corruption (Olivier de Sardan, 1999). Olivier de Sardan (1999; 2018) and Anders and Chirwa (2018), in their studies on practical norms which included the health sector argue that behaviours of critical actors in the health sector that are known to digress from official norms are informal and are in between "usual practice" and corruption practices (Olivier de Sardan, 1999; Anders and Chirwa, 2018; Olivier De Sardan *et al.*, 2018). Gaal and McKee (2005), also

relying on a horizontal approach framework, showed that patients and healthcare providers often recourse to informal practices outside official means to achieve their objectives of seeking care and providing services, respectively, due to rugged operational terrain within official norms (Gaal and McKee, 2005).

More corruption studies in the health sector that combine horizontal lenses to vertical lenses, such as that using Olivier de Sardan's framework and Vian's vertical theoretical frameworks, have been advocated by stakeholders in the global south. This combination is needed to fill the current gap in the literature where there is the need for a more nuanced and complete understanding of how corruption is understood (i.e., top-down and bottom-up), especially from the view of the consumers- patients and providers including the incentives, norms and relationships that continue to propagate these practices (García, 2019; Onwujekwe et al, 2019).

#### **2.2.3.1. The “Corruption Complex”: Understanding the Nexus of Informality, Political Economy, and Health Systems**

This sub-section focuses on the concept of “corruption complex” which is central to this review where the broader concept of corruption is adopted. The “corruption complex” refers to the intricate and interrelated web of corrupt practices, informal arrangements, and power dynamics that exist within a particular sector, often affecting service delivery, policy implementation, and overall governance. This concept recognizes that corruption is not simply a one-dimensional issue but a multifaceted and evolving problem that needs to be analysed and addressed comprehensively. The “corruption complex” is particularly pertinent when examining the health sector, as the consequences of corruption within this domain can be a matter of life and death. To understand this concept better, this review draws on relevant existing literature on informality and corruption, health systems, and political economy, drawing on seminal works by Khan et al (2019), Hutchinson et al (2020), Odii et al, (2022)

amongst other authors. In synthesizing these perspectives, this review aims to define and conceptualize the “corruption complex” in a nuanced and encompassing manner.

### ***Informality and “Corruption Complex”***

Informality plays a central role within the “corruption complex”. Informality within the context of “corruption complex” refers to practices that occur outside the bounds of established rules and regulations (Hutchinson *et al.*, 2020). These informal activities often thrive when formal rules and regulations are weakly enforced, creating opportunities for corruption. However, Hutchinson *et al.* (2020) and Anders and Chirwa (2018) also suggest that not all forms of informality are corrupt, and some practices within the broader complex are considered “survival corruption” said to provide practical solutions to the difficult realities in delivery health care in underfunded health systems, especially those in LMICs (Anders and Chirwa, 2018; Hutchinson *et al.*, 2020).

Khan *et al.* (2019) discusses how conventional anti-corruption strategies, which primarily focus on enforcing the rule of law and increasing the costs of corruption for individual officials, may be ineffective in contexts characterized by widespread informality (Khan, Roy and Andreoni, 2019). Informality in corruption can manifest as unofficial payments, patronage networks, and nepotism within the health sector, compromising the integrity of service delivery and undermining public trust (Khan, Roy and Andreoni, 2019; Hutchinson *et al.*, 2020).

Again, Hutchinson and colleagues in their paper on developmental governance highlight the role of informality in corruption within the broader context of governance. They emphasize that the “corruption complex” is deeply rooted in informal power structures and networks that often work against formal institutions (Hutchinson *et al.*, 2020). In the health sector, these informal networks can impede effective policy implementation, resource allocation, and decision-making.

Similarly, the health sector is particularly vulnerable to the “corruption complex” due to the high stakes involved. Corruption can lead to substandard care, drug shortages, and unequal access to health services. Odii et al. (2022) in their paper on corruption in Nigeria discuss leveraging power, politics and kinship and explored the intersection of health systems and corruption, emphasizing that the corruption complex can undermine health systems by diverting resources, compromising healthcare quality, and eroding public trust. Their research underscores that addressing corruption in the health sector requires a comprehensive understanding of the various informal practices, networks, and power dynamics at play (Odii et al., 2022).

### ***Political Economy and the “Corruption Complex”***

The “corruption complex” is also deeply intertwined with the political economy of a country and consequently sectors. Corruption within the “corruption complex” is not just a matter of financial mismanagement but is deeply intertwined with political arrangements, power dynamics, and the distribution of resources. The political economy plays a significant role in sustaining corrupt practices. Khan et al. (2019) argue that anti-corruption strategies in developing countries and LMICs must consider the broader political settlements and economic interests of powerful individuals and organizations (Khan, Roy and Andreoni, 2019). In many cases, powerful entities may benefit from corrupt practices, making it challenging to enforce anti-corruption measures effectively. The political economy plays a critical role in shaping the “corruption complex” within the health sector, as vested interests may hinder efforts to tackle corruption.

To understand the “corruption complex”, it is crucial to recognize that it operates both *horizontally* and *vertically* within a society (Khan, Roy and Andreoni, 2019). Horizontal corruption refers to interactions among individuals, while vertical corruption involves

relationships between individuals and institutions. Khan and his colleagues suggest that anti-corruption strategies should consider these dimensions and should be tailored to the specific context (Khan, Roy and Andreoni, 2019).

Similarly, Hutchinson and colleagues in their paper on developmental governance further explores the political economy aspect of the corruption complex, emphasizing that the informal networks and vested interests often perpetuate corruption (Hutchinson *et al.*, 2020). These interests can manifest in the form of rent-seeking, where powerful individuals seek to maximize their gains through corruption, even if it comes at the expense of public welfare.

Furthermore, as suggested by Olivier de Sardan, a leading scholar in the field of corruption in African states, the influence of everyday corruption, particularly in health service delivery, does not only regard to corruption in the technical or strict legal term alone but instead to “corruption” in a broader way that encompasses other related informal practices that may or may not be illegal but however put the interest of individuals at the expense of public interest (Olivier de Sardan, 1999, p. 27). Other scholars such as Blundo and Olivier de Sardan (2006), Hahonou (2015), and Anders and Chirwa (2018) have extended such posture which views related informal practices (Blundo and Olivier de Sardan, 2006b; Hahonou, 2015; Anders and Chirwa, 2018). This broader complex includes nepotism, patron-client relationships, abuse of power, embezzlement and various forms of misappropriation, influence-peddling, prevarication, insider trading and abuse of the public purse; hence described as the “corruption complex” (Olivier de Sardan, 1999, p. 27).

The “corruption complex” includes illicit or quasi-illicit practices, which are not considered to be corruption in the strict sense of the term primarily understood as bribery, but all of which share similarities with corruption based on their interconnection with state and bureaucratic procedures. These practices usually counter official public and private service principles,



providing a favourable habitat for illegitimate amassing and the abuse of power for personal gratification (Hahonou, 2015; Olivier de Sardan and Hamani, 2018; Shah, 2019). Blundo and Olivier de Sardan created an extensive typology of corrupt practices (Blundo and Olivier de Sardan, 2001, pp. 12–16). They differentiate seven "basic" forms of corruption: (i) *commission*, (ii) *gratification*, (iii) *The “piston” or “being connected”*, (iv) *undue remuneration* for public services (informal payments), (v) *The “tribute” or “toll”* i.e., extortion, (vi) *The “wig”* i.e., private use of government property, and (vii) *The “diversion”* i.e., appropriation of government property.

The first category- *commission* relates to payment for an illegal favour and encompasses kickbacks for the award of contracts of government tenders, and the beneficiary does something illegal or fails to disclose or stop an illicit activity. The second category- *gratuity* is a recompense for a state employee who has performed well in carrying out his or her public duties. In this regard, it varies from the compensation paid for illegal activities. The third type, *use of connection* is essential in all dealings with bureaucrats. In the fourth category, users were expected to pay public servants for services performed. According to Blundo and Olivier de Sardan, these payments were not authorised payments, but rather *informal payments*. The fifth category- *extortion* is a kind of corruption in which a public servant requests payment in exchange for falsified "infringements" or services. The sixth type- *private use of government property* is a type of corruption that varies from the last category – *appropriation*, in that public property is either brought back or continues to remain in the office after being used (Blundo and Olivier de Sardan, 2001, pp. 12–16).

In conclusion, the “corruption complex” is a multifaceted and interrelated concept that encompasses various dimensions of corruption, informality, health systems, and political economy. It acknowledges the intricate web of corrupt practices and power dynamics within a

specific sector, such as the health sector, and underscores the challenges of addressing corruption in adverse contexts. Drawing upon key literature by Khan et al., Hutchinson, and Odii et al., and Olivier de Sardan (2013), Hahonou (2015) and Anders and Chirwa (2018), this review provided insights into the definition and conceptualization of the “corruption complex”. Understanding this complexity is essential for designing effective anti-corruption strategies that can mitigate the adverse effects of corruption within critical sectors like healthcare.

#### **2.2.4. “Everyday” Corruption in Health Service Delivery**

This section narrows down to the form of corruption which this study focuses on. Here, this review comes down from broader conceptual and theoretical understanding of corruption in health care to a more focus on “everyday corruption” in health service delivery- including the empirical evidence base. This empirical research is focused on understanding the causes, manifestations, and impact of everyday corruption on health service provision in LMICs such as Nigeria’s healthcare delivery system resulting from the day-to-day interaction of healthcare workers and patients in health facilities. This section, therefore, reviews the scholarship on everyday corruption with emphasis on the African state where there has been increasing interest on corruption in the health sector (Olivier de Sardan, 1999; Blundo and Olivier de Sardan, 2006a; Vian, 2008a; Anders and Chirwa, 2018; Hutchinson, Balabanova and McKee, 2019, 2020; Onwujekwe et al, 2019).

First, beyond the health sector, what does the literature say on what “everyday corruption” is understood to be? Everyday corruption, also known as petty corruption, has been defined in several ways by scholars, policymakers and think tanks. The definition of “everyday/petty corruption” has ranged from broad-ranging to specific distinct phenomenon (Stahl, Kassa and Baez-Camargo, 2017). For example, Transparency International defines everyday corruption as the “*everyday abuse of entrusted power by low- and mid-level public officials in their*

*interaction with ordinary citizens, who often are trying to access basic goods or services in places like hospitals, schools, police departments and other agencies”* (Transparency International, 2017, p. 2). Another think-tank on corruption, the U4 Anti-Corruption Resource Centre in Norway defines everyday corruption *“as one that takes place at the "implementation end of politics [policies], where public officials meet the public most commonly in the form of acts of bribery or abuse of power in day-to-day situations”* (Dupuy and Neset, 2018). Similarly, an evidence paper by the Department for International Development (DFID) review that focused on everyday corruption described it in terms of size:

*“small amounts of money or in-kind payments and thus, it often manifests in different forms and has different aims such as to "extra demand payment for the provision of government services including health services that may or may not be free; make speed money payments to expedite bureaucratic procedures; pay bribes to allow actions that violate rules and regulations obtain posts or secure promotion, or the mutual exchange of favours”* (DFID, 2015, p. 13).

According to Hahonou (2015), everyday corruption is justified by high-level corruption, which allows ruling elites to enrich themselves quickly and ostentatiously. Therefore, taking a piece of the national cake and serving the interests of relatives is a way for civil servants to exact revenge on the state (Hahonou, 2015, p. 135). Anders and Chirwa (2018) expressed similar findings as they suggested that partaking in everyday corruption by public servants is seen as eating one's “share of the state cake” to take revenge on the state and its elites who have plundered the state's resources (Hahonou, 2015; Anders and Chirwa, 2018).

The prevalence of everyday corruption has been suggested to worsen societal corruption since it is likely to become widespread and endemic (Steiner, 2017, para. 8). One reason is that corruption networks frequently. For example, a low-level official who demands a bribe at the point of service can be obliged to pass along a portion of the bribe to the person above them, who might then be required to do the same, which goes up the chain. Thus, what may appear

to be "petty" or "everyday" corruption is a part of the larger corruption system rather than an isolated incident and often reflects societal/systemic (Steiner, 2017, para. 7).

The scholarship has seen an increasing amount of literature relating to day-to-day corruption in health service delivery, especially in the past two to three decades, attesting to the increasing interest by scholars in this field (Blundo and Olivier de Sardan, 2006a; Hussmann, 2011b; Kankeu and Ventelou, 2016; Mackey, 2016, 2019; Anders and Chirwa, 2018; Hutchinson, Balabanova and McKee, 2019; Onwujekwe et al, 2019; Vian, 2020). This renewed interest also testifies to the complexity of understanding corruption in healthcare systems, particularly those in LMICs where global efforts to eradicate the menace have been the focus in these past two decades but have produced mixed results (Hirschfeld, 2006; Nishtar, 2010a; Lyrio, Lunkes and Taliani, 2018; García, 2019; Kirya, 2020).

Previous corruption studies, particularly those related to health service delivery in the last two decades, laid the foundation for this renewed interest (Olivier de Sardan, 1999; Balabanova and McKee, 2002b; Vian, 2002, 2008b; Gaal *et al.*, 2006a; Hussmann, 2011b). Such studies provided some unique insights which are relevant to this index study. Firstly, corruption studies provide an entry into a broader set of problems, including informal practices that impact service delivery. Hence, more studies like this index study are needed to expand on this view, not the constrictive or legal view of corruption. Similarly, they showed that contexts matter in corruption field studies, as what constitutes illegality in one setting is socially acceptable in another. Therefore, empirical research that is culturally and geographically sensitive is needed to engage in the debate of what is and is not corruption which is the basis for this index study in Abuja, Nigeria's mixed health system.

While more recent studies have begun to be more empirical, the need for specific contextual insights at the healthcare facilities can incorporate more evidence base to understand how

corruption in Nigeria's mixed health systems can be better addressed through combined top-down and bottom-up approaches, which are currently being advocated. For example, in Nigeria, the focus of this index qualitative study, majority of the studies concerning corruption in the Nigerian healthcare system and its impact on health service delivery were published in the last 10-15 years (Onwujekwe *et al.*, 2010; Uzochukwu *et al.*, 2011; Akokuwebe and Damilare, 2015; Aregbeshola, 2016; Tormusa and Idom, 2016; Aregbeshola and Khan, 2018; Onwujekwe *et al.*, 2019; Akinbajo, 2020). However, a substantial portion of this literature in Nigeria needs more empirical insights from in-depth interviews. These studies have mainly focused on Nigeria's public health system, while most Nigeria's healthcare is sourced from the private health sector (Hafez, 2018b). Therefore, most of these studies lack relative insights into corruption in the private sector, making the findings from these studies reflect only a part of the problem in Nigerian health mixed health system.

Furthermore, most of these previous studies highlighted above concerning everyday corruption were lacking in having a nuance view from the complainants of these alleged corrupt practices- *patients* and the alleged accused- *providers*. In doing so, that might not be a fair representation in dysfunctional health systems like Nigeria where both views are needed. Also, several of these studies were documentary reviews and opinion pieces, with limited empirical insights that provide context and “real” lived experiences of patients and healthcare providers. The growing literature on corruption in health systems and its diverse manifestations has shown that it is fundamental to have a firm grasp of critical actors in these health systems and how they relate to each other within them if we are to understand their impacts on healthcare systems. Although several systematic reviews in the literature have shown that these critical actors and their relationships vary within geographies, however, their roles at the level of health service delivery as it relates to the continuum of care to patients are similar (Gaitonde *et al.*, 2016; Onwujekwe *et al.*, 2019; Naher *et al.*, 2020; Vian, 2020). Evidence from the available

systematic reviews across Africa and south-east Asia showed that at the level of direct service delivery, corruption is as strive as it is at the supra-systemic levels.

Although by no means are these typologies exhaustive, the reviews within the field of corruption studies in healthcare identified several of these practices, including informal payments and bribery, absenteeism, leakage/theft of health commodities, dual practice and diversion of patients from public to private facilities, health insurance frauds and claims, counterfeit medical supplies, and procurement irregularities (Olivier de Sardan, 1999; Balabanova and McKee, 2002b; Gaal and McKee, 2004, 2005; T. Vian *et al.*, 2006; Vian and Burak, 2006; Anders and Chirwa, 2018; Olivier De Sardan *et al.*, 2018; Onwujekwe and Odii, 2018; Onwujekwe et al, 2019; Kirya, 2020; Naher *et al.*, 2020).

Onwujekwe et al (2019) and Vian (2020), in their respective systematic reviews on corruption in health systems, showed that corruption was striving at all levels of the health system and involved multiple actors which stem from complex relationships (Onwujekwe et al, 2019; Vian, 2020). A strength of both reviews was in identifying the most common corruption problems, which gives policymakers focus on their anti-corruption drive in these health systems. They ranged from bribery and informal payments, absenteeism, leakage of health commodities, diversion of patients, and corrupt procurement. However, a common limitation to these reviews was that although the health systems of these LMICs had a mix of public and private health facilities, these reviews were made up of studies highly skewed towards public health facilities. Thus, excluding experiences of corruption from patients who seek care in private health systems creates a misperception of corruption-free private health systems in mixed health service markets. Furthermore, most of these previous studies of corruption in health service delivery provided evidence of the causes and consequences of corruption, however, there needs to be more progress in the scholarship regarding the context, incentives,

and conditions under which these causes emanate and how these corruption problems are experienced by the end users receiving care.

#### **2.2.4.1. Common Forms of “Everyday” Corruption in Health Facilities**

This section reviews the common forms of corruption in health facilities, focusing on corrupt practices at the service delivery level. These practices often arise from the interaction between patients and providers regarded as “everyday” or “petty” corruption in health facilities (Blundo and Olivier de Sardan, 2006b; Nguyen, 2008; Smith, 2010; Panth, 2011; Pieterse and Lodge, 2015; Steiner, 2017). Therefore, these forms of corruption are the focus in this review.

##### **A). Informal Payments**

In many LMICs, informal payments by patients and their care-seekers for health services have been well established (Delcheva, Balabanova and McKee, 1997; Liaropoulos and Tragakes, 1998; Balabanova and McKee, 2002b; Lewis, 2002; Gaal and McKee, 2004; Vian and Burak, 2006; Liaropoulos *et al.*, 2008; Kaitelidou *et al.*, 2013). Informal payments to healthcare providers are a common occurrence, accounting for 10% to 45% of total out-of-pocket healthcare expenditures in many low-income countries (Balabanova *et al.*, 2004; Vian *et al.*, 2006). These payments have the potential to jeopardise governments' efforts to improve equity, access to care, and reforms aimed at helping the poor and vulnerable (Gaal *et al.*, 2006a).

In several reviews, the terms "informal payments" and "bribery" are frequently used interchangeably, and many other studies have suggested that it can be challenging to distinguish between the various manifestations (Gaal and McKee, 2005; Azuh, 2012; Hahonou, 2015; Saka *et al.*, 2016; Onwujekwe *et al.*, 2018). However, "bribery" is more frequently used to describe giving gifts, money, or other in-kind payments to expedite services or gain a service, whereas "informal payments" are more frequently used to describe paying fees for purportedly free services or extra payments on standard payments, including in-kind payments

for health care (Onwujekwe *et al.*, 2020). This practice is quite manifold, ranging from tokenised in-kind gifts from patients to healthcare providers through cash payments for diverse health commodities, including drugs, laboratory tests, syringes, and bed spaces (Gaal *et al.*, 2006b; Hahonou, 2015). Thus, this review considers informal payments under the broader category.

Lewis (2002), in her works on informal health payments in central and eastern Europe including the former Soviet Union, described informal payments as creating “*an informal market for health care within the confines of the public healthcare service network*” and in effect are a form of corruption” (Lewis, 2002, p. 5). Lewis defines informal payments in two folds; (i) “*as payments to individual and institutional providers, in kind or cash, that is made outside official payment channels* and (ii) *purchases that are meant to be covered by the health care system*”(Lewis, 2002, p. 6). The first component of the definition that relates to corruption which is synonymous to bribery and includes “envelope” payments to healthcare workers and “contributions” to health facilities. The second component of the definition includes the cost of medical supplies bought by patients and drugs procured from private outlets such as community pharmacies that ideally should be provided free or bought at government set price in public healthcare services.

Furthermore, Gaal *et al.* (2006) defines informal payment as “*a direct contribution, which is made in addition to any contribution determined by the terms of entitlement, in cash or in-kind, by patients or others acting on their behalf, to healthcare providers for services that the patients are entitled to*” (Gaal *et al.*, 2006a). These payments are diverse, and although not all of these payments are always corrupt (Balabanova and McKee, 2002b; Ensor, 2004; Gaal *et al.*, 2006a; Rădulescu *et al.*, 2008; Stepurko *et al.*, 2010). Authors such as Balabanova and McKee (2002), and Lewis (2002) suggest that generally speaking, informal payments are more



likely to constitute corruption if they are requested before treatment or are actively demanded by the healthcare providers, and when often they involve cash or expensive items (Balabanova and McKee, 2002b; Lewis, 2002). (Gaal *et al.*, 2006b).

Informal payments in health care systems pose an increasing concern (Balabanova and McKee, 2002b; Vian and Burak, 2006; Onwujekwe *et al.*, 2010; Schaaf and Topp, 2019). According to Onwujekwe *et al.* (2010) in southeast Nigeria, informal payments are a major health system challenge and have been identified as a significant source of catastrophic health expenditure, in which medical expenses exceed 30% of household income (Onwujekwe *et al.*, 2010). Kankeu and Ventelou (2016) also showed that informal payments are common in public health facilities across 33 country surveys of LMICs, including Asia and Africa. However, they also showed that informal payments were found in private health markets. The same study showed that the highest incidence of informal payments in the 33-country survey was found in private for-profit health facilities, indicating that no sector is spared (Kankeu and Ventelou, 2016).

Informal payments have been described as a coping strategy payment to healthcare workers to make up for remuneration that does not match their perceived efforts (Kankeu and Ventelou, 2016). It has been suggested in the literature that informal payments sometimes even up the shortage of health commodities in health facilities and provide enticement for healthcare providers to provide services in health facilities where funding is a significant challenge (Belli, Gotsadze and Shahriari, 2004; Gaal *et al.*, 2006b; Tatar *et al.*, 2007; Maestad and Mwisongo, 2011). Conversely, informal payments are also said to worsen equity and efficiency problems, including barriers to access, especially for the poor and vulnerable seeking care in most LMICs (Ensor, 2004; Gaal and McKee, 2004, 2005).

Two main categories of informal payments have been identified in the literature; those that occur from donations which suggests “free will” and those that are meant as "fee-for-service",

which suggests the givers were left with no choice (Hahonou, 2015; Pourtaleb *et al.*, 2020). The former arises as “tokens” or monetary gifts from patients to health service providers, which can sometimes be in kind or non-monetary terms, hence the argument of it being legal (Ensor, 2004; Gaal and McKee, 2005). In the same vein, bribes are also not limited to cash payments or money inducements, one of the arguments being the notion that bribery and informal payments are often indistinguishable; however, informal payments are broader in scope.

Hahonou (2015), in his empirical research in the republic of Niger suggests that two categories of informal payments exist: ex-post payments and ex-ante informal payments. The first group of informal payments, labelled as *ex-post payments*, are considered “benign” forms of unofficial payments as they are made after receiving the service (Hahonou, 2015, p. 123). A socio-cultural dimension is offered to explain these “free will” informal payments. Some scholars argue that these are voluntary actions rooted in social norms considered part of a known culture of giving gifts (Lewis, 2002; Ensor, 2004; Gaal and McKee, 2004; Gaal *et al.*, 2006b). The second group of informal payments is *ex-ante payments* received by providers before rendering health services (Hahonou, 2015, pp. 123–124). These informal payments can be considered as bribes, which is morally wrong and unethical since they can lead to service refusal or poor service quality if not paid (Hahonou, 2015, p. 124). Available explanations for such acts by healthcare providers anchor on the economic perspective of corruption (Klitgaard, 1988; Klitgaard, Maclean-Abaroa and Parris, 2000). It is suggested that healthcare providers resort to such practices due to poor salaries; hence it is a “survival strategy” for public servants (Hahonou, 2015; Anders and Chirwa, 2018; Olivier de Sardan and Hamani, 2018). Balázs (1991) quoted in Gaal and McKee (2005), suggests another dimension that hinges on the economic explanation for such informal payments, which centres on the twists that monopolistic or quasi-monopolistic conditions infer for health markets, public and private alike (Gaal and McKee, 2005).

Studies suggest that informal payments increase health service prices without often a concurrent assurance for meaningful improvement in service provision for the end users. They act as a barrier to receiving care; thus, worsening the already existing inequalities between the affluent and the vulnerable, which in turn influences all dimensions of healthcare service - equity, quality, resilience, performance, and responsiveness (Weaver, 1995; Ensor and San, 1996). On the other hand, some studies have highlighted the so-called “positive” effects of this kind of informal payments, which includes improved quality of care for those patients who made the “under-the-table” payment as it acted as an incentive to “grease” a paralysing health system (Gaal and McKee, 2005; Hahonou, 2015). Others have even called for the formalisation of informal payments as a measure to reduce corruption in health facilities (Baschieri and Falkingham, 2006).

In Nigeria, the evidence suggests that informal payments may be widespread in public health facilities (Onwujekwe *et al.*, 2010; Akokuwebe and Damilare, 2015; Uzochukwu, Onwujekwe and Mbachu, 2015; Aregbeshola, 2016; Tormusa and Idom, 2016). These studies reported several reasons for informal payments. However, the empirical data from these studies could have been more extensive, particularly on data that provides context and understanding of the institutional incentives that allow informal payments to thrive in Nigerian health facilities. For example, in Nigeria, where the use of cash-based payments is still the order of the day in many public health facilities and with an apathy for electronic payment methods, there is a need to investigate this to see how much such lack of institutional drive aids the practice of informal payments. Similarly, could the not-for-profit nature of public health facilities be less of an incentive for the system to ensure that only official payments are made since the management does not gain from the accrued revenue? Studies with contextual insights into such debates from an empirical standpoint are needed in Nigeria.

For example, Abba-Aji and colleagues (2020) in Nigeria suggested that informal payments were prevalent in public facilities (Abba-Aji *et al.*, 2020). However, the findings in their study relied on newspaper reports of informal payments. “Hard” evidence from empirical studies sourced from patients and healthcare providers in Nigerian health facilities would be an invaluable addition to such findings. Onwujekwe and colleagues (2010) in south-eastern Nigeria revealed that informal cashed-based payments made by patients to healthcare workers in Enugu, Nigeria, which was layered on official payments/user fees for conditions such as malaria in government health facilities did generate the needed internal revenue to run the health facilities. However, the informal payments received by healthcare providers were suggested to have been diverted to augment their meagre salaries rather than funding the public facilities (Onwujekwe *et al.*, 2010). This can be argued in some quarters as bribery which falls technically as plain corruption if the healthcare workers requested these extra payments in addition to the official payments before providing services for these patients. From a legal perspective, this could be viewed as bribery. Thus, classifying it as informal payments by Onwujekwe *et al.* (2010) might be a more neutral way of them referring to bribery. Therefore, this recognises some of the constraints of looking at corruption from mainly a legal or strict technical term which made scholars such as Olivier de Sardan and Blundo prefer the broader term "corruption complex" (Olivier de Sardan, 1999, p. 27; Blundo and Olivier de Sardan, 2006b, p. 74).

Similarly, other studies have suggested that in addition to poor remuneration as a significant reason for health workers demanding informal payments, the lack of resources in public health facilities, including health commodities, drugs, and hospital equipment, led most health workers to charge informal payments (Azuh, 2012; Saka *et al.*, 2016). These proffered reasons were from the health worker's perspective, with few views from the patient's perspective. Similarly, little attention has been given to the debate on the "negative" vs "positive" effects of

informal payment practices in the literature on corruption in the health systems of low-and-middle-income countries, including Nigeria. Understanding such nuances using empirical evidence can also be invaluable to the debate in the corruption literature.

## **B). Bribery**

At the health service delivery level, bribery has been described as offering cash or in-kind payments by patients/care-seekers to healthcare providers or their proxies to expedite health services (Transparency International, 2006). Several studies have reported patients paying bribes to healthcare providers in cash or in-kind, suggesting that this is a major problem in LMICs (Garuba, Kohler and Huisman, 2009; Hahonou, 2015; Saka *et al.*, 2016; Turay, 2016).

Multiple reasons have been suggested in the literature for why health workers demand bribes and why patients pay bribes. For example, Panth (2011) suggested that bribery has been justified in several instances as “facilitation fees from those who can to those who need” (Panth, 2011). In the transition economies of the former soviet states, Ensor (2004) showed that bribe-taking was believed to compensate for the poor wages of healthcare workers (Ensor, 2004). Similarly, in another study which surveyed 33 low-and-middle-income countries, Kankeu and Ventelou (2016) suggested that patients often paid bribes or demanded to jump queues in health facilities or receive preferential treatment (Kankeu and Ventelou, 2016). A limitation of the study by Kankeu and Ventelou was that, as a survey, it highlighted reasons for paying bribes, however, it needed to provide the rationale for these actions by both patients and healthcare workers which would have been provided through qualitative interviews. Furthermore, Saka and colleagues (2016) found that payment of bribes in health facilities to hasten services has been accepted by many as expected. They argued that bribery aids patients and their care-seekers to avoid bureaucratic bottlenecks because this has become a routine practice, with patients sometimes initiating the process (Saka *et al.*, 2016). In Colombia, Panth (2011) showed

that the citizens who pay such bribes justify their disregard for the law. They suggested that the government provided no alternative pathway for them as failure to pay such bribes resulted in consequences on the citizens' health in government health facilities (Panth, 2011).

Similar studies have also revealed instances where physicians insist on being paid bribes before seeing patients (Chimezie and Costa, 2015; Turay, 2016). Turay (2016) in Sierra Leone, suggested reports of nurses refusing to monitor newborns until their mothers bribed them. Although some of these studies, such as that by Saka and colleagues (2016) and Turay (2016), provided insights into the rationale for why bribery occurs in health facilities, they were commentary and opinion pieces which needed more detailed empirical data. Several other studies have revealed bribery's impact on patients' health outcomes. Most of these studies suggest that bribery negatively correlates with healthcare outcomes (Azfar and Gurgur, 2007; Tatar *et al.*, 2007; Nguyen, 2008; Matsushima, 2016; Stepurko *et al.*, 2017). For example, Matsushima and Yamada (2016) found in Vietnam that bribery worsens patient health outcomes, including patients' enrolment in health insurance programmes, as it acted as a barrier to health insurance enrolment (Matsushima, 2016). Also, Azfar and Gurgur (2007) showed that requests for bribes in the Philippines led to a reduction in immunisation rates, delays in the vaccination of new-borns, and apathy for seeking care in government facilities (Azfar and Gurgur, 2007).

Similarly, some studies have also shown that health workers pay bribes to health officials within the health system (Abdallah, Chowdhury and Iqbal, 2015; Hahonou, 2015; Hutchinson, Balabanova and McKee, 2020; Naher *et al.*, 2020). In South-East Asia, Abdallah *et al.*, (2015) in Bangladesh showed that healthcare workers, especially medical doctors pay bribes to health officials at the ministerial level to avoid being posted to certain health facilities especially the

more remote and rural locations. Their findings further suggested that the more remote the location, the more significant the bribe to be paid (Abdallah, Chowdhury and Iqbal, 2015).

In addition, other studies suggest healthcare workers paid bribes to secure employment, sometimes to the detriment of qualifications. Azad (2014) revealed in Bangladesh that bribery was prevalent and at the centre of most decisions by health officials when recruiting physicians and deciding postings and transfers of healthcare workers to health facilities (Azad, 2014). Similarly, Naher et al. (2020), in their scoping review of the literature in Southeast Asia, found that healthcare workers gave bribes to hospital management leaders to take unlawful leave or be absent from work, steal public health facility revenues such as patient registration fees, and receive payments for doing training that either did not take place or was not attended (Naher *et al.*, 2020). Das et al (2016) in India also showed that paying bribes to health workers in the private health sector, which has been suggested to earn higher salaries compared to their public sector counterparts, was expected (Das *et al.*, 2016). These included bribes to private health operators to falsely claim benefits for insurance purposes or the death of family members and unlawful absence from work.

In a study in Nigeria that comprised of frontline health workers from Enugu, Southeast, Nigeria and Abuja, using a Nominal Group Technique Exercise, Onwujekwe et al (2019) identified several drivers of corruption including bribery in public health facilities such as the normalisation of giving bribes by patients to gain access to services relatively quicker, poor salaries of public health workers, and lack of electronic modes of payment (Onwujekwe *et al.*, 2020). However, a limitation of this study by Onwujekwe et al (2019) was that it was mainly a public sector study and was unable to examine in-depth, the specific forms of corruption that were highlighted including bribery. Hence, they acknowledged the need for empirical

qualitative research which uses in-depth interviews to offer deeper contextual insights into the dynamics of these practices including bribery (Onwujekwe *et al.*, 2020).

Furthermore, Turay (2016) in Sierra Leone and Saka and colleagues (2016) in Nigeria showed that bribery in health facilities was higher in the villages than in cities and often asymmetrically affecting those at the bottom of the economic pyramid (Saka *et al.*, 2016; Turay, 2016). Although Hahonou (2015) in the Republic of Niger also found that the poor and vulnerable often bear the brunt of paying bribes in health facilities, bribery was more common in the General/referral hospitals, which are situated in cities (Hahonou, 2015). In addition to patients paying bribes to seek care, studies have shown healthcare workers doing same as well. For example, Onwujekwe et al (2019) systematic review of Anglophone West Africa across Ghana, Sierra Leone, Gambia, Liberia, and Nigeria, showed that payment of bribes was striving amongst medical doctors to avoid been posted to rural areas. Such practice led to a disproportionate lack of doctors in specific locations with consequent worsening of health outcomes for patients in those regions (Onwujekwe et al, 2019).

While most of the reviewed literature argued that poor remuneration was a leading factor for seeking and paying bribes by patients and providers of care in government facilities, evidence of bribery in the private health sector including providers who engage in dual practice despite having supplementary income does not fully support the remuneration theory. More empirical insight is needed to fully explain the incentives, norms, and social relationships within the health systems, allowing bribery as a corruption problem to be normalised by health workers and patients both in public and to some extent in private health facilities. For example, the evidence in the media on the normalisation of bribery in health service delivery needs more contextual insights (Okoosi-Simbine, 2011; Transparency International, 2017).



### **C). Theft, Diversion of Health Commodities/Patients, and Embezzlement**

Theft and embezzlement in health facilities are straightforward illegal, corrupt practices. Couffinahl and Frankowski (2017) describe the theft of health commodities as a rampant corruption problem where individuals saddled with trust and authority take resources and commodities for which they are not authorised. Diversion of patients is also categorised as a corrupt practice due to the intent of healthcare providers to benefit from such diversions from public to private facilities and vice versa. At the same time, diversion includes the taking of commodities for personal use or another purpose other than the original intent and often reselling them without authorisation (Couffinhal and Frankowski, 2017, pp. 291–292).

Health workers stealing and diverting medical supplies from public to private facilities or outright sale for private gain have been highlighted severally in the literature. Studies have revealed that healthcare workers divert health commodities such as drugs, hospital supplies, equipment, and often official fees/user fees paid by patients (Vian, 2008b; Barr, Lindelow and Serneels, 2009; Hussmann, 2011a; Hahonou, 2015; Anders and Chirwa, 2018; Olivier De Sardan *et al.*, 2018; Onwujekwe *et al.*, 2019; Glynn, 2022). Studies revealing health workers' diversion of high-grade hospital commodities for personal use while reselling inferior ones have also been documented (Akinbajo, 2012; Jain, Nundy and Abbasi, 2014; Onwujekwe and Odii, 2018; Hutchinson, Balabanova and McKee, 2019; Abba-Aji *et al.*, 2020). Similarly, corrupt practices related to providing health services such as diagnosis, treatment, surgeries, and patient referrals that are not guided by pure medical reflection are striving (Peixoto *et al.*, 2012; Aregbeshola and Khan, 2017; García, 2019). There have also been reports in the literature of doctors using public health centres to provide treatment for private clients, often at the expense of their public clients (Akpomuvie, 2010; Akinbajo, 2012; Chimezie and Costa, 2015).

Within the healthcare system, theft and diversion of health commodities can occur at all levels. Although the extent and magnitude of theft and diversion of health commodities at the health service delivery level are challenging to ascertain accurately, the evidence suggests it is worse at the service delivery level because of the diverse and opaque activities involving multiple players as well as poor supervision and lack of accountability (McPake *et al.*, 1999; Ferrinho, Omar, *et al.*, 2004). Even though theft and diversion of health commodities have been reported globally, compared to other distinct forms of corruption, they are more pronounced in the global south compared to the OECD countries of the global north (Couffinhal and Frankowski, 2017). Ferrinho *et al.*, (2004) and Lindelow and Serneels (2006), in their qualitative studies on everyday corruption in the health sector in sub-Saharan Africa, suggest that theft is a more significant concern in African health systems due to the weakness of public health systems in the region (Ferrinho, Omar, *et al.*, 2004; Lindelow and Serneels, 2006).

Similarly, several systematic literature reviews found that healthcare workers from numerous sub-Saharan African countries have had individual experiences with theft and diversion of health commodities at the health service delivery level (Onwujekwe *et al.*, 2019; Naher *et al.*, 2020; Vian, 2020; Glynn, 2022). It has been suggested that the government's laissez-faire attitude with implications on consumer protection laws allows this type of corruption to thrive (Vian, 2002, 2020; Koller, Clarke and Vian, 2020). However, others have argued that the problem is deep-rooted and embedded in norms and behaviours, underpinned by a morality that cannot be controlled with only protection laws as espoused by vertical approaches, but the need for additional horizontal approaches that factor networks and deeper systemic issues (Uzochukwu *et al.*, 2011; Olivier de Sardan, 2013b; Hahonou, 2015; Anders and Chirwa, 2018; Blundo, 2018). Although this argument has begun to take root in the literature, the empirical evidence needs to be studied more widely.

For example, scholars in Francophone west Africa, particularly in the Republic of Niger, have had empirical works concerning practical norms and corruption in the health sector as it relates to norms and behaviours underpinned by morality (Hahonou, 2015; Olivier de Sardan, Diarra and Moha, 2017; Blundo, 2018; Olivier De Sardan *et al.*, 2018). Similarly, Camargo (2012), working in East Africa, including Uganda, Tanzania, and Rwanda, highlighted the role of norms and social behaviours concerning corruption in the health sector (Camargo, 2012; Anders and Chirwa, 2018). They suggested that corruption, such as theft and leakage of health commodities, are deeply embedded within the social norms and must be understood within this context before meaningful anti-corruption measures can permeate these social structures.

In Anglophone west Africa, including Nigeria, empirical studies providing the role of norms and behaviours are on the rise (Onwujekwe *et al.*, 2010; Onwujekwe and Odii, 2018; Onwujekwe *et al.*, 2019; Abba-Aji *et al.*, 2020). Similarly, the Anti-corruption Evidence Network on Corruption in the health sector in Nigeria led by a consortium that is made up of the DFID, School of Oriental and African Studies (SOAS), London School of Hygiene and Tropical Medicine (LSHTM) and the Health Policy Group (HPP) at the University of Nigeria Nsukka (UNN) has advocated for more empirical studies that contextualise social norms and relationships and their roles in corrupt practices such as theft and diversions. The patients' perspectives from most of these previous empirical findings above were not the focus of the studies. For example, in their three-phased approach, Onwujekwe and colleagues (2019), had limited evidence of “lived” patients' experiences of thefts and diversion one of the five categories of practices reviewed. The second and third phases of the methodology employed in their study involved mainly the perspectives of frontline healthcare workers and policymaker regarding these forms of corruption including theft and diversions.

On the other hand, embezzlement is a distinct type of corruption, and several reports highlight how rampant it is across health facilities (Hussmann, 2010; Holmberg and Rothstein, 2011; Kohler, 2011; Maduke, 2013; Mackey, 2016; Saka *et al.*, 2016). Embezzlement has left most health facilities non-functional and dilapidated (Blundo and Olivier de Sardan, 2006a; Akpomuvie, 2010; Tormusa and Idom, 2016; Olivier de Sardan, Diarra and Moha, 2017). For example, at the management level of health facilities, theft often takes the form of embezzlement. Several studies have revealed that health workers have embezzled user fees from health facilities and others have colluded with government officials and health insurance firms to siphon health-related funding from state and non-state funds for personal use (Couffinhall and Frankowski, 2017). In addition, large-scale theft of donor funding allocated to low-and-middle-income countries by government officials have also been reported (Associated Press, 2011). However, studies in the Nigerian literature have focused on highlighting the scale and magnitude of these corrupt practices – in quantitative terms, with little insights into the underlying motivations and drivers of why such acts persist.

#### **D). Health Worker Absenteeism and Related Practices**

Health workers' absenteeism and related practices often associated with dual practice has increasingly gained attention in the health systems literature. According to the definition by Transparency International, health worker absenteeism constitutes corruption “*when public employees choose to engage in private pursuits during working hours, either pursuing private business interests or enjoying unauthorised leisure time at public expense*” (Transparency International, 2019, p. 5). A leading cause of health worker absenteeism in public health facilities is *dual practice*, where many healthcare providers frequently pursue private interests (García-Prado and González, 2011; Hipgrave and Hort, 2014; McPake *et al.*, 2016; Hoogland *et al.*, 2022). For example, being at their private practice during working hours while neglecting

their taxpayer-funded jobs, which fulfils the definition of corruption as the abuse of public office for private gain (Onwujekwe *et al.*, 2023). Therefore, absenteeism considered in this review is the variant that excludes legitimate reasons for workers being absent during working hours, with that period of absence used to pursue private interests. This variant has been cited as a common practice in healthcare facilities in many LMICs (Vian, 2002; Belita, Mbindyo and English, 2013; Kisakye *et al.*, 2016; Hutchinson, Balabanova and McKee, 2019; Onwujekwe *et al.*, 2019; Naher *et al.*, 2020).

In contrast, other studies have suggested that health worker absenteeism is not considered corruption when health workers are legitimately absent from work and, in the process do decide to engage in their private interests. Scenarios such as being on official leave and engaging in a second job or being absent from work on compassionate grounds, ill health or off duty (Kisakye *et al.*, 2016). However, some variants of these forms of absenteeism can be difficult to classify correctly. For example, scenarios where health workers get legitimate approvals from work on account of being sick with uncomplicated conditions like the common flu and malaria but instead use that legitimately approved absence to engage in dual practice can be a challenge, and have been documented in the literature (Lewis, 2011; Kisakye *et al.*, 2016; Namadi, 2020).

Although healthcare worker absenteeism excluding legitimate reasons for absenteeism has ranked high recently in the list of corruption-related practices in the literature, studies still suggest that it is poorly understood (Chaudhury *et al.*, 2006; Onwujekwe *et al.*, 2019, 2023; Naher *et al.*, 2020; Odii *et al.*, 2022; Angell *et al.*, 2023). Vertical approaches which are top-down in nature have had limited success in addressing this corruption problem in most LMICs, and more contextual insights embedded in systemic factors are needed to understand absenteeism as a practice that undercuts health service delivery in LMICs (Angell *et al.*, 2023). Health worker Absenteeism in this regard has been categorised as corruption by several

scholars and think tanks including Transparency International and U4 anti-corruption resource centre, because most of the accused healthcare workers were said to be involved in private jobs during such hours that typically pay higher at the expense of their public jobs, which are left to suffer (Hutchinson, Balabanova and McKee, 2019; Onwujekwe et al, 2019; Vian, 2020). Similarly, the health systems literature has begun to report health worker absenteeism as a distinct form of corruption in health facilities because of the increasing evidence that even in instances where it has been claimed that health workers were provided with the tools needed to work, some still skipped work without legitimate reasons to engage in private interests (Lewis, 2011; Hipgrave and Hort, 2014; Agwu *et al.*, 2020).

Belita and colleagues (2013) suggested a typological framework that attempted to categorise the varied classifications of health worker absenteeism into; *planned/voluntary and unplanned/involuntary* (Belita, Mbindyo and English, 2013). However, a limitation to this classification is that it primarily relies on the health worker's reports for reasons for being absent, of which the veracity of their claims cannot be established (Beil-Hildebrand, 1996; Bouchard *et al.*, 2012; Kisakye *et al.*, 2016). It also excluded the views of patients who, for example, have an idea of where some of the health workers might have been, based on their frequent interactions with these patients at those "supposed" absent hours. Furthermore, several factors have been suggested in the literature to influence absenteeism rates, including workplace, personal, organisational, and cultural factors. Commonly cited factors that have been suggested for driving health worker absenteeism include weak or total lack of monitoring and accountability measures in the public health sector, poor and substandard working conditions in healthcare facilities with resultant worker burnout, and meagre wages in the public health sector (Lewis, 2006; Nanjunda, 2014; Ramadhan and Santoso, 2015). However, the scholarship depicts a conflicting narrative of the effects of these factors, further requiring a

need for more contextual insights and nuanced views that relate to absenteeism as a corruption problem in the health work force in LMICs.

In a review of health worker absenteeism in developing countries by Lewis (2006), she found that absenteeism in India, Bangladesh, and Indonesia was as high as 40% - 50% (Lewis, 2006). McDevitt (2015) in Bangladesh showed that regulatory regimes to manage absenteeism were weak, fragmented, and misaligned due to a lack of understanding of contextual insights, incentives and norms that aid the practice (McDevitt, 2015). In relation to absenteeism distribution, several studies have highlighted absences by doctors from work without leave in public health facilities to be the commonest among healthcare workers (Manzi *et al.*, 2012; Hipgrave and Hort, 2014; Nanjunda, 2014; Ramadhan and Santoso, 2015). In a study of thirty selected community health centres in southern India by Nanjunda (2014), it was found that 30% of medical doctors were absent on the day the survey was conducted and only 19% of the doctors were present most time. Although most of the doctors claimed they often decided with other colleagues to cover their absence, however, these claims were difficult to verify (Nanjunda, 2014). Similarly, Ramadhan and Santosa (2015) also found that 26% of medical doctors were absent in nine urban community health centres suggesting that absenteeism among doctors transcends the rural-urban divide (Ramadhan and Santoso, 2015).

Qualitative studies looking into health worker absenteeism amongst public sector healthcare workers in the global south suggest varied challenges faced by healthcare workers. In their systematic reviews, Rose, and Colleagues (2014) and Naher and colleagues (2020) showed that unlike in the global south, in most of the high-income economies of the global north, health systems are developed, governance is robust, the private health system is formalised, and in cases of dual practice, clear rules are outlined on how to engage in it. Therefore this combined effect makes absenteeism far less likely in high-income countries (Lewis, 2011; Lambert-

Mogiliansky, 2015; Naher *et al.*, 2020). Conversely, in most low-and-middle-income countries of the global south, the systems are weak in governance coupled with mixed health systems that have blurred separation in terms of public and private healthcare systems and the abundance of poorly regulated private health systems devoid of oversight. These factors, combined, worsen absenteeism as a practice emanating from dual practice (Vian, 2002; Lewis, 2011; Belita, Mbindyo and English, 2013; Naher *et al.*, 2020).

In their study in Bangladesh, McDevitt and colleagues reported instances where healthcare workers had been without salary for over a year in government health facilities (McDevitt, 2015). It is suggested that this, in turn, leads health workers to engage in dual practice, i.e., providing care for patients in public and private health facilities in a bid to earn wages concurrently (Lewis, 2006; Cherecheş *et al.*, 2013; McDevitt, 2015). Even though the reviews in the literature have shown that dual practice is present both in high-income and low-income countries, the evidence suggests it is more endemic in low-and-middle-income countries (Hipgrave and Hort, 2014; McDevitt, 2015; Naher *et al.*, 2020). The reason for this endemicity in large part has been suggested to be responsible for health workers being absent from their public health facility roles while working in private health facilities as many of these low-and-middle-income countries are mixed health systems (Olivier de Sardan, 1999; Vian and Norberg, 2008; Hipgrave and Hort, 2014; García, 2019).

Controversially though, in some instances, absenteeism is sometimes what these workers consider legitimate, but it deviates from official norms and compromises the effective delivery of services. For example, in Malawi, Anders and Chirwa (2018) showed that absences among midwives in Malawi due to attendance at baptisms, weddings and funerals far exceed the 21 days maximum legal period of annual leave, and these have negative consequences on health service delivery for patients seeking care (Anders and Chirwa, 2018). Similar findings were



revealed by Olivier de Sardan (2013) amongst nurses in the Niger republic (Olivier De Sardan and Ridde, 2015) and further corroborated by Hahonou's (2015) findings on healthcare worker absenteeism in the Niger republic as well (Hahonou, 2015).

In sub-Saharan, health worker absenteeism has been identified as a menace impacting the delivery of health services to patients, especially in public health facilities (Hahonou, 2015; Aregbeshola, 2016; Saka *et al.*, 2016; Olivier de Sardan, Diarra and Moha, 2017). A World Bank service delivery indicator survey data from Africa between 2012–2016 showed that absenteeism rates among workers in health facilities ranged from 14.3% in Tanzania to 33.1% in Niger (Vian, 2020). Similarly, an Afrobarometer survey also reported absenteeism in over 50% of respondents across 25 countries, ranging from 23% in Burundi to 90% in Morocco (Belita, Mbindyo and English, 2013). Serneels and Lievens (2018), in a study in Rwanda, also found that one-third of healthcare workers in primary health facilities were absent (Serneels and Lievens, 2018). Although empirical studies on health worker absenteeism in the African literature have seen a recent uptick, it is still limited and poorly understood in terms of causes, contexts, incentives, and norms (Manzi *et al.*, 2012).

In Nigeria, there have been reports of healthcare worker absenteeism (Odii *et al.*, 2022; Angell *et al.*, 2023; Onwujekwe *et al.*, 2023). Odii and colleagues suggested that public Primary health centres (PHCs) in Nigeria are faced by shortages of health workers from several reasons that has been aggravated by chronic absenteeism (Odii *et al.*, 2022). Another recent study in Enugu, south east, Nigeria by Angell and colleagues that focused on health worker absenteeism in public facilities suggested that it is a major form of corruption in the Nigeria health system which has reduced the impact of healthcare investment and asymmetrically affects the vulnerable communities in Nigeria (Angell *et al.*, 2023). They argued that top-down governance and accountability initiatives to increase attendance have had little impact, possibly

due to failure to address the incentives and motivations behind health worker behaviours. Similarly, Onwujekwe and colleagues in other studies in Enugu, southeast, Nigeria also explored health worker absenteeism where they found that absenteeism was highly prevalent among PHCs health workers and even a bigger problem if partial absenteeism such as lateness was considered (Onwujekwe *et al.*, 2019, 2023).

Furthermore, Oche and colleagues (2018) showed in the Northern Nigerian state of Sokoto that although healthcare worker absenteeism is a problem when viewed as corruption, the rates are lower as the reasons given by healthcare workers superficially are often hidden under the guise for health-related excuses for been absent from work (Oche *et al.*, 2018). However, increasing evidence, at least from the grey literature and newspapers, seems to suggest that healthcare workers who claim to be absent due to ill health have been reported seen by patients to be providing care in private practice during those periods (Fikayo Olowolagba, 2018; Oche *et al.*, 2018; Abba-Aji *et al.*, 2020). These claims need contextual substantiation in empirical terms especially from other regions of Nigeria to add to the empirical literature on health worker absenteeism that have been skewed to studies arising from Enugu, southeast Nigeria.

#### **2.2.4.2. Summary of the corruption strand and implications of the review**

In summarising the corruption strand of the literature review, the review showed that there is quite a lot about the common types of corruption in health care in LMICs including Nigeria. More recent studies have adopted a broader approach to include several practices as corruption in health care especially where the intent is for private gain even if it were not illegal. However, with emphasis on Nigeria as it is with most LMICs, the focus of these practices that are generally regarded as corruption is skewed to public health service delivery and not on private health service delivery as well as its interaction with public health facilities. Similarly, even in public health facilities, the causes, and underlying motivations for these forms of corruption

are poorly understood, especially in Nigeria, with the limited studies that have attempted to provide such insights largely limited to Southeast Nigeria. Several others were commentaries, opinion pieces, and newspaper reports lacking contextual insights from empirical standpoints. Furthermore, several of the studies in Nigeria and specifically in Abuja, lacked nuanced perspectives in their analysis of corruption from the combined experiences of patients (users of services), healthcare providers (providers of services), and policymakers (regulators of services). Similarly, most of these studies that analysed corruption in Nigeria also lacked insights into how both patients and healthcare providers navigate corruption within a dysfunctional health system such as Nigeria's. These gaps in the scholarship formed key justifications for this present empirical research, as there is the need for the scholarship to provide empirical insights from both the patient and provider perspectives into the causes, manifestations and impacts of corruption across both public and private health facilities including their interactions in LMICs such as Nigeria.

### **2.3. The Private Health Sector in Mixed Health Systems in LMICs**

You will recall that this review set to address two focus areas- corruption in health care and the private sector operations and performance in mixed health systems due to the potential of corruption in aggravating performance problems in mixed health systems in LMICs which several of them are predominantly private health sector dominated. Therefore, this second strand of the literature review specifically focuses on the conceptual and empirical studies regarding private health sector operations and performance in health service delivery within the context of mixed health systems in LMICs- i.e., how private health sector facilities operate side by side public facilities within mixed health systems in LMICs and the potential influence of corruption. Further, this section critically reviews the mixed health systems in LMICs and the interactions including the inherent structures and relationships within these systems that make them prone to corruption in comparison to high-income health systems. It then situates

corruption within the broader mixed health systems syndrome. This strand of the review shows how countries in the global south are referenced and located within mixed health systems based on the nature and size of their private health sector entities and how this relates potentially to the influence of corruption in such health systems using the public health sector as a common denominator.

Private health care in LMICs is very heterogeneous, ranging from itinerant medicine sellers through millions of independent practitioners—both unlicensed and licensed—to corporate hospital chains and large private insurers (Mackintosh *et al.*, 2016). The private healthcare system in LMICs provide between one-third to three-quarters of all primary and secondary healthcare services despite increased public health sector funding (Coarasa, Das and Hammer, 2014). Coarasa and Hammer (2014), over a decade across 77 countries through 224 surveys, showed that 50% of the population had sought care in private facilities, with 40% of the poorest population amongst those surveyed (Coarasa, Das and Hammer, 2014). Other primary and secondary care-seekers surveys ranged from 25% in sub-Saharan Africa to 63% in South Asia (Wagstaff, 2013).

One explanation offered for this private health facility-seeking behaviour seen in these studies above was unavailable or overcrowded public health facilities. However, evidence from studies in Tanzania, Senegal and India showed that patients still opt to seek care in private health facilities even when public facilities are accessible (World Bank, 2011). The evidence suggests that a substantial proportion of patients seek health care from both subsystems consisting of public and private health facilities with out-of-pocket payments astronomically high at 74% (Hafez, 2018). In Nigeria, one study revealed that each year, at least 60% of Nigerians receive some form of primary or secondary care in the private sector, with many of these patients shuttling between public and private facilities (Uzochukwu, 2017). Another study in Nigeria

revealed that the average rural public health facility attends to as low as one patient a day (Coarasa, Das and Hammer, 2014). Hafez (2018) in Nigeria suggested that often but not invariably, the few populations at the top of the economic pyramid prefer to use private facilities, and those at the bottom attend public health facilities. However, the remaining chunk of the population shuffles between public and private facilities (Hafez, 2018a).

Mackintosh and colleagues (2016) argue that private health systems and their related problems cannot be understood except within their context of mixed health systems since private and public health systems interact. However, the literature has been underdeveloped in this area of private-public mix and associated problems, including corruption (Nishtar, 2007; Coarasa, Das and Hammer, 2014). Mackintosh et al., (2016) developed an illustrative country typology using metrics to illustrate how the scale and operation of public health systems in such countries are likely to shape the private health systems of such countries in terms of structure and behaviour, including operationalisation and provision of health services (Mackintosh *et al.*, 2016). The five types of the private sector in mixed health systems include (i) a dominant private sector (e.g., India and Nigeria); ii) a non-commercialised public sector and complementary private sector (e.g., Sri Lanka and Thailand); (iii) a private sector at the top of a stratified system (e.g., Argentina and South Africa); (iv) a highly commercialised public sector (e.g., China); (v) and a stratified private sector shaped by low incomes and public sector characteristics (e.g., Tanzania, Ghana, Malawi, and Nepal).

For this study, whose focus is on Abuja in Nigeria, this review narrows on two typologies which has direct relevance to Nigeria. The evidence in the literature suggests that Nigeria has a large private sector and a public sector that mimics the commercialised private sector. These two characteristics makes the Nigerian health system closely linked to two of the five

typologies of mixed health systems developed by Mackintosh and colleagues - *dominant private sector* and the *commercialised public sector undergoing reforms*.

#### **A). Dominant private sector in mixed health systems**

Available evidence in the limited literature of mixed health systems has identified several LMICs such as India, Pakistan, and Nigeria, amongst others, as examples of countries with a dominant private sector relative to their public health sector component (Nishtar, 2010a; Mackintosh *et al.*, 2016). Mackintosh and colleagues (2016) describe this variant of the mixed health system as one with the following characteristics: an excessive amount of OOP spending in total health expenditure, primary and secondary care facilities of such countries have dominant private sector entities, and a deteriorated public health sector with heavy reliance on user fee payments (Mackintosh *et al.*, 2016). In addition to the regular private health facilities, there have also been several reports of unlicensed sole practitioners and patent medicines vendors in this mixed health system typology.

India and Nigeria are typical countries in the global south under this variant of mixed health system. India has a history of meagre spending on public health services. For example, as a percentage of GDP, the Indian Government, at some point in the last decade, spent only 1.1% on health care (Government of India, 2009). Similarly, Nigeria's health expenditure has hovered between 2% -3% of its GDP (Hafez, 2018a). In relation to Nigeria, Mackintosh and colleagues (2016) and Hafez (2018) suggested that user fees, including informal payments, create an additional barrier to seeking health services, especially for the poor and those at the bottom of the economic pyramid (Mackintosh *et al.*, 2016; Hafez, 2018a). Thus, these complexities have the potential to leave patients in such mixed health systems vulnerable to other forms of corruption (Nishtar, 2010b).

## **B). The commercialised public sector undergoing reforms in mixed health systems**

China is a typical example of a mixed health system with the commercialised public sector that relies heavily on user fees, even though it is said to be undergoing reform (Mackintosh *et al.*, 2016). Many low-income and middle-income countries, including Nigeria, have also introduced charges for public sector health services, a reform leading to the emergence of public health sector commercialisation (Hafez, 2018a; Aregbeshola, 2021). It has been argued that commercialising the public healthcare systems in some of these countries could lead to unintended side-effect of the market-oriented economic reforms, whose impact needs to be fully understood (Mackintosh *et al.*, 2016).

Although these public health facilities are fully government-owned, their daily operations have taken the form of a business nature with an emphasis on internal revenue generation from user fees. Necessary consequences of such commercialisation reforms include a focus by hospitals on generating income through high mark-ups on privately procured drugs, resulting in inappropriate and unnecessary prescribing (Yip *et al.*, 2019). The fee-for-service payment method has led to high OOP spending and has also led to incentivised over-prescription and over-charging. Yip and colleagues (2019) suggested that countries with mixed health systems face enormous challenges in returning a commercialised public system to its original purpose, and this is in part due to the undesirable practices, including corruption, that arise from the commercial behaviour of these public sector entities (Yip *et al.*, 2019). Such commercialised behaviours have been documented in African states, such as the user fee experiences in Ghana, the Niger republic, and Nigeria (Hahonou, 2015; Aregbeshola and Khan, 2017; Olivier de Sardan and Hamani, 2018; Onwujekwe *et al.*, 2019; Aregbeshola, 2021). However, the impact of this commercialised behaviour has yet to be extensively studied in LMICs including Nigeria.

## 2.4. Reflections of the Review and Contributions to the Literature

This review identifies gaps in the literature, the points from which this thesis was launched. The review identifies that the analytical way in which “everyday” corruption in health service delivery is currently understood in LMICs such as Nigeria within the extant discussion is incomplete, given that it says little about the influence of corruption in health service delivery in private health systems which is a dominant in Abuja and the rest of Nigeria. Further still, it says very little of how corruption within the context of the interaction of public and private health facilities is potentially enabled. Therefore, with these gaps in the literature, this study’s contributions to scholarship includes the following:

- This study contributes to the corruption literature by looking at the differences in causes, manifestations, and impacts of corruption between the public and private health facilities in Abuja, Nigeria, through the patients’ and providers’ perspectives. These two perspectives offer a more comprehensive yet nuanced view by providing insights into the complexities and nuances of the interactions between patients and providers regarding corruption in each of the two health sectors.
- This study also contributes to the limited literature on mixed health systems in Nigeria regarding the extent to which, in the views of patients and healthcare providers, corruption is enabled by the existence of and interactions between the two health sectors as patients and healthcare providers navigate the mix in health systems in Abuja, Nigeria - including the role corruption plays within the broader mixed health systems problems and its potential to aggravate existing performance problems.

In concluding this chapter, the conceptual literature on corruption in the health sector is large, but empirical evidence is limited. There has been some attempt to categorise types of corruption in the literature, especially in Nigeria, which is helpful. However, it has not been applied much



in actual empirical work in the field. Therefore, this understanding and deficiency from the scholarship are taken into account in this present empirical research which also focuses on the neglected topic of corruption in health care, mainly as it manifests in mixed health systems. There is a very limited understanding of how corruption differs across sectors and how the existence of the sectors enables corruption, and this seems undesirable given the fact that in almost every health system in the world, including LMICs such as Nigeria, public and private health sector facilities do exist - hence the need for this present study to close such a gap in the literature of corruption in mixed health service delivery.

## **Chapter Three**

### **Methods and Ethical Reflections**

#### **3.0 Introduction**

This chapter presents the methodological steps taken to address the research problem - how is corruption experienced by, and impacts upon, patients and providers as they navigate the mixed health system of Abuja, Nigeria. The first section of the chapter presents the rationale for the methods employed in this project. The second section presents information on the study setting, rationale for choosing Abuja including its merits and limitations, research sites, sample population, recruitment process, and the duration of the study. The third section presents the data collection methods employed, the techniques used for the data analysis, and an outline of how these were applied. The fourth section presents an account of the ethics process, and reflections on that process, given the sensitivity of the topic at hand. The fifth section concludes with an outline of the role of the researcher during the research process, and the study's methodological limitations.

#### **3.1 Rationale for the choice of methods**

This study employed a qualitative exploratory research design, using in-depth interviews and participant observation to collect data on the research problem (Bryman, 2012; Maxwell, 2012; Creswell, 2013; Pope and Mays, 2020). The qualitative exploratory research design was thought suitable and employed in this study because its use of semi-structured in-depth interviews (IDIs) enhanced the understanding of peoples' (patients and healthcare workers) experiences and processes because of its fit and flexibility to rigorously investigate a complex phenomenon such as corruption in healthcare facilities. The study met these methodological criteria as it primarily explored the "lived" experiences of patients and providers concerning

their perception and experiences of corruption as they interact with each other in Abuja's public and private health facilities. This exploration, in turn, led to the gathering and collection of "rich" and "thick" descriptive data using semi-structure in-depth interviews and the eventual identification of emerging themes from the qualitative data (Creswell J, 2009; Creswell, 2013; Braun and Clarke, 2014, 2019).

Specifically, the qualitative exploratory research design was employed because its best suited to explore and allow the congruity of peoples "lived" experiences about a phenomenon to be made manifest through verbal and non-verbal responses that are expressed in in-depth interviews and observations (Giorgi, 2009; Crowther and Smythe, 2016; Holloway and Galvin, 2017). It was also chosen because it is concerned with understanding peoples' perceptions and perspectives of a particular situation. Hence, it focuses on what it is like to experience inquiries under study, such as corruption in health facilities. This methodological choice also allowed for collecting data through IDIs that provided unique individual experiences, culminating in a more composite narrative of the participants' (patients' and providers') experiences and meanings.

This research design also aided the study participants, i.e., patients, to describe their "lived" experiences as individuals as they sought and received care and for the healthcare providers as they delivered care to patients. Thus, it helped in achieving the central purpose of the study, which was to capture the total patients' "lived" experiences as they interact with health workers in Nigeria's mixed health systems (public and private facilities) and their experiences of how corruption manifested in these two settings. Similarly, the qualitative exploratory research design using semi-structured IDIs guided the approach needed to understand how the incentives and organisational and functional set up between these two healthcare settings

differed, and how these differences in the mixed health system set up impact on patients experiences regarding corruption in Abuja, Nigeria.

### 3.2 Study Setting

Nigeria is a lower-middle-income country located in west Africa (World Bank, 2021). The Niger Republic bounds it in the north, Chad in the northeast, Cameroon is its neighbour in the east, and the Benin Republic in the west (Hafez, 2018b). It is Africa's most populous nation with a population of 206 million people in 2021 (World Bank, 2022). Forty per cent (40%) of the population live below the poverty line of 1.93 dollars per day (NBS, 2021; World Bank, 2021). The country has a decentralised governance system consisting of 36 states and the Federal Capital Territory- Abuja. The Nigerian healthcare delivery system is pluralistic, with about 60% - 40% split between the private and public health systems (Hafez, 2018b).



Figure 3.1: Map of Nigeria (source: [www.mapsofworld.com](http://www.mapsofworld.com))

### 3.2.1 Rationale for the choice of Abuja as the study site

The choice of Abuja in Nigeria, as the research site for this study was based on several factors. Therefore, there were both pros and cons associated with this choice which are enumerated below.

#### **Advantages:**

- **Representativeness:** Abuja was selected because it is representative of the mixed health system structures that exist in Nigeria, particularly in larger urban areas. The city's diverse population, which includes people from various socio-economic classes, ethnicities, religions, and education levels, mirrors the broader Nigerian patient population.
- **Central Location:** Abuja is the most central part of Nigeria and serves as the country's capital. It is easily accessible and attracts a wide range of people from across the nation. This central location allows for a diverse and representative sample of both patients and healthcare providers.
- **Variety of Healthcare Facilities:** Abuja has a mix of public and private healthcare facilities in close proximity. This setting is ideal for studying patients who may seek care in both public and private health facilities and for healthcare providers who may work in both sectors. This provides valuable insights into the dynamics of the healthcare system.
- **Feasibility:** Abuja's infrastructure and accessibility made it a practical choice for conducting the research within the realistic time limits for a Ph.D. project. The city's well-developed facilities and transportation networks facilitate data collection and

interactions with study participants. Similarly, considering the security challenges and fragility of the country, Abuja was a more feasible location for this study with less risks.

- **Population Diversity:** Abuja's diverse population, including people from different backgrounds and socioeconomic statuses, allows for a more comprehensive understanding of healthcare-seeking behaviour and service delivery in Nigeria.

### **Limitations:**

- **Urban Focus:** The research site, Abuja, is an urban area, which may limit the generalizability of the findings to rural or less urbanized parts of Nigeria. Healthcare utilization patterns and the healthcare system's dynamics can differ significantly between urban and rural settings.
- **Sample Bias:** The convenience sampling method used to select Abuja as the research site may introduce sample bias. The city's unique characteristics may not fully represent the entire country's healthcare landscape, potentially leading to skewed results.
- **Resource Availability:** While Abuja offers excellent infrastructure and access, other regions in Nigeria, particularly in rural areas, may lack the same resources and facilities. This could affect the applicability of the findings to less developed parts of the country.
- **Economic Disparities:** The study area may have a higher concentration of wealth and resources, potentially impacting the way healthcare services are delivered and accessed. This may not be representative of areas with more significant economic disparities.
- **Healthcare Facility Distribution:** While Abuja has a mix of public and private healthcare facilities, the distribution may not be uniform across the entire country.

Other regions may have different proportions of public and private healthcare providers.

- **Absence of Ward Development Committees/Facility health committees:** Compared to other states in the federation especially those with more homogenous settings unlike Abuja, Ward development committees are often present at the health facilities, and these set up involving patients and community leaders might play a critical role in anti-corruption efforts in many Nigerian states. This absence in Abuja might serve as a limitation in understanding the corruption dynamics in Abuja.

In summary, selecting Abuja as the research site offers advantages in terms of representativeness, accessibility, and the variety of healthcare facilities. However, it may not fully capture the diversity of healthcare experiences in less urbanized and economically disadvantaged parts of Nigeria. The convenience sampling method may introduce some biases. These limitations are considered when interpreting and applying the research findings regarding corruption to the broader context of Nigeria's mixed healthcare system.

### **3.2.2 Overview of Abuja's Health System: Governance, Structure, and Funding**

The study was conducted in Abuja, the Federal Capital City of Nigeria, and was selected by convenience sampling as the city is representative of the mixed health system structures that exist in Nigeria, especially in the country's larger urban areas. Abuja is in Nigeria's north-central region, with a total land size of 7,315 km<sup>2</sup> and a population of 3,464,123 persons (NBS, 2021). It is a large cosmopolitan area with surrounding suburban and rural areas and with ethnic, religious, and economic diversity, hence, representative of the diversity seen in Nigerian patients. Abuja comprises six area councils, including Abuja Municipal Area Council (AMAC), Abaji, Bwari, Gwagwalada, Kuje, and Kwali area councils (NBS, 2021).

Abuja's Federal Capital Territory (FCT) health system comprises multiple levels, including primary, secondary, and tertiary care facilities. It features a mix of public and private providers, with most primary care facilities privately owned. Primary healthcare facilities are the first point of contact for patients and are predominantly privately owned. Secondary healthcare facilities, overseen by the FCT administration via the Health and Hospital Management Board, provide intermediate healthcare services and are a mix of public and private facilities. Tertiary healthcare facilities offer specialized services and are limited in number.

The FCT government oversees healthcare services, and it offers a range of medical services, including outpatient, inpatient, emergency, and specialized care. The healthcare system is funded through a combination of government allocations, user fees, and private funding. Dual practice arrangements, where healthcare providers work in both public and private facilities, are common in the FCT, allowing providers to serve a diverse patient population.

**Levels:** The health system in Abuja's FCT includes primary, secondary, and tertiary healthcare levels. Primary healthcare facilities serve as the first point of contact for most patients, while secondary and tertiary facilities provide more specialized care.

**Structures:** Abuja's FCT has both public and private healthcare facilities. Public facilities are government-owned, while private facilities are owned by individuals or organizations. The focus of the study in the methodology section was on secondary healthcare facilities (FCT HHS, 2021).

**User Pathways:** Patients in Abuja like the rest of Nigeria have the flexibility to seek healthcare services from both public and private facilities. They move between these sectors to access care, depending on their preferences and needs.



**Funding:** Healthcare services in Abuja are funded through a combination of sources, including government funding for public facilities, out-of-pocket payments by patients, and private health insurance. The specific funding mechanisms can vary between public and private providers.

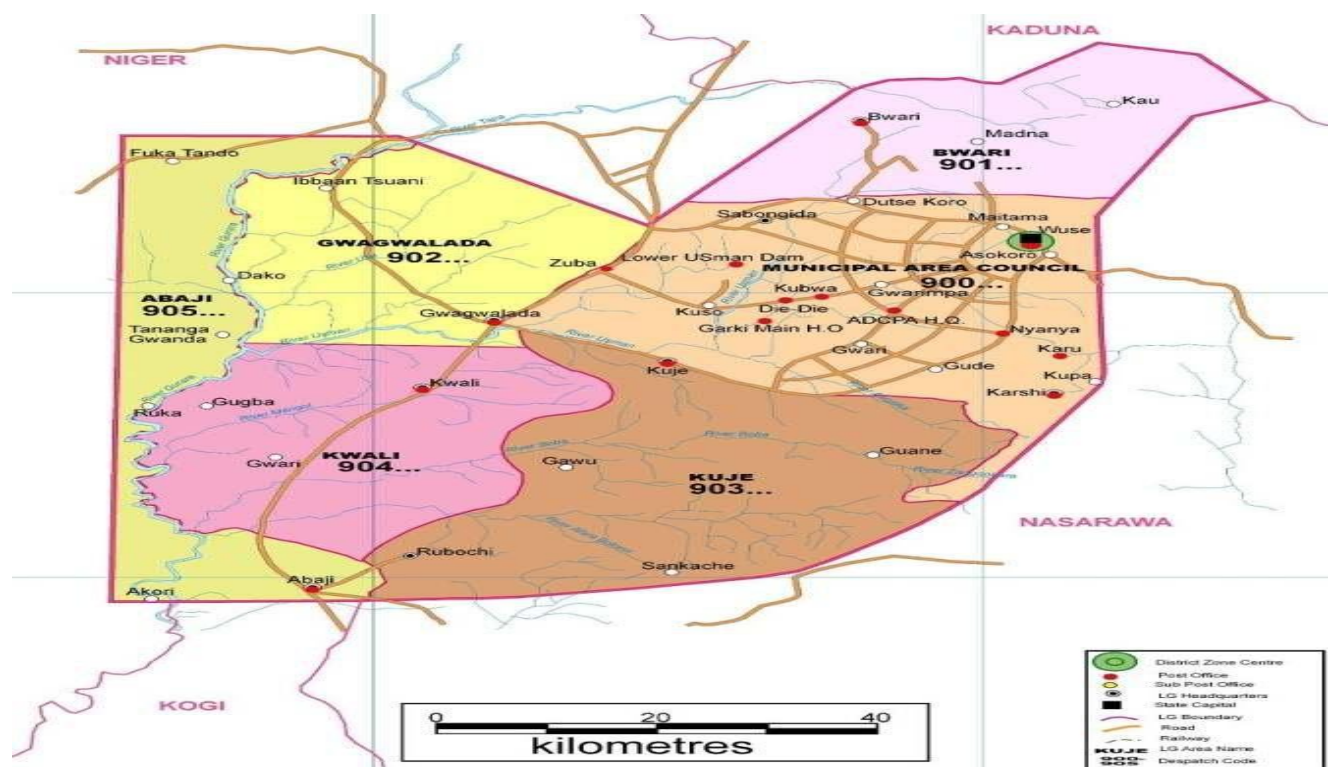
**Governance Arrangements:** The FCT administration oversees the management and governance of healthcare facilities in Abuja. Public healthcare facilities are typically managed by the government, while private facilities are independently operated (FCT HHS, 2021)..

**Dual Practice Arrangements:** In the secondary healthcare sector, both public and private providers coexist. This dual practice arrangement allows healthcare providers to work in both public and private facilities, offering services in multiple settings.

**Distribution of Health facilities:** In terms of healthcare facilities, Abuja, the federal capital territory (FCT) has both public and private healthcare facilities. There are 656 health facilities across the six area councils in Abuja, with 85 per cent (559) primary health facilities, 14% (90) secondary health facilities and 1% (7) tertiary health facilities. Of the 559 PHC facilities, 28% (179) are publicly owned. The remaining 72% (380), are private providers. However, at the secondary healthcare level which are the research sites where this study was conducted 85% (76) are privately owned and only 15% (14) of the 90 health facilities are publicly owned (FCT HHS, 2021). The secondary healthcare hospitals, which were the focus of this study, offer an intermediate level of healthcare and are overseen by the FCT administration via the Health and Hospital Management Board. These facilities offer outpatient and inpatient services ranging from medical, surgical, paediatric, obstetrics, and gynaecology. Other services include urgent care for accidents and emergencies, immunisation services, family planning, maternal & child health; Bamako Initiative/Essential Drug Programme; schools' health services; Baby Friendly Hospital Initiative Programme (BFHIP) and nutrition services (FCT HHS, 2021).

Specifically, the study was carried out in the two largest area councils of Abuja, the Abuja Municipal Area Council (AMAC) and Bwari area council. AMAC and Bwari area councils were chosen because of their centrality to the remaining four area councils. They also have many public and private health facilities spread across these councils with blurred boundaries and easy movement. With this setting, their constituent districts represented a typical mixed health system usually seen across Nigeria's mixed health system. Hence, this setting made it easier for the representative patient and healthcare provider to move easily between public and private health facilities to seek care and provide health services.

In summary, Abuja's FCT health system includes various levels of care, a mix of public and private healthcare facilities, flexible user pathways, diverse funding sources, government oversight, and dual practice arrangements among healthcare providers. These elements collectively contribute to the complex healthcare landscape in the region.



*Figure 3.2: Map of Abuja- Federal Capital Territory (source: [www.mapsofworld.com](http://www.mapsofworld.com))*

### 3.3 Study Sites

This study occurred in Abuja, Nigeria, between October 2021 and May 2022. The study sites for this empirical study were selected public and private healthcare facilities in Abuja, Nigeria, where patients and healthcare workers interacted during service provision. As discussed in the next section of this chapter, Purposive sampling was employed to select the study sites and participants. The specific sites for this study included three referral public health facilities that were at a secondary level of care and three equivalent sized private health facilities, which all provided a continuum of both primary and secondary care services to patients including outpatient services and emergency care as well as consulting, diagnosis, laboratory services, prescriptions, and follow-up services. The three public health facilities included the Gwarinpa, Kubwa, and Wuse General Hospitals. The private health facilities were Nissa premiere hospital, Garki specialist hospital, and King's care specialist hospitals.

Although both outpatient and inpatient experiences of patients and providers care formed part of this study, outpatient care was a key focus for several reasons. First, it accounts for 80% of healthcare services in most facilities in Nigeria as measured by the amount of consultation visits to outpatient clinics including outpatient prescriptions, laboratory and radiological investigations of patients (Aregbeshola and Khan, 2017). Similarly, patients seeking outpatient care services have been shown to likely move around quite easily between public and private facilities on an outpatient basis compared to inpatients (Nishtar, 2010b). Lastly, patients are most likely to encounter healthcare providers at a higher frequency in outpatient clinics because of the several categories of illnesses, therefore, offering a “rich” and “thick” description for the research problem under review.

In terms of the choice of the study area and sites, in addition to the fact that Abuja is representative of the mixed health system structures that exist in Nigeria, especially in the

country's larger urban areas, the city was also chosen as it provided several advantages in terms of the feasibility of successfully carrying out this project to a conclusion within the realistic time limit for PhD research as well as achieving the aim and objectives of the project. Abuja provided a fair representation of the average Nigerian patient that closely mirrors patients across the 36 states and six geopolitical zones of the federation. More importantly, being the most central part of the country and the capital of Nigeria, Abuja is where a good spread of Nigerians with its diverse population that cuts across socio-economic class, ethnicity, religion, and education can be found. Similarly, Abuja has many public and private health facilities that are close to one another, making it an ideal setting for patients who are likely to "shop" for care between public and private health facilities and for healthcare providers who are also likely to crisscross between public and private health facilities to provide services.

### **3.4. Procedures in Data Collection and Analysis**

This section of the chapter describes the methods employed in this qualitative study. It starts by elaborating on the sampling and selection process of the participants engaged in this study. It then describes the sources of data collection, sample population, data collection processes, and the technique and steps of the data analysis employed in this study.

#### **3.4.1. Sampling Techniques**

This study employed a combination of purposive sampling and snowballing techniques of the heterogeneous variants to ensure informative study participants were selected into the sample population. To identify critical informants for IDIs on a sensitive phenomenon such as corruption in healthcare, purposive sampling of the criterion variety is best utilised. Purposive sampling, also known as purposeful sampling, involves choosing participants based on specific and relevant characteristics (Tashakkori and Creswell, 2007). This sampling strategy is well established in qualitative research enabling the targeted identification and selection of data-rich

sources with limited resources. It is often chosen when the research participants are difficult to access due to the limited number of study experts that will shed light on the topic under study, or the topic is a sensitive one, as was the case with this study on corruption in healthcare which is not an openly discussed topic in the general population (Palinkas *et al.*, 2015).

In this study, a purposive sample encompassing heterogeneity was selected to provide a diverse range of opinions from the study participants. The choice of such a sampling design avails the researcher of multiple insights and views from various individuals who might have experienced the event under exploration. This study applied this approach to provide multifaceted views and experiences from the participants. The process involved identifying individuals, officials or organisations that are remarkably knowledgeable, experienced, and well-positioned from an organisational perspective in the subject matter of interest (Creswell and Clark, 2017).

Regarding the study participants' selection, firstly, corruption is an overly sensitive area of research due to its concerns with the public around moral grounds and the illegitimacy of such acts. Hence, people do not often talk about it freely or openly to researchers for fear of being victimised. Second, corruption in healthcare makes it even more sensitive than other sectors, as healthcare is a private area for people. They are often worried that in discussing corruption, they might inadvertently have to discuss their health conditions; therefore, care has to be taken to ensure confidentiality is maintained, and also to ensure that such information is not shared. Most of the components that can identify patients were redacted and anonymised and the study only focused on corruption rather than the patient's health conditions. Third, because of the secrecy and privacy concerns with corruption in healthcare, the study participants, both patients and healthcare providers who are knowledgeable on this topic based on their “lived” experiences, are often not easy to identify and would need a painstaking effort to identify and

select these participants into the study to have participants who will contribute to a deep understanding of this subject matter.

Based on the factors identified above, purposive sampling was anchored by a snowballing process to select the study sites and study participants. Snowballing yielded the recruitment of 53 participants into this study until data saturation was achieved. The 53 study participants included 31 patients, 18 healthcare workers, and four health officials/policymakers. The predetermined criteria which guided the selection of the study participants were any patient/caregiver who sought care in any of these selected public or private health facilities in Abuja and who has had experience of corruption while seeking care in the selected facilities.

#### **3.4.2. Recruitment Procedure**

An essential step in this empirical research was recruiting the study participants. Before the eventual take-off of the study, I had an ordinance with critical members of the senior leadership in each of the selected health facilities and introduced myself. I presented the ethics approval from the University of Edinburgh and that from the Federal Capital Territory Health and Hospital Services Board, Abuja, allowing me to carry out the research in health facilities in Abuja. I subsequently described the research topic, the purpose of the study and what the study intended to add as knowledge to the healthcare field. I conveyed my desire to recruit participants willing to share their experiences concerning the topic. The facility leaders were supportive, given the aim of the study for a few reasons. They wanted to provide their account regarding the problems responsible for certain practices regarded as corruption which, in their opinion, was beyond their control. Similarly, with me, the researcher being a Physician, they were more accepting of me, presumably because they felt I empathised with their plights.

Some senior leaders I engaged also doubled as “gatekeepers”, including heads of clinical services, outpatient department clinics, nursing services, pharmacies, and laboratories in the selected public and private health facilities. These engaged senior healthcare leaders also linked me to further “gatekeepers”, who introduced me to key individuals at the various clinics and relevant units of the facilities where the fieldwork took place. At each point in the health facility, I further explained to potential recruits, patients, and healthcare workers the nature and purpose of the study. A similar process through direct referral was used to identify the health officials/ policymakers in the supervising ministry and health agencies in Abuja who participated in the study.

Gatekeepers in this study referred to key persons with intricate linkage and connection to the study participants by their virtue as persons who shared similar characteristics with one or more members that were recruited for this study or had proximity to persons who could access these study participants (Pope and Mays, 2020). Gatekeepers are essential to penetrating a sensitive group of study participants, as was the case in this study. They played a vital role in making me, the researcher, accepted readily by the study participants. As a researcher and a primary care clinician, who had worked in both public and private health facilities in Abuja, I also exploited this advantage to identify such key “gatekeepers” that eventually led me to gain access to the broader study population as recommended by (Pope and Mays, 2020).

The snowballing sampling technique was employed throughout the recruitment phase, which lasted over eight months from October 2021 to May 2022. This process led to the identification of more study participants that shared their experiences and “lived” realities. Snowballing sampling is *“a nonprobability sampling technique where existing study subjects or participants recruit future subjects or participants from among their acquaintances”* (Naderifar, Goli and Ghaljaie, 2017, p. 2). Similarly, according to Polit-O'Hara and Beck quoted in Naderifar et al

(2017), this approach, sometimes known as the "chain method", is effective and efficient for reaching target audiences who would be extremely hard to find or be willing to share their experiences of the phenomenon under research. In this approach, the researcher asks the initial few samples, typically chosen through convenience sampling, if they know any individuals who share their opinions or circumstances and might be willing to participate in the study (Naderifar, Goli and Ghaljaie, 2017, p. 3)..

This technique aids researchers in finding study participants that would otherwise have been quite challenging due to difficulty accessing such groups or sensitive topics such as corruption, where individuals stand the risk of backlash and victimisation (Bowling, 2014; Halperin and Heath, 2020). The snowballing sampling approach also helped reduce the low response rate from study participants and increased responses from participants that needed candour. Therefore, a respondent-driven sampling that factored heterogeneity of the participants, as suggested by (Heckathorn, 1997), a variant of snowballing approach, was utilised and did improve the recruitment process in this study.

I asked my initial study participants to nominate other persons they know might have had experiences related to corruption while seeking care in these public or private health facilities in Abuja. This process was continuously repeated with each participant until I obtained enough study participants, which was only stopped when no new information was been added. In terms of the sample size to be achieved in a qualitative study such as this, there have been differing opinions by different experts. Bryman (2012) and Ellis (2016) suggested that the higher the number of sampled individuals, the better. However, they suggested that

attaining data saturation was still the best guidance for sized samples in qualitative studies using IDIs such as this study (Ellis, 2016). As a rule of thumb, having at least 30 participants is often recommended due to issues relating to time constraints, the labour-intensive nature of



these IDIs and other resources (Bryman, 2012; Ellis, 2016; Pope and Mays, 2020). This study had a sample size of 53 study participants, above the recommended 30 participants for most qualitative studies.

The point of data saturation, as recommended by experts, is that sample size attained when the researcher gets no new additional information from the study participants (Mason, 2010). With respect to the patients and providers' category, data saturation was attained when no added information was discovered from the IDIs with the addition of new study participants. This redundancy signalled to me that data collection through interviews may cease. In this study, the selection of participants was based on their experiences as patients/caregivers concerning practices they had encountered regarding corruption as they sought care. The healthcare providers were also selected based on their own experiences or those of their colleagues as they interacted with patients in these selected facilities.

In relation to the recruitment of policymakers in this study, policymakers that were most relevant to the topic and who had direct oversight of the selected healthcare facilities in this study as well as supervisory knowledge on the operationalisation and provision of services by healthcare workers were the target of the recruitment. This was also based on their experiences of either uncovering corrupt practices in these selected healthcare facilities or having dealt with cases of corruption brought to them as regulators of care in these specific health facilities under study. However, some of this category of participants said no and were less reluctant to participate, with most opting out. Some of the reasons given by the relevant policymakers for opting out include not their being in the health facilities when most of the alleged practices do occur. Others mentioned that they were often considered the mouthpiece of the government. Therefore, they were uncomfortable sharing their experiences despite the assurance that they would remain anonymous. This affected the number of policymakers as shown in *section 3.4.3*

under sample population of study participants who had initially agreed to participate but did not turn up for the interviews even after several follow-ups. This was one of the limitations of the study which is presented in *section 3.7*. However, the policymakers who eventually participated provided insights and agreed to follow-up interviews to further provide insights into questions that arose from the first interviews.

In recruiting participants in this study, the selection of participants was a crucial step. Great care and consideration were given to ensuring a diverse and heterogeneous pool of respondents, encompassing a wide range of perspectives. The aim was to avoid biases related to sex, gender, socio-economic status, educational background, age, and other essential factors. Here, I outline the careful thought process behind the selection of the participants, emphasizing the use of a respondent-driven sampling method inspired by Heckathorn's (1997) approach.

#### **3.4.2.1 Ensuring Diversity and Avoiding Bias in Participant Selection:**

##### **Emphasizing Diversity:**

Recognizing the importance of diverse perspectives, I made a conscious effort to include participants from various backgrounds, ensuring representation from different sexes, genders, socio-economic statuses, educational levels, religious backgrounds, and adult age groups. By including individuals with diverse characteristics, I aimed to capture a comprehensive view of the subject matter under investigation.

##### **Avoiding Bias:**

To avoid biases in participant selection, I employed a respondent-driven sampling method, as recommended by Heckathorn (1997). This variant of the snowballing approach allowed me to tap into the networks of the initial participants, ensuring a more extensive and varied sample. By relying on existing social connections, I minimized the risk of inadvertently introducing biases that might arise from traditional sampling methods. The respondent-driven sampling

technique specifically accounted for the heterogeneity of our participants. By leveraging diverse networks, we maximized the chances of including individuals from different backgrounds, experiences, and perspectives. This deliberate strategy enhanced the overall heterogeneity of our sample, thereby enriching the depth of our findings.

### 3.4.3. Sample Population

Based on the conceptual framework for this study earlier presented in the introductory chapter of this thesis, this empirical study relied on the following three categories of informants to collect its primary data.

- The first group included adult patients/caregivers attending clinics in public and private health facilities in Abuja, Nigeria.
- The second group included healthcare providers such as doctors, nurses, pharmacists, laboratory technologists, hospital managers, healthcare attendants, security personnel and other allied health workers in public and private health facilities in Abuja, Nigeria.
- The third group included health officials/policymakers who have oversight on healthcare facilities in Abuja, Nigeria.

The first group – *the patients' group* included 31 patients, 19 of whom were recruited from public health facilities and 12 from private health facilities. The second group – *the healthcare providers' group*, included 18 healthcare workers, 12 recruited from public health facilities and six from private health facilities. The third group - *the policymaker's group*, included four health officials/policymakers, of which three were from the Federal capital territory health and hospital services administration board, and one was from the Association of General and Private Medical Practitioners of Nigeria (AGPMPN).

**Table 3.1: Summarising the different categories of key informants**

<b>Public Facility</b>	<b>Private Facility</b>	<b>Policymakers (oversight)</b>
Patients - 19	Patients - 12	Health officials- 4
Healthcare workers – 12 <ul style="list-style-type: none"> <li>• Doctors</li> <li>• Nurses</li> <li>• Pharmacists</li> <li>• Laboratory staff</li> <li>• Record Clerks</li> <li>• Health attendants</li> <li>• Admin staff</li> <li>• Security staff</li> </ul>	Healthcare workers – 6 <ul style="list-style-type: none"> <li>• Doctors</li> <li>• Nurses</li> <li>• Hospital Manager</li> <li>• Pharmacist</li> <li>• Laboratory staff</li> <li>• Record clerk</li> </ul>	<ul style="list-style-type: none"> <li>• FCT Health &amp; Hospital services staff</li> <li>• AGPMPN staff</li> </ul>

Each individual in the groups highlighted above was selected for this study because it was expected that their “lived” experiences from their respective groups as interviewees would provide a rich, diverse, and nuanced insight that might include acts of corruption during the operationalisation and provision of services in these selected health facilities in Abuja, Nigeria.

First, the insights from the patients' group in this sample population addressed the demand-side corruption problems related to service provision, particularly regarding the manifestations and impacts in health facilities. These patients “lived” experiences yielded rich knowledge of their perceptions of the influence of day-to-day corruption problems and related practices. The first-hand knowledge of the operationalisation and provision of services from these patients and

their caregivers enhanced this study's results as traced from their entry to exit in public and private health facilities.

Second, the healthcare workers' insights addressed the “supply side” corruption problems related to health service delivery in these facilities, particularly regarding the causes of corruption. Their views were necessary not just to provide their own experiences on the phenomenon under inquiry but also to provide a nuanced and more balanced view into the operationalisation and delivery of services concerning corrupt practices from the healthcare provider's perspective. The healthcare provider perspective gave more profound insight into these facilities' organisational structure and function and the management of health resources in these public and private health facilities.

Lastly, the policymakers/health officials who are “system-level” actors were purposefully chosen because, as policymakers and regulators, their oversight can influence practices at the service delivery level through actions or inactions regarding regulations of public and private health systems in Abuja, Nigeria. As earlier stated in *section 3.4.2*, the policymakers that were most relevant to the topic and who had direct oversight of the selected healthcare facilities in addition to their supervisory knowledge on the operationalisation and provision of services by healthcare workers in the selected facilities were chosen to form the sample population. Their insights also shed light on the government's claims on health reforms, including corruption tackling at the health facility level.

Therefore, in terms of the sample population for this qualitative study, exploring the experiences of these three groups of participants provided a more comprehensive and nuanced view of the various incentives, norms and relationships within public and private health service delivery systems and the practices these give rise to at the facility level, which in turn influenced the operation and provision of health services at these health facility levels in Abuja.

### 3.4.4. Data Collection

This section describes the various data collection methods that were employed over eight (8) months conducting the fieldwork for this study in selected public and private health facilities in Abuja from October 2021 to May 2022. This empirical qualitative study employed several data collection methods- *primary and secondary* data sources- and triangulated the data across these sources. This triangulation led to the increased “richness” and “thickness” of the study's findings, as presented in the three results chapters of this thesis.

The primary data sources included findings from *in-depth interviews (IDIs)* and *participant observation*. The secondary data sources collected in this study included policy documents at the facility level and oversight institutions for these health facilities, including the ministry of health and the FCT health and hospital services board. These secondary data included policy documents on service delivery to patients; triaging of patients at emerging points and clinics; code of conduct of health professionals in health facilities. These documents provided insights into the organisational and functional structures of health facilities in Abuja, Nigeria, and the stipulated behaviours of healthcare professionals and patients in health facilities in Abuja and the rest of the country. Other secondary data sources included peer-reviewed articles from databases such as PUBMED, Scopus, JSTOR, EMBASE, Google scholar, and websites of international development organisations such as Transparency International, WHO (World Health Organization), World Bank, and U4- Chr. Michelsen Institute (CMI), DFID through some of its consortia such as the Anti-corruption evidence network (ACE) amongst others, as well as the grey literature.

#### A). In-depth Interviews

With this exploratory qualitative study, the principal method for collecting data was through *in-depth interviews (IDIs)*. Interviews are the leading source of data collection in qualitative

studies (Giorgi, 2009; Bowling, 2014; Halperin and Heath, 2017; Pope and Mays, 2020). More importantly, interviews are the cornerstone of data collection in exploratory qualitative studies and often the only primary source of data collection in most qualitative research designs. However, other primary sources of data collection can be added if there is an added value from those additional data collection tools when time and resources permit.

Interviews for a qualitative exploratory studies provide thorough, contextualised, non-restrained responses from study participants concerning their perceptions, perspectives, judicial opinions, and experiences (Giorgi, 1997; Idczak, 2007). The importance of the IDIs in this study was to gather information from the study's participants, particularly the patients' experiences and healthcare workers' practices, to gain in-depth knowledge and understanding of the causes and manifestations of corruption as patients interacted with healthcare workers at the facility level. Furthermore, the interviews also collected in-depth information on how the impact of these corrupt practices affects these patients' including their choice of seeking care within and between public and private health facilities in Abuja.

#### ***A1). Interview Protocol***

Before the commencement of the semi-structured interviews, I had developed a topic guide/ interview guide/ (see appendix E), which was to act as the prompt and opener for key areas on the research topic, thereby giving the interview guide and form. Pope and Mays (2020) define a topic guide as *"a set of the key issues, themes, and possible probes that steer and focus a qualitative interview"* (Pope and Mays, 2020). They suggested that the interview guide varies in depth and comprehension based on the composition of the interview.

In this study, the initial interview guide was based on the subsisting knowledge of the topic in the current scholarship and my prior experience as a healthcare provider who had interacted

with patients and from the inputs of experts on corruption in healthcare. This initial guide was further reviewed in the definitive version following the pilot interviews conducted before the commencement of the interviews in the main study. The pilot interviews highlighted the improvisation and ensured that the questions to be asked were captured in a manner that interviewees in the main study could comprehend and that it truly reflected the realities and context of the research problem under inquiry in Abuja, Nigeria.

The definitive version of the question/topic guide was then used for the IDIs in the main study but continually adjusted as added information emerged from preceding interviews. The key feature of the topic guide employed in this study was that I ensured it was flexible and not prescriptive and continuously reviewed as new perspectives on the experiences of interviewees emerged, which needed further exploration in subsequent interviews. The interview guide questions were tailored compositely to the three categories of the study's participants; *patients, healthcare providers, and policymakers* (see appendix E). Furthermore, the interview guide was also designed to allow for diversity in study participants along gender, socio-economic, educational, and religious status and their differing experiences, perceptions, and opinions concerning the research topic under inquiry.

The interview guide consisted of two sections for each study participant. An initial section briefly describing the participants' ethnic, educational, and socio-economic backgrounds. This first section was relevant as it provided the context upon which the individual situates most of his or her responses to the primary substance of the interview questions. The second and main part of the interview guide contained vital questions related to the topic of interest on corruption including perceived causes and underlying motivations, manifestations and impacts in health facilities as patients seek care and health workers provide services in these health facilities.



The interview guide was also designed to allow for open-ended responses but with prompts and guides; hence they were semi-structured. The questions probed the 'lived' experiences of the study participants, including their perceptions and thoughts on how healthcare services were provided, the patient-healthcare provider encounter, and the resulting practices that ensued during these encounters. It further probed patients to trace their pathway from entry to exit in these health facilities, their experience during such visits, and their resultant choices. The prepared question guide set the stage for the participants to describe their views and beliefs on how they felt corruption influenced the operationalisation, provision, and delivery of healthcare services in either public or private health facilities or a mix of both. A variant of the interview guide, which consisted of questions that probed health officials/policymakers on their oversight experiences regarding services provided by healthcare workers, also set the stage for the interviews with policymakers.

#### *A2). Interview Process*

Before each IDI with a study participant, an agreed date, time, and location was reached with each participant. Before the interviews, each interviewee had to return the signed consent form previously given to them. Each potential interviewee was told that the data collection involved audio recording with a handheld recorder, note-taking, and eventual data transcription. Each interviewee was offered the option of being debriefed following transcription in case they wanted to crosscheck if their views were captured correctly. I further informed the interviewees of the possibility of a follow-up interview should the need arise for any additional information. Study participants were also informed that the research findings would be freely available for those interested to know the outcomes.

The interviews were face-to-face and took place in the health facilities. The IDIs lasted between 1-2 hours, most averaging 1-hour 30minutes. The advantage of conducting these interviews in

these facilities was more than just the convenience for these patients. It also acted as a familiar territory which in turn helped both the patients and healthcare providers recall specific details. To maintain anonymity and minimise victimisation, quiet and discreet locations within the health facilities were used for the interviews.

The semi-structured interviews were conducted using a set of questions in the question/topic guide, but I also responded with additional questions as they became relevant. The interview process was iterative and involved active participation, as suggested by Pope and Mays (2020). Contrary to the old approach, where the researcher plays a docile role in qualitative interviews, the current approach recommends active listening and participation to engage the interviewees yet being careful to allow them to talk freely and openly without interruptions (Pope and Mays, 2020). The active listening and iterative approach were employed in these IDIs with 53 participants across the patient and healthcare provider categories and relevant policymakers. The interviews were flexible, allowing me to probe deeper depending on the interviewees' answers. These IDIs were in keeping with the suggestion by (Pope and Mays, 2020) that in semi-structured interviews, researchers should ensure a flexible approach that will propel informants into being more open while at the same time probing key issues that are raised. The interviews were conducted in English and were recorded with a handheld recorder, and field notes were taken in detail. Following that, all recordings and field notes were transcribed verbatim. The details of this are presented under the section on data analysis later in this chapter.

## **B). Participant Observation**

In addition to interviews as the main source of primary data for this empirical study, I also employed participant observation of the moderate type to support the primary data. Several reasons exist for employing such an observational method. For a sensitive topic such as

corruption in healthcare facilities, corruption is often not discussed openly, and some corrupt practices are often difficult to elicit. Therefore, researchers sometimes need more context on what informants had offered via interviews, especially those whose activities are being scrutinised (Spickard, Heritage and Garfinkel, 1987). Therefore, moderate participant observation can assist in addressing this shortfall by providing more insights. For example, as part of this study, healthcare workers' practices at the facility level, which sometimes occur discreetly and where these workers filter what they share, were observed to corroborate with some of the experiences shared by both patients and some healthcare providers. In this study, some of the questions about the behaviour of healthcare providers and their interaction with patients were crosschecked by this method and the data collected.

Participants and their environment are observed in participant observation, including their everyday activities within their social world and relationships (Spickard, Heritage and Garfinkel, 1987). As suggested by (Bowling, 2014) and (Halperin and Heath, 2017), a significant merit of participant observation is the belief that it adds elevated levels of internal validity to qualitative research, as was with this index study. Very importantly, participant observation provides insights into corrupt behaviours that are difficult to elicit through interviews. Hence, its choice as a data collection method finds credence in this study. In this data collection method, two key roles are ascribed to the researcher: a subjective participant and an objective observer (Bowling, 2014; Halperin and Heath, 2017; Pope and Mays, 2020).

This moderate participant observation method of data collection supported the interviews in achieving the aim and objectives of this study because corruption often occur as discreet and illicit practices in health facilities. Similarly, it guided the collection of information on how the organisational set-up, institutional frameworks, and incentive regimes in the selected public and private health facilities gave rise to corrupt practices and how these practices undermined

health service provision and the observable norms and social relationships at play. For example, participant observation was used to corroborate practices such as health worker absenteeism by looking at the publicly placed duty rosters of healthcare workers to see if they tallied with the number of staff available on duty at a particular date. It also helped to crosscheck the working conditions upon which healthcare providers operate and deliver services to patients and how these conditions influence the practices they exhibit. This study employed a moderate participation observation subtype where the researcher maintained a balance between being an “insider” and an “outsider.” Choosing this subtype of participant observation allowed for a good combination of involvement while maintaining the necessary detachment to be as objective as possible.

### **3.4.5. Data Analysis**

This section describes the processes and techniques involved in analysing the data collected from the IDIs and participant observation. Thematic analysis, as championed by *Braun and Clarke*, was employed as the data analysis technique for this study (Braun and Clarke, 2006, 2014, 2019). Before the actual data analysis, this study collected qualitative data, i.e., audio records of interviews and field notes, including those from participant observation. These data were transcribed verbatim into a Microsoft word document using NVivo 12.0 and then analysed via a combination of inductive and deductive thematic approaches known as *reflexive thematic analysis*, as presented in detail under the thematic analysis subsection of this chapter. In addition, some input in themes was guided by the literature review in relation to types/manifestations of corruption in health care. These provided some initial organising framework for the analysis, which was further refined on an iterative basis as my familiarity with the generated data from IDIs increased through the data analysis process.

The transcription process, alongside my field notes, allowed me to become more engaged and familiar with the interview findings from the study participants. This critical transcription process further enabled me to gain an in-depth understanding and “feel” of each of the interviewees as I transcribed the data to understand the context in which these interviewees gave most of the information. In doing so, this process ensured that I interpreted as correctly as possible and, where necessary, made clarifications on the transcribed data, such as buzzwords and phrases misrepresented by the transcription software. Some Interviewees were contacted for these clarifications during the transcription phase of the data analysis on a need basis.

#### **A). Thematic Analysis: Inductive/Deductive Combination Approach**

The analysis that was used in this study was *inductive/deductive approach* - using theory to guide the analysis while at the same time allowing for new themes to emerge, hence reflexive in nature which combines both inductive and deductive approaches. Braun and Clarke (2006) defined thematic analysis as an “*analytic method that emphasises identifying, analysing, and interpreting patterns of meaning (or "themes") within qualitative data*” (Braun and Clarke, 2006). This technique is known for its “rich” description and interpretation of the research’s raw data (Boyatzis, 1998). Braun and Clarke (2006) recommended thematic analysis as the first qualitative data analysis approach often used by qualitative researchers as it lays the foundational skills helpful in carrying out other kinds of qualitative data analysis (Braun and Clarke, 2006, p. 78). Better still, the most important advantages of this data analysis technique are its flexibility, which is a method rather than a methodology (Braun and Clarke, 2019). Meaning, that, unlike other data analysis techniques which are tied to specific methodological designs, thematic analysis is not tied to a specific epistemology or conceptual construct, thereby making it a flexible technique of data analysis in qualitative research as was the case with this study (Braun and Clarke, 2019).

Thematic analysis has several other approaches (see: Boyatzis, 1998; Alhojailan, 2012; Javadi and Zarea, 2016). However, in this study, I used the reflexive thematic analysis method advocated by (Braun and Clarke, 2019) to analyse the generated data. This reflexive approach combines inductive and deductive approaches as the data is being analysed. Reflexive thematic analysis as a data analysis technique was chosen for this study because of its compatibility with participants' subjective experiences (Guest, MacQueen and Namey, 2012). Thematic analysis as it aligns with qualitative exploratory research designs has been well-established in the literature (Dapkus, 1985; Bouchard *et al.*, 2012; Braun and Clarke, 2014). The same was applied in this study, where the analysis explored patients' perceptions, feelings, "lived" realities and experiences of health service provision with regards to the causes, manifestations, and impacts of corruption within public and private health facilities and the interactions between them as patients seek care from providers in Abuja, Nigeria.

Furthermore, this approach by *Braun and Clarke* was chosen because it is user-friendly, with clear steps even for novice researchers. As earlier highlighted, its flexibility allowed it to be used across several data collection methods, including IDIs and participant observation, as the case with this study. It is an iterative rather than a linear approach which allowed me, the researcher, to go back and forth as expected with the large volume of transcribed data from the IDIs such as the one generated from this study.

In analysing the data for this study, I was guided by the six-phase guide provided by (Braun and Clarke, 2006, 2019). However, before the six-phase guide by Braun and Clarke, there was a previous step guided by the data from my literature review which considered the existing evidence on what kinds of corruption we would expect to see as this informed my questions in the semi-structured interviews. This initial step had an impact on both the data collection and data analysis process.

These six steps guided by Braun and Clarke included.

- (i) *Becoming familiar with the data*
- (ii) *Generating initial codes*
- (iii) *Searching for themes*
- (iv) *Reviewing themes*
- (v) *Defining themes*
- (vi) *Naming and writing- up themes*

In this study, the first step of the thematic analysis- was *becoming familiar with the data*, which entailed reading and re-reading the cleaned transcripts I had generated. This first step enabled me to become familiar with the body of the data generated. Essential notes and an initial sense of the data were taken at this first stage.

The second step- *generate initial codes*. This step guided and enabled me to organise the data purposefully and methodically. With this process stage, the initial coding helped reduce the voluminous data into smaller pieces of meaning. Open coding was done with no predetermined codes and continual modification as the process ensued.

The third step was *searching for themes*, bearing in mind that a theme is a pattern that captures an important finding related to answering the research problem. I assembled the codes that fit together and then organised them into themes. The themes I developed were descriptive, which was in keeping with my study's research design of being exploratory in nature. These descriptive themes embodied the “thick” and “rich” descriptions from the data.

The fourth step was *reviewing the themes*. Here the preliminary themes identified in step 3 were assessed, re-evaluated, and developed into further aligned themes. I assembled all the data that I found relevant to the main themes, using the cut and paste function of the Microsoft word

document and the NVivo software for qualitative analysis. Also, in this stage, I took time to ensure that the themes made sense and were coherent, and that the generated data supported the themes.

The fifth step was *defining the themes*. This step involved doing a final refinement of the themes to ensure that I identified the essence of each theme, as recommended by (Braun and Clarke, 2006, 2019). Here the main concern was ensuring that the themes conveyed their correct meanings to the reader and interacted well where I had sub-themes. I also ensured they related to the central theme and were well subsumed under the main theme.

The sixth step was the *writing-up stage*. In this last step, I wrote my thematic findings in a narrative form, forming the results chapters of this thesis.

This combined approach of *inductive* and *deductive process*, otherwise known as *reflexive thematic analysis* as recommended by (Braun and Clarke, 2006, 2014, 2019), entailed that one closely read and reread all the transcripts, followed by an iterative process of finding patterns to provide explanations. In this study, the inductive approach led the way for the reflexive thematic analysis. In the later phase, the deductive approach followed, which is the pattern for ideal exploratory research designs where there were no predetermined or pre-codes before the onset of the thematic analysis. The assembled data was allowed to generate the codes through an inductive process of repeated analytical patterns and deductive meanings at the last steps. Themes were actively sorted from the data by the researcher, as suggested by Braun and Clarke (2019), who argue that the researcher should play an active role in the creation of themes – "*so themes are constructed, created, generated rather than simply emerging*" (Braun and Clarke, 2019).

Although several analytic methods also emphasise patterns and meanings in qualitative research, including content analysis, discourse analysis, and grounded theory, however, most



data analysis techniques are theoretically bounded and regimented, making them quite restrictive for this highly interdisciplinary and empirically data-driven study (Gale *et al.*, 2013). On the other hand, thematic analysis, is not bound to a specific prior theoretical construct, allowing it the room to be used with latitude across several theoretical frameworks (Braun and Clarke, 2014). Therefore, the reflexive thematic analysis for this study was of the “contextualist” method sitting in between critical realism and interpretivist constructionism, a key variant of the naturalist paradigm that guided this study. It appreciated how people perceive and make sense of their own “lived” experiences of a phenomenon and how this influences those meanings while focusing on the bounds of “reality” (Braun and Clarke, 2019; Pope and Mays, 2020). Hence the choice of utilising thematic analysis as the appropriate technique for this study’s data analysis.

## **3.5 Ethical Considerations**

### **3.5.1 Ethical requirements**

The ethical clearance for this study was gained through a two-stage procedure. The first ethical clearance was received from the School of Social and Political Science Ethics Review Committee at the University of Edinburgh in August 2021 where the PhD in Global Health Policy is being pursued. The second ethical clearance was obtained in September 2021 from the Federal Capital Territory Health Research Ethics Committee in Abuja, Nigeria which allowed this study to be carried out between October 2021 and May 2022. See *Appendices A and B* for both ethical approvals.

First, I discuss the ethical approval from the Ethical Committee of the School of Social and Political Science, University of Edinburgh. Before my first-year board review, an ethics application was submitted to the review committee after my PhD supervisors' review and

assent. The committee sought clarity on how patients' confidentiality and anonymity would be addressed to ensure that privacy related to their health conditions was protected during the interviews. This concern was addressed and factored into the topic guide - as the focus of the study and the interviews conducted was on corrupt practices experienced by these patients rather than their ailments. Therefore, in addition to maintaining strict anonymity of each participant, specific health conditions of the patients were not the emphasis in this study, and I ensured that such could not be tied to any participant by anonymising all patients. This concern is addressed in further detail in *subsection 3.5.3* of this chapter.

Similarly, concerns raised about uncovering illegal activities or near criminality by participants if they ever do arise were considered as the study pertains to corrupt practices in health facilities. My interest was to establish general patterns of corrupt behaviours rather than forensic evidence of specific illegal activities that can be ascribed to individuals. As a social science researcher, although I gathered information from individuals, my interest lies in general patterns of behaviour and narratives about corruption. Therefore, the focus of this study was not on individual acts of criminality but on drawing on the patterns of corrupt practices as experienced by patients and providers. If any act posed a direct threat to a participant's life, the country's law requires something to be done in discussion with the participant. However, none of these scenarios was encountered during the research process. Also, no vulnerable patients were part of the study. Strict confidentiality and anonymity in all discussions regarding corruption were adhered to throughout the research process, and this is also addressed in detail in *subsection 3.5.3* of this chapter.

Second, because this study was conducted in Abuja, Nigeria, I also sought and obtained ethical clearance from the Federal Capital Territory Health Research Ethics Committee in Abuja. This second step was mandatory because the study was carried out amongst participants (patients,

healthcare providers and health officials/policymakers) in selected health facilities in Abuja whose authority falls under this Ethical Committee. The ethical consideration by this second committee primarily related to the confidentiality of interviewees and identifiable information. Also, undertaking participant observation in the hospital setting required confidentiality as well. This empirical study involved interviews among adult patients/caregivers and healthcare workers in selected public and private health facilities in Abuja who gave informed consent. It also involved interviews with selected policymakers who had oversight of some of the healthcare facilities. The committee in Abuja were satisfied that all areas regarding patient confidentiality and anonymity were taken into consideration by the application made. They were also satisfied by the rigorous ethics approval the researcher had obtained from the University of Edinburgh. Therefore, the second ethics approval was granted. None of the rules for carrying out this study in Abuja, Nigeria, was violated.

Before the actual commencement of the study, the ethics approval from the review committees at Edinburgh and Abuja were presented to the six health facilities where this study took place. These facilities granted access to the selected facilities and potential study participants based on the two ethics approval. See *appendices C and D* for the relevant study participant information sheets and consent forms. This study's ethical considerations and procedures were per the Good Practice guidelines and the framework laid down by the Ethics Review Committee of the School of Social and Political Science at the University of Edinburgh (2020). The Good Practice guidelines stipulated in this framework spell out the ethical, procedural steps regarding participant recruitment and the protection of study participants from any harm. It further ensures that researchers respect participants and maintain strict anonymity and confidentiality, which this study enforced.

### 3.5.2. Informed Consent

Before the recruitment and during each recruitment briefing, potential participants were made aware that all data collected from them, or the health facilities would be anonymised. Any distinguishable data would not be shared with anyone. I discussed all information written in the consent form to be sure that all potential interviewees understood the purpose of the study, what was required of them, and if they were comfortable with embarking on the process. No monetary gain or financial inducement occurred while recruiting the study participants. Nonetheless, I ensured that all potential participants understood the importance of partaking in this study and their contribution to the greater good by sharing their experiences regarding corruption. As a further point of information, I shared with them my experience participating in past research and the positive effect such participation had on me.

Study participants were told of their right to opt out of this study at any point in time. I stressed the point to each participant not to feel compelled to continue with the study or interviews should they want to withdraw from the study at any time and for whatever reason(s). I emphasised to each participant that their participation was strictly voluntary. The information sheet was shared alongside the informed consent form, which gave the study participants further details to read in their spare time on the nature and purpose of the study. The consent-seeking process was always double-checked at each stage. Some potential participants opted out of the study for personal reasons, which was well respected.

### 3.5.3. Confidentiality and Anonymity

A critical issue that I pondered throughout this research process was how to maintain anonymity and confidentiality for all study participants based on the several reasons I had raised throughout the research process, including the sensitivity of this topic. Polit and Beck defined the two intricately linked terms *confidentiality* and *anonymity* as the “*protection of study participants such that individual identities are not linked to information provided and*

*are never publicly divulged*” (Polit and Beck, 2006, p. 494). This aspect of the research work was taken seriously and protected by several approaches during the research process.

First, starting with the patients, I avoided designating a specific spot within the health facilities for patient interviews. Preceding each interview, each patient and I agreed on a quiet place within the health facility where the interview would take place. These interview spots were often rotational to prevent healthcare workers or other persons from identifying that patients seen at a constant spot were participants of this sensitive study. Also, most of the interviews were conducted on days when these patients did not come to these health facilities to seek care but primarily for the interviews. Doing so helped to partly minimise and address the issue of anonymity as these patients did not have contact with most healthcare workers on those days other than myself. In addition, to the above, the initials used in this study were pseudonyms only identifiable by the researcher.

Second, concerning confidentiality and anonymity regarding healthcare workers, I had instances where unit heads and senior healthcare workers who had acted as my gatekeepers for the study wanted to informally enquire which staff had agreed to help with the research. However, I presumed that such enquiries were made from a genuine desire to see if I was progressing with recruiting study participants of mere curiosity. I, however, politely declined to provide such information as most of these healthcare workers know each other and have worked together for a long time. Therefore, this could have made it easy for them to be identified. I politely explained why I could not provide a further response, and this often sufficed.

Another issue of concern that was raised by some healthcare workers had to do with publishing and disseminating of the study findings. Some concerned healthcare workers needed to know if their views could be easily identified as an informant when the research is presented to the

broader public. I observed that this query often sprung out when the study participant wanted to share a piece of sensitive information and wanted reassurance that this information would not be traced back to him or her. Therefore, they wanted their views aired but their identity protected. In addressing this genuine concern, other than using pseudonyms, the specifics of the hospital was redacted and only written as public or private health facility. On each of these instances and throughout the process, I reassured the participants that protecting their identity was a solemn pledge and a top priority, and that they would remain anonymous. Locations were also discreet and continually changed with the healthcare workers who participated in the study, as was done with the patients' participants, often far away from the units where these healthcare providers work. Burns and Grove (2005), regarding their works on ethics, confidentiality, and anonymity in nursing practice, suggested that every study participant has the right to confidentiality, privacy, and anonymity. They, however, pointed out that “true anonymity” or total anonymity is often a challenge and can only occur when the participant's identity can never be linked to the data, including the researcher (Burns and Grove, 2005).

Other experts, such as Pope and Mays (2020), argue otherwise. They argued that the idea of “true anonymity” propelled by Burns and Grove is not a realistic feat in qualitative research. They argued that it is usually tricky concerning the researcher anonymity aspect, as researchers would often have immersed themselves in the interviews and transcripts that it might sometimes be impossible not to link some data to a participant (Pope and Mays, 2020). My experience during this research agreed with the view of Pope and Mays. The participants know they shared their experience with me, the researcher, and to do so meant they were comfortable with me knowing the data but no one else outside the researcher-participant confidentiality axis. Nonetheless, Pope and Mays (2020) recommended further, that to protect the identity of study participants where possible, the researcher should transcribe the generated interview data except in the cases of translation from one language to another. In my case, the interviews were

done in English and transcription was done by myself. In the few instances where participants spoke Nigerian pidgin English, I translated them myself since I am a native speaker of pidgin English as well.

Furthermore, I took all the needed precautions to ensure that digital recordings, field notes, transcripts from the interviews, and other data collected from participant observation in this study were all anonymised. Identifiable details, such as names, positions, or job titles, were removed or replaced with pseudonyms in the study transcript to give the context of the information gathered. The anonymised data was stored on a secure, password-protected cloud storage system with backups only accessible to the researcher. In the event of future publication of the thesis, no identity of any study participant will ever be disclosed as from the get-go, no data was stored with real names but with initials or pseudonyms. All data handling complied with the University of Edinburgh's Data Management Policy.

#### **3.5.4. Sensitive Information**

Regarding sensitive nature of this research as it relates to some of the experiences of corruption shared by patients and providers, a fundamental issue during such interviews was what to do when stories that bothered patients' direct safety and well-being was shared. There were a few instances where the findings suggested harm to patients, leading me to ponder my responsibility as a researcher while maintaining confidentiality and non-interference.

Based on the principles of strict confidentiality and privacy, it was not in my power to divulge or pass on such information that was shared in confidence with the facility authorities. However, when study participants who raised those issues sought my advice on what to do, I suggested they write to the relevant authority – Service compact (SERVICOM) i.e., the government body designated to receive consumer complaints through anonymous portals provided at the SERVICOM desk in each facility. Healthcare workers who insisted on my view

on what to do were encouraged to do the same if they were afraid of relating such information to their supervisors. In this way, I ensured non-interference and maintained the strict confidentiality of my informants, and this also allowed the study participants to make informed decisions when it came to sensitive experiences including how they chose to do their obligation within the confines of the law.

### **3.6. Role of the Researcher**

In qualitative studies like this, where the primary mode of data collection is through IDIs, a distinctive feature is that the researcher is often the primary instrument of data collection (Maxwell, 2012; Crowther and Smythe, 2016). Hence in this empirical study, as part of my role as the researcher, I also served as the research instrument.

Being the research instrument was advantageous on several fronts. First, as someone with prior “lived” experience from the provider perspective and someone who has worked and interacted with patients in both public and private health facilities in Nigeria, including Abuja, the location of this study made it more contextually feasible to have designed the tools needed to gather comprehensive data and the eventual data analysis. However, I was mindful of my prior role as a healthcare provider in this setting. It was even more critical to ask this fundamental question *"how does who I am, who I have been, who I think I am, and how I feel affect the data collection and analysis?"* (Pillow, 2003, p. 176). As suggested by Braun and Clarke (2019), being reflexive was an acknowledgement that my role as the researcher was influential in the healthcare environment under study including the collection of the patient and provider experiences, construction of the narrative, and interpretation of the findings generated (Braun and Clarke, 2019).

In being constantly reflexive during this study, techniques such as intersubjective reflection were employed, i.e., I was aware of how the intersections in my identity raised a few



unconscious bias issues (Marzi, Hautmann and Maestro, 2006). Also, my reality as a prior healthcare provider helped me identify which questions in the interview schedule were based on my own contextual realities as a healthcare provider in Nigerian health facilities, not just theoretical literature. This contextual reality was crucial for ensuring transparency and went a long way to keep me, the researcher, of my unconscious bias as much as possible throughout the research process. As a Nigerian healthcare provider who had spent over a decade and a half previously working in several public and private health facilities in Abuja, I had some anecdotal knowledge of health facilities and their working environment both at the organisational structure and functional levels in Abuja. Therefore, this anecdotal evidence created the background knowledge that made it easier for me to identify and meet “gatekeepers” and set the entire research process in motion.

Mindful of these biases at the outset, some factors played to my advantage in reducing these biases to a minimum. First, my background, training and experience helped with the self-preparedness of the study participants as well as workings of health facilities, which was where the patient - provider interactions occur. Furthermore, the problem under study was familiar to me as a researcher in the healthcare environment, having worked in both public and private health facilities and being aware of anecdotal issues around corruption in the operationalisation and provision of health services in Abuja, Nigeria. Although I was a trained physician before conducting this research, I had not been in direct health service delivery to patients in Abuja, Nigeria in the five preceding years. Therefore, this helped to detach me to a considerable extent and provided a high degree of objectivity and trustworthiness. I kept my subjective opinions, beliefs, perceptions, and experiences concerning the research topic while engaging with patients and healthcare workers during the study.

### 3.7. Methodological Limitations of the Study

Although qualitative studies using IDIs, as was the case in this study, provided persuasive “rich” empirical data, certain limitations abound that were considered upfront. Furthermore, efforts were made to mitigate these methodological limitations where possible. A fundamental limitation of this qualitative study using IDIs is that it is time-consuming and labour-intensive. Essential information can be omitted with such a copious number of texts. To mitigate this, transcribed recordings and field notes were read and reread several times during the transcription and data analysis stage of this project.

Similarly, there are always trade-offs between time and the benefits of additional interviews. The number of policymakers interviewed in the study was a limitation. More comprehensive interview process was not feasible here due to the reasons earlier enumerated in *section 3.4.2*. One could have carried out more interviews with respect to policymakers opted out if time and resources had been available. Future research priorities could address this limitation.

Furthermore, there is the issue that findings from qualitative studies such as this cannot be easily generalised as with most qualitative research due to the trade-off between the depth of data gained from interviewing limited numbers of people and larger study samples (Pope and Mays, 2020). This study recognises this limitation, and it is reflected as the study’s findings were interpreted and discussed in the respective chapters. Lastly, in terms of the problem of bias that comes with qualitative interviews such as this, ‘bracketing’ as suggested by qualitative experts was employed as one way of minimising such biases from the researcher's angle (Willis *et al.*, 2016). Therefore, bracketing was employed throughout this project by trying to suspend judgement about the natural world as much as possible.

## **Chapter Four**

### **Corruption in Public Health Facilities: Patients' and Providers' Experiences**

#### **4.0 Introduction**

This chapter addresses this study's first objective, which sets out to investigate the experiences of patients and healthcare providers concerning the causes, manifestations, and impacts of corruption as they occur in public health facilities in Abuja, Nigeria. In order to understand the problem of corruption in Nigeria's mixed health system which consists of publicly funded health facilities sandwiched between private health facilities, this thesis takes the approach of first presenting an analysis of the empirical findings regarding patients' and providers' experiences of corruption in the public health sector. It then builds from this chapter to analyse the experiences of patients and providers concerning corruption in the private health sector presented in chapter five, which little is known in Abuja, Nigeria. The two chapters in turn lay the foundation for chapter six which focuses on how, and the extent to which, corruption is enabled by the co-existence of and interactions between public and private health facilities in the context of the mixed health system of Nigeria – and of Abuja in particular.

The focus of this chapter is to investigate the experiences of patients/providers as they utilise/provide health services in Abuja, which this thesis argues in chapter one has been lacking in the literature. Particularly, the combined views of patients and providers regarding their experiences of corruption in public health facilities have not been fully explored. You will also recall a case was made in chapter one that previous reforms to address the problems of corruption, even though not ideal that they were skewed to the public health sector, they also lacked insights into the “lived” experiences of patients' and providers' who are the users and

suppliers of health services. The views of these two groups as they interact in public health facilities are crucial to understanding what causes corruption in these public sector facilities, how and why corruption manifests in the forms it does in public health facilities in Abuja, Nigeria, and its impacts on patients. This forms this chapter's contribution to the thesis and the scholarship.

The analysis in this chapter is presented in three sections. First, *section 4.1* presents an analysis of the causes of corruption in public health facilities from the perspectives of patients and providers. Next, *sections 4.2 and 4.3* present the various manifestations and impacts of these corrupt practices in public health facilities.

## **4.1 Causes of Corruption in Public Health Facilities**

From the perspectives of patients and healthcare providers that were interviewed in this study, the following prominent themes emerged as causes/drivers of corruption in public health facilities in Abuja, Nigeria: (i) *the shortage of resources from underfunding*, (ii) *the commercialisation of health care and the impact of this on the relationships between patients and providers*, (iii) *poor remuneration/salaries of workers*, (iv) *lack of accountability and weak oversight*. The findings in relation to these themes are outlined below.

### **(a). Shortage of Resources: Scarcity and Rationing**

The shortage of resources in public health facilities in Abuja, Nigeria, emerged as a recurrent theme concerning factors that drive corruption in public health facilities. In the views of both patients and providers, there is a shortage of resources relative to need. This includes: a shortage of workers (such as doctors, nurses, pharmacists, laboratory technologists, and other workers needed to provide care). Other shortages concern the number of consulting rooms, theatres, and other treatment facilities, among other things. Most public providers interviewed

in this study felt these shortages resulted from low government funding and a lack of efficiency in the management of resources.

For example, in an interview with a senior medical officer in one of the General public hospitals where this study was carried out. The informant said:

*"You would not believe it, but the last time we had official employment of health workers across all categories of staff in this General hospital was over four and half years ago. Meanwhile, several of our doctors and nurses have left for greener pastures abroad; others have retired, but there is no replacement. For example, the doctor-to-patient ratio here is alarming. We sometimes have only five doctors in this outpatient clinic with over 300 patients daily. Why wouldn't there be endless queues and long waiting times for patients"* **[Senior Medical officer- Public Health Facility].**

In another interview with a patient who attends one of the General public hospitals, the informant described experiences relating to long waiting times beyond the usual and how in the opinion of the informant, the shortage of health workers and infrastructure is an avenue for corruption to thrive.

*"The queues at the card section and payment points, as well as the clinics, pharmacy and laboratory, are scary each time one comes here. The staff here are just too few. The consulting rooms are too few, and the crowd scares me each time I bring my family here. From the card section and payment points, the only way to jump the queue is to give in to the demands made by some record clerks and cashiers if you want to be seen faster. They take advantage of these long queues and remind us that few doctors are around today. So, if one wants to be seen, he or she better do the needful except for those who had some internal connection with workers"* **[Patient- Public General Hospital].**

Similarly, another informant described their family experience of being exploited in a bid to jump queues at the outpatient clinic.

*"The outpatient clinic was like a market square, everywhere was upside down and the queues were virtually endless. I have been on the queue since 7 am and yet at 1pm I had not been seen yet. They claimed they had few staff to attend to the crowd. I was desperate and hadn't even taken permission from work. One of the two different hospital attendants approached me and offered to help me get to the front of the queue if I paid 2500 naira. I had*

*no choice since I was desperate. I paid and at about 2 pm they opened me a card and I was finally able to see the doctor. It was a difficult and traumatic experience for me” [Patient- Public Health Facility].*

Furthermore, in other interviews with patients at one of the public general hospitals, the informants described the following experience.

*“I had been at the laboratory waiting area for several hours waiting for them to collect my blood samples. The crowd here was something else. People were shouting at each other and calling names as everyone was trying to jump the queue. One of the laboratory technicians announced that their reagents would not be enough for the patients available that day and suggested we come back the next day, but we did not leave. While waiting, another lab technician through a health attendant offered to help me get my blood samples taken if I gave them something (money). Although, I did not have much money, I gave them 1500 naira and that was my saving grace that day”. [Patient- Public Health Facility].*

*“They gave me 1 month appointment just to do a CT scan. I was told that they can only do a limited number of patients per week. The wait was just too long. I could not bear it. I came back the following week and was told the same thing. However, a cashier in that unit finally approached me and asked I part away with something [money] and they would speak with the appointment people to get me an earlier appointment. I cannot remember how much I gave them in return, but that was how I was finally able to do the CT scan that second week [Patient- Public Health Facility].*

As suggested by the evidence above, the shortage of resources relative to need, especially that related to the low ratio of healthcare workers to patients, is a major cause for prolonged waiting times for patients in these public health facilities, particularly in a densely populated urban area like Abuja. This study defines *prolonged patient waiting time* as a waiting period greater than four (4) hours for “cold” cases or greater than 1-2 hours for emergency cases, as recommended by the Federal Ministry of Health in Nigeria (FMOH, 2016). Therefore, in a bid for patients to cut down on such prolonged waiting times at service points as they scramble for limited services, the evidence in this study suggests that healthcare providers exploit the desperate state of patients in these "chaotic" environments created by the shortage of these resources into succumbing to certain forms of corruption. Similarly, the findings also showed that patients

initiated certain forms of corruption by pressuring healthcare workers into engaging in corrupt practices to circumvent the rationing of these scarce medical resources often in the forms of queue-jumping in public health facilities. The evidence in this study reveals that patients and providers use various main mechanisms to navigate this shortage of resources as a primary cause of corruption in public health facilities. These include the use of influence associated with nepotism and paying of bribes in order to circumvent the rationing of scarce resources. These mechanisms are presented in detail under the manifestations of corruption in public health facilities in section 4.2.

Furthermore, several public healthcare providers in this study suggest that providing services to patients in public facilities is particularly challenging due to the dysfunctional states of these facilities created by the shortage of resources from years of chronic underfunding. In their bid to provide services in such dysfunctional facilities, they felt that they had no choice but to circumvent certain rules through *pressure from informal rules* which often deviates from official codes of practice for public servants by which they are ideally also guided by. Therefore, in the view of several patients and healthcare providers interviewed in this study, the shortage of resources, including personnel, medical supplies, and equipment, largely from underfunding of public health systems in Abuja, Nigeria, was a leading cause of various forms of corruption in public health facilities, as providers exploited this resource scarcity and rationing in exchange for personal benefits which manifest in various forms. The manifestations of these various forms of corruption arising from these shortages of resources are presented in *section 4.2* of this chapter.

## **(b). Commercialisation of Health and Relationships in Public Facilities**

In this study, the commercialisation of health in public facilities refers to Nigeria's government's policy where most services initially provided free by public facilities with the government's support through public funds was no longer free but have to be paid for by patients except for a few services still funded by donor organisations (Aregbeshola, 2021). The commercialisation of health in public facilities emerged as one of the prominent causes of corruption in public health facilities in Abuja, Nigeria, from the perspectives of patients and some healthcare providers that were interviewed in this study, and from participant observation employed in this study.

The evidence shows that Nigeria's commercialisation of health in public facilities has been a government-directed policy in the last few decades (Aregbeshola, 2016; Tormusa and Mogom Idom, 2016). These commercialised services include card fees, laboratory and investigation costs, bed/admission fees, drugs, and surgical procedures fees, among others. Patients are now expected to pay for most of the services they receive in public facilities except in a few areas, such as consultation fees, some mother and child health services like immunisation, and donor-funded services like treatment of HIV/AIDS (Aregbeshola, 2021).

Several patients interviewed in this study described the commercialised behaviour of public health facilities as a key factor that opened up channels for public healthcare providers to exploit them and perpetuate certain forms of corruption, such as *informal payments*. In this study, the evidence reveals that the commercialised behaviour of public health facilities causes corruption at two levels. First, at the level of *individuals*, i.e., patients and healthcare workers. Second, at the *organisational level*, i.e., at the management level of public health facilities. At the individual level, public healthcare providers exploit loopholes in the system to charge extra payments through informal charges in addition to the approved user charges. At the



organisational level, health officials with oversight on the management of these public facilities also suggest that the commercialisation of health had led to unintended effects. In addition to workers receiving informal payments from patients, they use the opportunity to steal cash payments made formally. Therefore, corruption occurs also in this instance due to loopholes that have opened up channels for health workers to steal internally generated revenue from user fees paid by patients. These loopholes include insufficient/failure of Point-of-Sale Machines (POS) making cash readily available to hospital staff to be stolen especially in the face of lack of accountability and checks by supervising health officials. This loss in revenue affects the sunk in capital by public health facilities. For example, the costs of drugs and hospital cards procured by the public health facilities and the generated marginal profit meant to be re-invested in these facilities were sometimes stolen by these public health workers such as cashiers and record clerks. Thus, defeating the purpose of self-sustenance of these public facilities as intended by the commercialisation policy of the Nigerian government.

In an interview with patients in the selected public health facilities. Some described the following experiences.

*“Each time I come here, these people prefer I and my family make most payments for cards, tests, and medicines through cash. But I also noticed on several occasions that in this process I have been asked to pay for other things which were different from what we normally know are being charged here and we are not given receipts [Patient- Public Health Facility].*

*“I recall one time, that my wife was asked to pay for hospital delivery things as written on the board of the maternity ward, but suddenly they added some other payments that were not there. We tried to clarify, and the nurse got very upset. To avoid their wrath, my wife just told me to pay them because she wanted to have a good relationship with these nurses and these payments were all made in cash. However, I strongly feel these other payments that the nurse was upset about were unofficial and unfair [Patient’s Husband].*

*“Some years back, I know very well that mothers and children did not pay for somethings in this hospital. But since we started paying for some of these things which they told us that it is the new government rule, several other payments in addition to ones they give*

*us receipt for are often demanded from me here. This was not happening some years back*  
**[Patient- Public Health Facility].**

Most patients highlighted that public healthcare workers were able to exploit this commercialised relationship between providers and themselves because cash payments are the dominant mode of payment in public health facilities in Abuja and the rest of Nigeria. Here, the vulnerability is that, because some services offered to patients are paid for in cash, the levying of informal payments is therefore enabled since its easier for the providers to gain directly to their pockets through cash payments and do not stand to make such gains if patients paid via electronic means to the hospital coffers. However, this is also distinct from stealing the cash payments made formally.

The evidence revealed that only a few electronic payment methods, such as Point of Sales (POS) machines or Internet banking options, were in use, compared to their counterparts in private health facilities. Where these electronic payment options did exist, they were usually not functional. The evidence also suggested that these cash payment points were generally uncoordinated and created multiple avenues for irregular payments, often with extra charges added to approved user fees by cashiers and record clerks. Several patients also revealed that they were not given receipts for some of the services they paid for, and other patients also suggested that even when these receipts were provided, they were sometimes altered before being issued. In several instances, the evidence suggests that some patients were not literate enough to cross-check if these charges were accurately reflected in those receipts. Even those who were literate were often under immense pressure due to the chaotic nature of these public facilities, that they did not scrutinise the receipts to see the extra informal charges added. Therefore, this chain of events arising from the commercialised relationships between patients

and providers in public facilities allowed healthcare workers to exploit and engage in corruption easily in public health facilities.

The following subsection under this theme presents case examples of empirical findings through an observational approach - *participant observation* which provides insights into different mechanisms by which public health providers exploit the commercialisation of health in public facilities in Abuja, Nigeria.

#### ***(b1) The ‘Ever faulty’ Point of Sale Machines: Participant/Direct Observation***

I observed that POS machines were at the designated counters and paying points in these public health facilities, but most patients still made cash payments. For example, in a discussion with a record clerk and a hospital cashier in one of the three General public hospitals, they both mentioned that the POS machines had technical issues.

*“These POS machines work on some days and do not on other days. Sometimes no electricity to charge them. We always have network problems with them and are tired of complaining to the banks that supply these machines. What else can we do but ask the patients to pay for services using cash?” [Record clerk- Public Health Facility].*

*“If we, the cashiers, are to rely on these POS machines that cannot even last for one hour without developing a fault, then we would spend the entire day here with these multitudes of patients. It takes forever for the network to link, and it has been a source of dispute between the patients and us. It will also delay the work of the record clerks, which is why we do not like POS machines. They will tell us their accounts have been debited, yet we have not been credited at our end. So, I am not too fond of these POS machines” [Cashier- Public Health Facility].*

Above are examples of several excerpts on the lack of POS machines for patients to make payments to retrieve folders at the outpatient clinics of public health facilities in Abuja. At the same time, these payment points in these public hospitals were notoriously known for demanding extra cash payments from patients and often refusing to give receipts for some payments. Other healthcare workers and health officials have also allegedly described these

cash points as avenues where hospital cash is stolen and not fully remitted by cashiers, which would have been easily prevented if POS machines were functional. So why are these issues affecting the use of these POS machines unresolved in public health facilities in an urban setting like Abuja, where private health facilities which face similar problems are able to resolve theirs?

*“Of course, everyone knows the connectivity issues that can sometimes occur with POS machines in Nigeria, just like we are used to same with our internet connection on our phones, but these things still work very well, and people use it everywhere. Let me be upfront with you as a healthcare attendant here. I am close to these record clerks and cashiers. No one likes these POS, including myself. The regular tip or change that remains when people pay with cash and tip you with are lost with the use of POS. Why would anyone like that? Also, there would not be the opportunity for cashiers and record clerks to pilfer cash if these POS machines are functional. That is why they deliberately spoil these POS machines or continually claim they are not working in order to get extra cash under various disguises from patients”*  
**[Health Attendant – Public Health Facility].**

The evidence from the interviews with some healthcare providers suggest that public healthcare workers' preference for cash payments compared to electronic payment was a deliberate ploy to provide an avenue for corruption and to exploit patients particularly when it involved cash payments. The findings suggest these healthcare workers preferred cash because they could manipulate the records and add extra charges to these patients, which was not easily obtainable with electronic payments. Therefore, several patients and some healthcare providers, including health officials, felt this motive for corruption was a deliberate attempt by healthcare providers in public health facilities to sabotage the use of POS machines. They felt it was deliberate to avoid making extra efforts to get the genuinely faulty POS machines up and running anytime these POS machines were down due to connectivity issues.

The general belief from my interaction in these public health facilities through participant/direct observation was that healthcare workers see public facilities and the drive to raise revenue to run these facilities as mainly the government's burden, not theirs. Therefore,

in instances where the unintended effect of commercialisation led to stealing of cash payments made formally, most healthcare workers who are not involved in such practices do not feel is their responsibility to report those known to be involved in such practices nor do they feel is their responsibility to protect the revenue. Even more apparent from my interaction was that these public healthcare workers feel that anything that is for the government is nobody's including the POS platforms. They generally saw even the accrued revenue as free and a "national cake" and not one that should be protected.

Although most informants believed that these commercialisation of relationships between public providers and patients had more disadvantages including being a leading cause of corruption in health service delivery, other interviewees, primarily providers, felt it had some advantages in reducing corruption in public health facilities through the payments of formal/user charges. They suggested that with accrued revenue from user chargers, public facilities are able to plug gaps in shortages of resources which reduces rationing of public services.

In summary, the reflection under this theme of commercialisation of health and relationships in public facilities as an enabler for corruption, suggests that, because most health services now offered to patients in public health facilities are paid for in cash, the levying of informal payments by healthcare workers is further enabled. Additionally, the stealing of formal payments by healthcare workers is further heightened under such enabling environment.

### **(c). Poor Remuneration/Salaries of Public Healthcare Providers**

Closely linked to the shortage of resources and underfunding of public health facilities is the issue of poor remuneration of health workers which emerged as one of the leading causes of corruption in this study. The findings in this study revealed that most patients and healthcare

providers suggest that healthcare workers in public facilities in Abuja and other parts of Nigeria were poorly paid compared to their counterparts in private health facilities. They believed this inadequate compensation was not commensurate with their responsibilities, and this often left them and their families in financial hardships. In their bid to compensate for these low salaries, this drives public health workers to seek other channels for additional income which includes engaging in corrupt practices such as bribery, theft, and diversions which are presented under the manifestations of corruption in section 4.2. The evidence further suggests that such acts engaged by public healthcare workers in a bid to compensate themselves illegally, in turn, worsen the already existing shortage of resources created by chronic underfunding of the public health facilities.

In an interview with a nurse who raised the issue of poor salaries as a cause of corruption in public health facilities. She said the following:

*"We cannot survive on this meagre salary from the government. It is challenging for nurses to survive in an expensive city like Abuja. Imagine me as a senior nurse surviving on 200,000 naira [430 USD] per month. How do I pay my house rent, school fees, feeding, transportation, and other needs? Where has a nurse survived on such a salary? Do you blame nurses who resort to other means of increasing their income to survive in this city? Certainly, this is a cause of corruption in my hospital"* **[OPD Nurse- Public Health Facility]**.

In another interview with a medical doctor in another public health facility, he echoed similar views to those of the nurse above.

*"The government is still unprepared to tackle the issue of poor remuneration in public hospitals. Even our senior colleagues who are consultants or professors earn between 600,000 to 850,000 naira [1400-2000 dollars] per month after over 15 to 25 years of medical practice. Moreover, this is even worse for junior medical doctors who earn just 220,000 naira [500 dollars]. This is why some doctors engage in corrupt practices if I must be frank with you"* **[Senior registrar- Public Health Facility]**.

The finding of poor remuneration of public health workers in this study is in keeping with findings from other studies which found poor remuneration as a leading driver of corruption in public health facilities in Enugu, southeast Nigeria and Abuja, Nigeria (Onwujekwe *et al.*, 2020). Other studies in LMICs, particularly in sub-Saharan Africa, found similar findings where due to poor salaries of healthcare workers in publicly funded health systems, their motivation to engage in corrupt practices were higher and their susceptibility for corruption was also higher in instances where patients or external actors initiated the corruption process (Vian and Norberg, 2008; Lewis, 2011; Onwujekwe *et al.*, 2020; Vian, 2020). The evidence provided in this study especially from the opinion of public health workers that were interviewed revealed similar motivations as a key driver of corruption in public health facilities in Abuja, Nigeria.

#### **(d). Lack of Accountability and Weak Oversight**

These two interrelated key factors emerged as drivers of corruption in public health facilities in this study. The lack of accountability by public healthcare providers upon the backdrop of weak oversight by health officials from supervising agencies were recurrent themes in this study. These factors were primarily highlighted by interviewed health officials overseeing the public health facilities in Abuja. Several of these health officials suggested that the failure in their oversight which is needed to hold public health providers accountable was due to poor funding by the FCT Health Administration. Therefore, they lacked the needed resources to perform this key function. They further suggested that such weakness and irregular oversights from their end as health officials, lack of accountability and transparency in the dealings of public healthcare workers and their management allows corruption to breed in several forms in public facilities in Abuja. For example, in an interview with one of the health officials in the pharmaceutical division at one of the supervising agencies in Abuja, he revealed that it was

usually a tug of war to get resources for his officials to embark on their bi-annual oversight visits to public health facilities.

*"There have been years where we have not had the resources to deploy our staff to perform their oversight in some public hospitals here in Abuja. Due to the meagre resources allocated for oversight visits, we randomly select a few public hospitals to visit. Then you can imagine what happens to other hospitals not visited. We have seen on our few visits that some public health workers engage in unacceptable practices without any checks and balances from their management and no repercussions"* **[Health official]**.

In another interview, one of the health officials suggested that it was high time for the management of public hospitals in Abuja and the rest of Nigeria to be held to a high standard of account.

*"Because these are public hospitals, the management of some of these hospitals do not bother to hold their staff to account. After all, it is not their business, so whether monies generated as internal revenue from the sale of drugs, cards, or procedures are not accounted for, they do not even bother. We found such a lack of accountability in several public hospitals in Abuja. Why wouldn't these health workers be encouraged to engage in corruption when they know they will not be held accountable"* **[Health official]**.

There was evidence of similar findings across various units of public health facilities where this study occurred, ranging from card retrieval points, pharmacy units, laboratories, radiological investigation units, and theatres, suggests a lack of rigorous scrutiny by the leadership and management of these units as well as inconsistent oversight by health officials from supervising agencies. These two interrelated factors allowed healthcare providers to engage in several forms of corruption in these public health facilities.

Having laid the foundation into the key underlying causes of corruption in public health facilities that were found in this study, the next section presents an in-depth analysis of how several forms of corruption arising from these causes manifest in public health facilities in Abuja, Nigeria.



## 4.2 Manifestations of Corruption in Public Health Facilities

Several major themes emerged relating to corrupt practices as they predominantly occur in public health facilities in Abuja, as revealed by the interviews of patients and providers in this study. These macro themes include the following: (i) *Use of influence as a corrupt practice associated with nepotism*, (ii) *Informal payments and* (iii) *Bribery*, and (iv) *Pressure from informal rules*.

### (a). Use of Influence associated with Nepotism - “Being Connected”

The *use of influence* was one of the most prevalent themes that emerged from the findings in this study on corruption as it affects the operationalisation, provision, and delivery of health services in public health facilities in Abuja, Nigeria. The use of influence, closely associated with nepotism, was a prominent practice seen in the day-to-day doctor-patient interaction in public health facilities. This practice involved using power, influence, and connection to give or receive unfair advantages to patients who are often friends, family, and colleagues.

In this study, the “use of influence” refers to undue influencing or informal influencing by healthcare workers ranging from doctors, nurses, pharmacists, laboratory staff, patient care attendants, record clerks, hospital managers and management staff from several sources within and outside the hospital to provide services that are often devoid of fairness to patients who do not have such influence. This practice sometimes occurred independently of any direct monetary involvement between the patients and the healthcare providers. The evidence in this study shows that influence-activities (“being connected”) at the health facility came from both external and internal sources. External sources refer to influence-activities from persons outside the public health facilities where this study occurred. Internal sources refer to influence-activities from people within the health facilities. In both cases, the extent of the influence depends on the influencers' financial, political, religious, and cultural status. The evidence as

will be shown in this theme further suggests that the underlying factor for such influence is the concept of power dynamics, where the influencer often had a “flexing power” relative to the healthcare provider rendering the service. In several of these instances, the healthcare provider has had to carry out the favour and, in the process, which do not benefit the public interest and are sometimes at the detriment of attending to sicker patients. The evidence in this study also reveals that healthcare providers benefit directly from such practice even if he or she was unduly influenced, as favours often are exchanged down the lane under this practice. Thus, favours often serve as the currency for payment and not necessarily in the form of money alone.

Interestingly, most doctors interviewed in this study admitted that undue influencing played a role on countless occasions on their decisions to provide patient treatment in public health facilities, often at odds with the principle of equity and fairness in these public hospitals. They revealed that they often had no option but to give in to these requests due to the power dynamics at play. Other doctors and nurses agreed that some healthcare workers also yield their power to provide services faster to their friends and family members - *a form of nepotism*. Thus, the use of influence is one of the major corrupt practices responsible for distorting the delivery of services to patients in a fair, orderly, and equitable manner in public health facilities- inequity of access.

For example, in interviews with doctors, they described instances where they were unduly influenced to provide services to patients who were “connected” with those who sought to influence them to jump queues or be provided “special” treatment. However, there was often personal interests and benefits to those superiors who asked them to engage in such practices at the expense of other patients who should have been seen first.

*"The pressure we receive to see patients we have nothing to do with is sometimes alarming. For example, at the beginning of this week, my consultant sent me three people to see who were not booked for that day's clinic. Who am I to say no to him? He also was given*

*marching orders by the head of clinical services, who had also been called by one of the local government chairpersons to see his relatives. I ended up pushing back some patients to the next clinic to accommodate these unplanned patients imposed on me. Unfortunately, in these kinds of situations, it is other patients without connection that suffer as it creates equity related issues" [Senior registrar- Public Health Facility].*

*"This day, our medical director called me at about 10 am, just an hour into my clinic, to see one of the senators who was not feeling well at home. I did not get a single kobo [Nigerian currency], but I had no choice but to see the senator. The senator sits on the committee on appropriation, and you know what that means for funding allocation to our hospital. That is how I abandoned my patients to the resident doctors even when clearly some cases were beyond their expertise" [Consultant Physician- Public Health Facility].*

Similarly, the evidence also revealed that undue influencing often came from health officials at the health ministry and other relevant health agencies overseeing these public health facilities.

*"Just a few days back, one of the top politicians called and instructed we do medical checks for 60 people going for a religious pilgrimage abroad. These people were not registered in our hospital, and no one had informed us of their coming. So, you can imagine how our clinics were distorted. Our regular patients were the ones who were affected as there was no way the doctors could see these added patients and the regular patients all promptly. Seeing these patients took most of the week, and I can tell you that that week frustrated both our patients and staff" [Hospital & Admin Manager - Public Health Facility].*

In another interview with a junior laboratory technologist, he described his experience where undue influence from his superiors led to the breakdown of established rules leaving patients dissatisfied and, in some cases, experiencing severe delays in getting their laboratory test results.

*"I sometimes dread the feeling of coming to work, especially after my bitter experience two months back where some patients blocked the door to the lab raining insults on my other colleagues and me for delays in their laboratory tests. Our ogas' [bosses] will bring samples of patients outside this hospital for us to process or for people who just came when other samples had been waiting for 2-3 days. [Laboratory technologist - Public Health Facility].*

This form of corruption evidenced above is akin to Blundo and Olivier de Sardan's third category of corruption semiology- "the piston", i.e., patronage or "being connected" (Blundo and Olivier de Sardan, 2001, p. 13). Studies have reported similar findings where the use of influence associated with nepotism and patronage was used to seek care and provide services in public health facilities (DeMeyer, 2018; Kirya, 2020; Vian, 2020). DeMeyer described how nurses use their power and relationships to favour some patients at the expense of others as a result of nepotism (DeMeyer, 2018).

The evidence in this study also reveals that patients sometimes play a role in unduly influencing public healthcare providers. These patients admitted that they had at some point used "connections" either within or outside public health facilities in Abuja to pressure healthcare providers to favour them. Some of these patients claimed that this was the only way to navigate the challenges associated with these public health facilities.

*“When I brought my aged mother last month, I had to beg my oga [boss] at work whose wife works here as a senior doctor. She instructed the doctors working under her to see my mom; the story would have been different if not. Even with all the laboratory investigations, this was how we jumped the long queues to do my mother's tests. Was I expected to be waiting in these long queues with my mom, who is already fragile?” [Patient- Public Health Facility].*

Similarly, a civil servant at one of the health-related agencies also described how the use of influence had helped him and his family to jump queues in public hospitals.

*“I know quite a few people who work in this hospital, and because I know people here who also owe me favours for getting their files to move in my workplace too. I, therefore, let them know I will be coming to the hospital and that makes it a bit easier for me each time I come, and I am seen more quickly” [Patient- Public Health Facility].*

The evidence suggests that patients who rely on the *use of influence* i.e., “being connected” were often seen the fastest at these public health facilities compared to those without connections. This is so because these patients rarely follow any queue when they arrive at these facilities. For example, in this study, a medical officer described how one of her superiors gave

an explicit order to attend to patients who had strolled into the hospital at past midday while other patients had been in the queue since 7 am. She highlighted that these patients spent less than 1-2 hours in the hospital compared to others who sometimes spend as much as 5-8 hours. She also suggested that the involved healthcare workers' friends, family, and relatives often enjoyed the shortest waiting period simply because they knew people or have “connections” within the hospital who could unduly influence her colleagues and her by helping patients skip queues.

In other instances, she and her colleagues had no personal connections to these patients. However, because these patients knew highly placed persons within or outside the public health facilities who yielded power, they had to see these patients. In her view, these experiences described here are synonymous with nepotism, where those with power or influence to favour relatives, friends or associates were seen quicker at the expense of other patients without any form of connection who were sometimes indirectly denied care by such actions.

*"Just three days ago, my oga [Consultant] sent me six folders of patients through the record clerk at about 2 pm when our clinic ends at 4 pm for them to be all seen and these patients had just arrived. Meanwhile, we had over 20 patients waiting in the queue to be seen before 4 pm. The clerk mentioned that these patients I am about to see had not even paid the 500-naira folder retrieval fees (user/formal fees) even though they were from a rich family"* **[Medical officer at a General public hospital].**

*"This pastor, simply because he is my Oga's [boss] spiritual father in Christianity, is seen at home using government's resources during working hours while other patients since 7 am were waiting. We returned 3 hours into a working day, so those assigned to my clinic room waited for those three extra hours. This kind of thing can only occur because of the influence this pastor had on my oga. I had no choice but to obey my oga. Who am I to say I will not?"* **[Medical officer - Public Health Facility].**

The cases above highlighted experiences where patient waiting time was cut down in public health facilities for those who had influence or “were connected”. In some instances, it was also revealed that the use of influence also short-changed the public health facilities from

internally generated revenue as the user fees for registering and opening of cards expected from these patients were not remitted. This category of patients views the use of influence as beneficial to them since it helped them cut the prolonged waiting time. To these patients, this view is supported by the “problem-solving” view echoed through the collective action problem lens postulated by Persson and colleagues (Persson, Rothstein and Teorell, 2013).

As revealed by both patients and healthcare providers, the evidence showed that the *use of influence* as a form of corruption was a predominant practice affecting public health facilities in this study. In these public health facilities, its manifestations impacted the timeliness of services for patients who depend on the public health system, particularly those without connections who are often of lower socioeconomic status. Also, the findings in this study suggests that undue influence led to instances where several patients were not able to access services due to limited availability of spots further worsened by those who had connections as they took most of the available appointment slots.

#### **(b). Informal Payments and Bribery**

Informal payments as a macro theme inclusive of bribery (a subtheme) also emerged as common corruption-related practices from the interviews with patients and healthcare providers. Informal payment is defined as “*a direct contribution, which is made in addition to any contribution determined by the terms of entitlement, in cash or in-kind, by patients or others acting on their behalf, to healthcare providers for services that the patients are entitled to*” (Gaal *et al.*, 2006a). Informal payments also include “*extra or unofficial payments made by patients/care-seekers at different points of receiving services in public health facilities or payments for health for services that were otherwise meant to be free in public health facilities*”

(Naher *et al.*, 2020, p. 5). These are usually unauthorised payments made to individual healthcare workers or institutional providers, often in cash but not exclusively.

The evidence in this study revealed that from the onset, there was dissatisfaction by patients with the formal/user charges levied by public health facilities as part of the revenue drive of these facilities, as earlier presented under commercialisation of health as a cause of corruption in *section 4.1*. In addition to these approved user fees, patients were even more dissatisfied with the extra informal charges from healthcare workers that often came in addition to the formal charges in these public facilities. The evidence in this study suggests that patients and their care-seekers experienced different variants of informal payments including “under the table” or under-the-counter payments in the forms of envelope, advance and brick payments, gifts, or the in-kind provision of drugs, nursing, or meals in inpatient care. For patients, these payments were often difficult to distinguish from outright bribery. However, most of them mentioned that these payments were not done voluntarily but they had made these payments to access services that should have been offered to them freely in these public health facilities. Due to the multifaceted views and arguments of informal payments being legal or illegal, voluntary, or enforced, this study for its analysis adopted the view by Gaal and McKee (2006) where the analysis of the interview findings from patients clearly regarded informal payments as a subset of OOP contributions. However, the distinguishing feature being that formal OOPs or approved user fees are stipulated in the terms of entitlements, whereas informal payments are made in addition to them (Gaal *et al.*, 2006a).

In addition to patients' experiences, some public healthcare providers also described their own experiences where they had to make informal payments, especially where it involved health services in other units of the health facilities where they did not primarily work and were, therefore, not recognised by healthcare workers who engage in such a practice. These health

workers include cashiers, record clerks, other support medical staff, nurses, doctors, pharmacists, and other laboratory staff, among many others.

The findings also reveals that these informal payments sometimes involved purchases meant to be covered by the healthcare system. These ranged from payments made for hospital trolleys and wheelchairs to extra payments requested for subsidised drugs and to secure hospital beds to admit patients. Sometimes, when patients eventually get admitted without making these extra payments to the healthcare workers involved, some patients suggested that they were punished using different tactics to delay the commencement of their treatments. When they eventually get treated, some of the patients suggested that they were subjected to neglect, insults, and sometimes even bullied, intimidated, and harassed. Some patients interviewed in this study said these experiences were worse when they had no connection to any healthcare worker in these public health facilities. For example, in an interview with a widowed stay-at-home mother, she recalled her experience visiting one of the General public hospitals and the additional costs and challenges she encountered. She had described how the distance and cost of transportation from her village, which was two hours' drive due to the unmotorable road was already a rate-limiting step for her to seek care. In addition, she had delayed over six weeks since her referral from the rural primary health care centre to seek care for her unexplained weight loss due to financial constraints. However, she faced multiple challenges on arrival, the most difficult being informal payment requests from public healthcare workers.

*"I could not account for the money I had come to the hospital with, yet I had not made much headway. I was told the money for opening a patient record card was 1500 naira, but I paid 3500 naira. They sold the card and then the folder separately to me. For the containers [sample bottles] used in collecting my samples, I was asked to pay 500 naira for each of them. Even the rubber [condom attached to ultrasound probe] inserted into my private part [ Vagina] for scanning, I was asked to pay 500 naira, which was also separate from the cost of the ultrasound scan itself. By the time I was admitted that day I had no money left for treatment" [Patient- Public Health Facility].*



Similarly, in another interview with a farmer who attends one of the general public hospitals, he described his experience of making informal payments on several occasions in public health facilities in Abuja.

*“They insisted I paid for some cleaning detergents and bedspreads before my daughter was admitted, meanwhile my wife saw the attendants bringing out these cleaning materials from the hospital store. So why would they still insist we pay for such things when government has provided them already? [Male Patient at general public hospital]*

*“On another occasion, my wife and I were asked to pay for antenatal card before they registered her for antenatal, but we were told that antenatal care was free in this hospital including children under five except the cost of drugs. So again, why all these payments? Who benefits from them since government has told us they are meant to be free? [Male Patient at general public hospital].*

In these instances, above, these patients felt that they were enforced to pay for services that were meant to be free and were not even sure whose pockets those payments went into. These patients suggested that without making these additional payments which were different from the formal charges they knew about before coming to these public health facilities, they would have been denied of such services which were otherwise meant to be provided free to them. These suggests that these payments are coerced and not voluntary and met the definition of informal payments as suggested by several scholars such as (Delcheva, Balabanova and McKee, 1997; Balabanova and McKee, 2002b; Gaal *et al.*, 2006a; Naher *et al.*, 2020).

As earlier stated, other than patients' experiences at these public health facilities, some healthcare workers also described their experiences regarding informal payment practices in these public health facilities. In an interview, a junior-level Intensive Care Unit (ICU) nurse in one of the general public hospitals described her experience with informal payments where she had to pay for a trolley to a healthcare attendant in the middle of the night to transport her aged mother who had a stroke in the same hospital where she worked.

*"I arrived with my aged mother at about 1 am as she had a stroke. I was told there was a shortage of trolleys to transport my mother from the car to the emergency room. I saw some patients lying outside, and because I was working at the ICU [Intensive Care Unit] and we did not have much contact with the wider hospital, I did not know this particular healthcare attendant. Despite introducing myself, I was still told by the healthcare attendant that I needed to pay 200 naira, which he claimed was used as a pool fund to keep maintaining or repairing the trolleys when they broke down. No receipt was given to me, but I had no choice but to pay. I wondered what other patients who were non-staff were charged" [ICU Nurse and Caregiver at a General Public Hospital].*

*"When my wife came to deliver, we had to pay for everything, including detergents and antiseptics, which were more expensive here than if we had bought them outside the hospital. So, my question was, what was the admission fee for, if we had to also pay for these things? The nurses would not allow us to bring those items as we had to buy from their private supplies in the labour ward at exorbitant prices. If this can happen to me a staff in this hospital, I wonder what other patients will be charged as extra charges" [Healthcare worker and Caregiver at a Public Health Facility].*

These pieces of evidence above showed that public healthcare providers took advantage of the commercialisation of healthcare in these public facilities to demand informal payments, which were sometimes difficult for patients to distinguish from official charges in these public health facilities. Even when patients could distinguish these informal charges from official charges, they had no choice but to pay if they wanted to be treated in these public health facilities. The findings in this study suggests that these informal payments increased barrier to access for patients and made some of them more vulnerable financially. The evidence revealed that these informal payments played a crucial role in the decision of patients to refuse to seek care in public health facilities, and instead go elsewhere, such as local community pharmacies and, in extreme cases, some patients suggested the fear of informal payments led them to choices that ended in the loss of loved ones. These choices and their dire consequences are a by-product of avoiding informal payments. In terms of health outcomes, the evidence revealed cases where there were fatal outcomes for those who were unable to pay for these informal payments.

On the other hand, even though these informal payments were sometimes difficult to separate from the formal charges made by patients, some healthcare providers including health officials interviewed in this study were of the opinion that on one front, some of these payments went into the public health facilities' coffers. They suggested that in doing so, these payments could serve as a source of health financing to these public hospitals in Abuja. Some of these arguments were debated in previous studies on informal payments including Balabanova and McKee (2002:2004) and Vian et al. (2006) where the schools of thought in favour of user fees in public health facilities argued that some of these payments served as an alternative mode of health financing for public facilities in the transitional economies of the former Soviet bloc (Balabanova and McKee, 2002b; Balabanova *et al.*, 2004; Vian *et al.*, 2006).

### ***(b1) Bribery***

Bribery an important sub-category of informal payments in this study refers to “*offering money, gifts, or other in-kind payments to obtain or hasten health services to patients*” (Onwujekwe et al, 2019, p. 533). Bribery a subtheme under the broader theme of informal payments was also an illegal practice which emerged as a recurrent corruption problem predominantly occurring in public health facilities in Abuja, Nigeria. Going into the interviews for this study, one would have been naïve to say I did not expect this corruption problem to be highlighted in some form, especially in public health facilities. It will even be more untrue coming from a local like me who had been a physician in several public health facilities across Abuja and other states in Nigeria prior to my PhD studies. However, the extent of this corrupt practice, as mentioned by most of the participants across the public health facilities was quite revealing even to a former healthcare provider like me who might have had an inkling of the existence of this corruption problem at least from an anecdotal point of view during my years of clinical practice. What was more revealing from the interviewees was the revelation of the

intricacies and dynamics arising from the daily encounter between patients and healthcare workers concerning bribery in these public health facilities in Abuja, Nigeria.

Even though the evidence in this study revealed that bribery as a corruption problem was overwhelmingly by patients, some healthcare workers also acknowledged the existence of this problem and their experience of it as well. Their experiences include when these public healthcare providers fell ill, so they assumed the “sick role” of patients or as caregivers who brought their relatives. Other times their experiences of bribery were even within units in the same public health facilities other than the units where they work. However, the evidence shows that most public healthcare providers acknowledged this was a problem among their colleagues, but most interviewed public providers did not accept that they, in particular, demanded bribes.

In describing the experiences of patients and healthcare providers concerning asking and giving bribes in public health facilities, the findings suggests that the initiation of bribes emanates from both healthcare providers and patients alike. Patients who had experienced this corruption problem described that bribes were either requested directly by healthcare workers who engaged in the practice or indirectly through third-parties acting as proxies to those whom the bribes were intended. In whatever manner or form the bribes were requested by healthcare providers from patients, the evidence suggest that, in most instances, this was accompanied by a subtle threat of the risk of being told to wait and be seen after others who can afford to pay these bribes or have used some forms of influence to be seen. In extreme cases, healthcare providers did not see those who were unable to afford or unwilling to pay these bribes further made worse by the patient load in these public health facilities. With scenarios such as these being experienced daily by patients in these public facilities, most of the interviewed patients described that their threshold to resist giving bribes was lowered.

Furthermore, the evidence showed that those patients who had a previous experience of paying bribes to healthcare providers in public health facilities initiated the bribe-giving themselves in their subsequent encounters with healthcare providers to prevent them from going through challenging scenarios such as queuing and other alleged forms of maltreatment at these public facilities. These patients suggested that initiating the bribe makes processes easier and was more acceptable to the public healthcare providers involved in such practices, who saw this approach as less of a hassle that comes with instances they had to request for the bribes.

In an interview, a patient who resides at one of the satellite towns close to Abuja described her experience as follows:

*"I was referred here, but each time they said there was no appointment to see the particular specialist. They finally gave me four months appointment. I kept begging for a closer date, but I was told no earlier date was available. I was approached by a healthcare attendant who told me that if I could pay 6000 naira, he would go to the record clerks and get me a closer date. I finally got a date to be seen in 1 month after I parted with 3000 naira (bribe) which was extra payment different from the approved payment for the card" [Patient- Public Hospital].*

Similarly, in another interview with a patient who needed to have both an ultrasound scan and X-ray, he described his experience of being asked to pay a bribe for these radiological investigations to be done at an earlier date.

*"I had no choice but to give the person at the radiology unit 5000 naira to get me a date the same week to do my scan and X-ray. If I did not pay, it could take 3–4 weeks to do these investigations, and I was in pain every day. I had similar past experiences in Lagos before I relocated to Abuja. It happens everywhere, and you either give them the money or suffer with your sickness" [Patient- Male hairdresser at a General Public Hospital].*

However, in another interview, a patient described that he learned to be the one to initiate the act of giving the bribe, as this made his life easier than when being asked.

*"After years of dealing with these health people, I have learned to give them what I have before they ask me for anything. Each time I see these long queues, I quietly approach them and give them something [money], and they will sort me out quickly. Do I have a choice? If not, I will be here all day while my shop is closed. The truth is these people are always*

*expectant, whether they ask, or you are the one who gives first. Sadly, the culture in this country, including hospitals, is that people always expect you to give them bribes before they do their responsibilities"* **[Patient- Trader at a General Public Hospital]**.

Similarly, as was shown with the *use of influence* as a corrupt practice, when *speed* is used as a criterion to circumvent rationing rules, patients who paid a bribe in these public health facilities were often seen quicker. Thus, reducing their patient waiting time either when it was prolonged beyond the recommended time or for those who did not want to wait at all even if it was still within the recommended waiting period. The findings suggest that some form of bargaining or negotiation often accompanied the payment of these bribes between these patients and the healthcare workers to reduce the patient waiting time

*"I never believed in paying bribes; however, my faith was tested once when I was referred to this hospital with my 9-year-old daughter, who had a swelling on her neck. My daughter was in severe pain, and no one cared. We were here for hours but could not open a card to see the doctor. Some other parents advised me to give a tip [bribe] to be seen quickly. I parted with 2000 naira by tipping a record clerk to help me open a card. I had no choice as I was to either wait while my daughter cried in pain or to give some money due to the long queues"* **[Patient- primary school teacher]**.

In another interview, a patient also described an experience where he had to pay a record clerk 1500 naira as a bribe to open a new card.

*"This record clerk told me that my patient record could not be found. I was asked to return the next day, but the same thing happened, and nobody even cared. It was suggested I open a new card which meant losing my past medical information. If not, I was told by a record clerk to "bring something" (a bribe), so he can mobilise some junior clerks to find the folder. But because I have a chronic illness and have been on drugs for several years, and doctors will need my folder to follow me up. I had to part away with 1500 naira before my old card was eventually found the next day"* **[Patient- security personnel]**.

On the other hand, some of the interviewed public healthcare workers admitted that they could not rule out that asking for bribes sometimes occur in these facilities. However, most suggested

that patients sometimes initiated this and how difficult it was to distinguish between tips/gifts from bribes.

*"One of my patients brought me a bag of Irish potatoes just the other day. Even though she gave me this shortly before my consultation with her started that day, she did it out of appreciation for saying I have been caring for her and her family in the past few months. Would I say no to such? The issue would have been different if I had told her or any other patient, I would not see you until you gave me "something" [money/gift]. I frown when a doctor asks for money before seeing the patient. However, if after you see a patient and he or she gives you "something" in appreciation, there is nothing wrong with that in my opinion"* **[Consultant physician - Public health facility]**.

In another interview with one of the nurses, she explained that although some patients indeed initiate giving a bribe to healthcare workers to gain favour, or be seen quickly ahead of others, she felt her colleagues often encouraged this practice. She described her experience where doctors had asked her and some of her colleagues to bring forward patients' files at the bottom of the queue to be seen ahead of others because these patients gave them money or in-kind payments such as food items which, in her opinion, was bribery in disguise.

*"Tell me why the other patients will not also try to give doctors cash or food items in the name of gifts, which is simply bribery if we all tell ourselves the truth. These aggrieved patients sit here from morning to night and see other people who came much after them jump the queue, and sometimes openly, you will see them bring a sack of onions, tomatoes, and oranges for the doctor or nurse. Tell me why they will not be encouraged to initiate the act of giving bribes next time, too"* **[Nurse - Public Health Facility]**.

Although the evidence in this study showed that bribery had a negative impact on the patient experience for those who did not engage or yield to such practices - *the negative effect of corruption*; however, for the patients who initiated the bribe, they revealed that it did enhance their patient experience positively. These patients suggested that the giving of bribe reduced the unpleasant experience they would have encountered if they had not engaged. Therefore, in the opinion of these patients who engage in such practice, the act of bribery as a corrupt practice

has a positive dimension as giving bribes helped them to scale through dysfunctional public health facilities at the expense of other patients.

### **(c). Pressure from Informal Rules**

Pressure from informal rules is a group of related corrupt practices and behaviours that emerged as a recurrent theme, particularly from healthcare workers interviewed in public health facilities. In this study, this group of practices refer to unofficial norms that healthcare workers perpetrate within public health facilities leading to the circumvention of official rules for their gains, including private interests and financial gains (Pourtaieb *et al.*, 2020). The evidence, mainly from the views of healthcare workers and some patients, suggests that the factors for why most healthcare workers in these public facilities often engaged in this group of practices include the quest to augment what they see as very poor remuneration compared to their counterparts in the private health sector. Even more so, some of these healthcare workers felt that despite their public health facilities' revenue, they had yet to have a commiserate effect on their remuneration.

Furthermore, the evidence suggests that several unwritten rules trickled down from the public service of which public health facilities such as theirs were part. Suppose healthcare workers wish to rise through the ranks in public service. In that case, they need to navigate through internal and sometimes external authorities that influence these informal rules, even when some of these informal rules lead to breaking them. The findings in this study further revealed that refusal to yield or bow to such pressures by healthcare workers often had dire consequences not just from their superiors within and outside the public health facilities but also from their equals and sometimes subordinates. Some healthcare workers described instances where they or their colleagues had been 'set up' simply because they had refused to participate or



overlooked situations involving rule-breaking due to pressure from colleagues. Fellow healthcare workers who exert these informal pressures often ask questions like:

*“Did you leave your village to come to Abuja to be looking at trees?”* **[Medical doctor]**

*“Are you sure you want to be promoted?”* **[Nurse]**

*“Is it that you enjoy poverty?”* **[Cashier]**

*“Is it that your ancestors have cursed you to hate money?”* **[Record clerk]**

Above were excerpts from some of the interviews with healthcare workers such as cashiers, record clerks, security guards, healthcare attendants, hospital cleaners, nurses, doctors, pharmacists, laboratory technologists and hospital drivers in charge of ambulances in one of the General public hospitals. The interviews revealed that healthcare workers who decided to play by the rules are victimised by the corrupt system and are often victims of demeaning comments that mock such healthcare workers, often in a very abusive manner. Some healthcare workers have even been told, *“Na your papa or mama get this hospital”* [Pidgin English]. This derogatory comment implies that if your father or mother owns the public hospital that you are so protective of and why do you not want to break the rules by joining them to get proceeds of corruption such as stealing hospital cash, inflating monies to get more from informal payments and diverting of public resources for yourself. Other healthcare workers were told comments such as:

*“The moment you drop dead, they would not even wait for your body to get cold in the mortuary, and you will be replaced.”* **[Laboratory Technologist- Public Health Facility].**

*“We have seen your type who want to act holier than the pope, and they ended up wretched, be wise and help yourself”* **[Cashier- Public Health Facility].**

In another interview with an ambulance driver at one of the General public hospitals, he described an experience that almost led to him being suspended due to his refusal to yield to pressure from informal rules by one of his superiors. He revealed that despite the shortage of

ambulances, his colleagues sometimes use these ambulances to make extra money for themselves at private health facilities that do not have ambulances. He suggested that this was a widespread practice that sometimes occurred with the knowledge of supervisors who benefit from the proceeds and are sometimes responsible for bringing these extra 'side jobs' to ambulance drivers. He suggested that because the hospital now rents these ambulances to the general public to increase the hospital's source of revenue, healthcare workers hide under this guise to do private deals without remitting any money to the hospital.

*"On this occasion, my then supervisor asked me to take a patient from another private hospital for dialysis using our ambulance in this government hospital. He mentioned that the private hospital would pay, and we could make some quick money for the weekend. I explained to him that I would be risking my job in case of an emergency, but he would hear none of it from me. He was upset with me for daring to refuse. Some days later, I got a query from him that the ambulance spare tyre was missing, and he accused me of stealing it, which I did not. He frustrated me until he retired from the service"* [**Ambulance driver- Public Health Facility**].

A similar experience was described by a medical doctor who had previously worked in several public hospitals in southern Nigeria and was now a general practitioner in one of the General public hospitals. He mentioned how his colleagues often mocked him.

*"Remain there, and soon retirement age will catch up with you. You will still be here paying rent while those who became doctors a decade after you are now your property owners and even renting their second and third houses"* [**Medical doctor- Public Health Facility**].

In another interview, a junior resident doctor at one of the general public hospitals described several occasions where they were pressured to sign attendance registers for some of their senior colleagues who were absent at work but were working in their private hospitals during official working hours, which in his opinion leads to an unbearable workload for other colleagues in their absence.

*"This is just expected of you to know that you must cover for your oga's [boss] absence even while they are making extra money at the expense of the government and the*

*patients. No one needs to remind you of this rule, as you know the consequences when you do not cover them. Here you will see a situation where there were supposed to be two consultants, 3-5 senior registrars on duty with us, and the junior residents, but you are all on your own. However, the record shows everyone was around, but that is not true; they were not. The pressure to cover them is on you, and the way and manner by how you see all these patients they abandoned is left to you" [Junior doctor- Public Health Facility].*

Other healthcare workers, such as hospital managers and management staff, had also described experiences where they had to yield to pressure from informal rules to get their hospital supplies and procurements approved. They mentioned that even though these were not written rules, they were expected to provide government resources ranging from using vehicles, employing relatives of health officials, collecting per diem for meetings not attended and even putting health officials for overseas training under health facility budgets. It was then left for them as healthcare workers in these public health facilities to retire these expenses through record falsification, like producing fake receipts. An example of pressure from informal rules was shared by an informant below.

*"There is no place where it is written that we are responsible for using the internally generated revenue that is barely enough to keep us going to pay for workshops or conferences for some of these ogas [bosses] in the ministry. These conferences are sometimes even held abroad. Nevertheless, they expect us to do so year in and year out; when we do not, there are repercussions. That is not all the pressure; they expect you to give them ambulances meant for patient use for free and even the hospital buses meant for staff for free so they can convey people to their far away villages when they lose a relative" [Clinical Director at a Public Health Facility].*

A common denominator underlying these experiences suggests that healthcare workers succumb to pressure from other colleagues to engage in such corrupt and related informal practices by exploiting laid-down procedures for personal gains. These practices are often considered part of informal norms in these public health facilities, which are part of the broader culture in Nigeria's public/civil service, from which healthcare workers in the public health sector also derive their ways of engaging. Therefore, the pressured public healthcare workers

fear the repercussion that might arise from other health workers if they do not join the crowd. This analysis suggest that informal behaviours of healthcare workers enhance corruption to thrive, which have negative impacts on patients and healthcare workers who are not powerful or influential.

### **4.3. Impacts of Corruption in Public Health Facilities**

The evidence in this study revealed that the various forms of corruption experienced by patients in public health facilities had a range of impacts, particularly on core universal health coverage (UHC) goals, including equity of access and financial protection. Several patients in these public health facilities suggest that the impacts of these various corruption problems created financial and non-financial barriers to healthcare – aggravating inequities of access. Furthermore, the evidence from the interviews with most patients affected by the impact of the various corrupt practices presented in section 4.2 above also reveals an erosion of the right to health care and patients’ dignity, alongside increase barriers to access- including financial barriers – especially for people of poorer patients. Several of these interviewed patients also suggest that these financial barriers were sometimes catastrophic and impoverishing, impacting other aspects of their livelihoods.

For example, corrupt practices such as bribery and informal payments that relate directly to financial barriers hindered some patients in these public health facilities in Abuja, Nigeria, from accessing some or all treatments needed to attain an optimal health status. In this study, some patients reported that after using their monies to pay bribes or make informal payments, certain aspects of their treatment, such as laboratory tests, prescriptions, and other ancillary treatments, were left unattended due to the shortage of funds having used them to sort demands of public healthcare providers. Some even suggested that they were financially constrained and

left impoverished following such practices. In an interview with one of the patients, she described the impact of informal payments as follows:

*"Because they ask us to pay for everything, including monies that go to their pockets, my husband had to sell all our pigs during my last delivery, which was still insufficient. We were left with no money after having my last child. It was very difficult for us. Even when the baby developed a cough and fever after they discharged us, we had no money to bring my child to the hospital because we had spent everything on those extra payments that were not related to tests or drugs during my delivery"* **[Patient- Public Health Facility]**.

In another interview, an elderly retiree who uses one of the public hospitals described the financial impact of corruption on his health-seeking behaviour.

*"Since my medicines are refilled every 2-3 months when I do not have any problem, I go to the local pharmacy and buy my drugs. If you go to the hospital, even with the suffering and long queues, you will pay for even your card, pay for this, pay for that, pay for everything that we have been told are free by government. Please tell me, where will I get the money? Is it with my pension that does not even come regularly? So, I avoid going to the hospital because of these extra charges and buy my refills from a local pharmacy, except I have serious health issues. However, this backfired once, and I was brought to the hospital almost unconscious"* **[Patient- Public Health Facility]**.

Regarding non-financial barriers to access, the evidence from the interviews of most patients in this study suggest that corrupt practices aggravate the existing barriers to access with increased inequity to access, particularly for those unable to yield to demands made by corrupt public healthcare providers. These impacts resulted in poor health outcomes in several instances, including increased morbidity and mortality in some cases due to poor health-seeking behaviours resulting from the barriers created by corruption. There were instances from the interviews that revealed extreme cases where some patients had to choose which illness to come to the hospital for and which they stayed home due to the fear of being asked to bribe and make informal payments. These patients suggested that making official charges/user fees in public health facilities paved the way for some public healthcare providers to demand other unofficial/extra charges that they strongly felt were not being remitted to the hospital purse. They suggested that they avoid coming to public hospitals because of these extra charges. In

some instances, the illness they had deemed not severe became complicated and even fatal for some of their loved ones including instances where parents lost their children. In some cases, others sought alternative care in local pharmacies, while others chose traditional medicine treatment options due to their inability to pay for the formal and informal charges in these public health facilities.

For example, in an interview, a rural farmer residing in a nearby satellite town described his experience of how informal payments made him lose one of his children due to delayed presentation.

*"I had come with my three children, who were all sick around the same time. I had about 15,000 naira, and the costs of cards had increased from 1000 naira to 1500 naira for each person. By the time we were through from the hospital, I had spent most of my monies with me on several things, and we had nothing much left to buy medications for the children. So, my wife and I decided to use the remaining money to buy the medicines for the two children we thought were sicker and left the older one, whom we felt was not so sick. Five days later, our elder daughter, whom we thought was not so sick, became extremely sick. We brought her to the emergency unit, but she died two days later. We were told she had complications that affected her brain because we brought her in late" [Caregiver- Male farmer].*

In another interview, a retired grandmother nearly lost her youngest grandchild on one occasion while trying to avoid going to the hospital because of bribes and informal payments.

*"Due to the extra unplanned charges, I keep making when I come here, I sometimes use the little money I have to go to local pharmacies to buy medicines for the children rather than come to the hospital. This time, the little one [youngest granddaughter] had an extremely high fever. As usual, I thought it was malaria with all the mosquitoes here in Abuja. I bought her the usual antimalarials from the local pharmacy, but after three days, she got worse and could not swallow or drink anything. I finally rushed her to the hospital and was told her tonsils were swollen. I had never seen her so sick as that, and I was so scared I would lose her. I would never have forgiven myself if, by that delay and self-medication, something wrong happened" [Caregiver/Grandmother].*

In another interview, another caregiver also described the impact of corruption relating to the loss of her dignity.

*"The nurses shout at you when you call for help and ignore you. Even the health attendants and cleaners will shout at you as if you are a child. I think because they know we are poor and have nothing to give them compared to other patients. Each time, we are on admission, the patients whose families are rich and give tips, were treated better, but us, no way. They treat us like we are not human beings. They will sometimes not clean my husband's wounds for days; meanwhile, they will insult us when we complain"* [Caregiver- General Public Hospital].

The evidence above suggested the loss of patient's dignity caused by corruption in public health facilities. This caregiver described that the impact eroded her sense of dignity and that of her husband due to health worker attitudes in their quest to make her and husband succumb to corruption. She revealed that they have been treated with sometimes the harshest behaviours that have stripped them of their sense of worth and dignity in these public health facilities.

#### **4.4. Summary of Chapter Analysis**

The empirical findings in this chapter suggest that from the perspectives of patients, healthcare providers and some health officials/policymakers, corruption in public health sector facilities is driven by a shortage of resources and poor remuneration of public health workers, primarily from chronic underfunding of the public health sector. Furthermore, the commercialisation of health in public facilities in Nigeria, especially with cash payments, and lack of accountability and weak oversight are also key causes of corruption in public health facilities.

The analysis in this chapter suggests that typically in public health facilities in Abuja, there is often a shortage of resources relative to need, leading to rationing of resources responsible for service delivery issues such as prolonged patient waiting times. Therefore, corruption in these public health facilities takes the form of bribes, the use of influence and pressure from informal rules amongst other forms of corruption as presented in *section 4.2*, which encourages patients to circumvent rationing rules resulting in practices such as queue-jumping in public health facilities. It gets even more complicated in a commercialised environment, where other opportunities for corruption are shown to open up due to the loopholes being exploited by

healthcare workers to engage in corrupt practices such as informal payments and theft of approved user fees in these public facilities. Therefore, corruption in public health facilities predominantly manifest through informal payments, bribery, theft of user fees and medical supplies, and influence- activities associated with nepotism.

**Table 4.1: showing causes, manifestations, and impacts of corruption in public facilities**

Manifestations of corruption	Key Actors	Causes	Impacts
Use of Influence (“being connected”)	Patients to healthcare providers	Nepotism	Increased barriers to care for those without “connection”
	External actors (politicians, health officials from ministries and agencies, policymakers) to healthcare providers	Patronage	Inequity of access
		Political Interference	Erosion of trust from patients to healthcare workers
			Differential feeling of preference from patients
Bribery	Healthcare providers demand from patients	Shortage of resources and rationing	Delay of care
	Patients initiate payments to healthcare providers	Circumventing rules	Denial of care
		Queue jumping	Increased financial barriers especially for the poor including catastrophic and impoverishing health expenditures
		Desire for preferential treatment	
		Poor salaries of public health workers	



Manifestations of corruption	Key Actors	Causes	Impacts
Informal payments	Patients to health providers	Commercialisation of health in public facilities	Increased financial vulnerabilities (catastrophic and impoverishing health expenditures)
	Patients and Health workers/managers	Cash based payments	Erosion of trust from patients to healthcare providers
		Poor penetration /deliberate interference of electronic payments	Differential quality of care
		Poor salaries	Delay/Denial of care
Theft (user fees and medical supplies)	Health workers (cashiers, record clerks, pharmacists, laboratory workers, Doctors, Nurses, Healthcare attendants)	Weak accountability structures	Decreased internal revenue of public health facilities
		Poor oversight from health officials/policymakers	Wastage of public resources
		Nonchalance of management and fellow workers	Pressure on the limited medical equipment
Pressure from informal rules	Health workers	Dysfunctional systems in public facilities	Normalisation of corruption/culture of acceptance
			Disregard for institutional rules

As summarised in *table 4.1* above, the empirical findings analysed in this chapter show interesting dynamics worthy of note, which reveals that, although healthcare providers initiate most forms of corruption in public health facilities; however, in some instances, patients are the initiators. In the opinion of these patients, they do this to circumvent challenges associated with the shortage of resources in public health facilities. While some of these practices, such as bribery, informal payments, influence activities associated with nepotism, and theft of formal charges/user fees from public facilities, are straightforward illegal activities, there are other distinct forms of practices which create the enabling environment and lower the threshold for healthcare providers and patients to engage in corruption in these public health facilities.

These practices include pressure from informal rules, and practices that undermine patients' rights and dignity. These groups of practices, when combined, fall under the broader "*corruption complex*", as described by Olivier de Sardan (Olivier de Sardan, 1999).

The impacts of these corrupt practices in public health facilities in Abuja are far-reaching. The evidence in this chapter reveals the erosion of the right to health care and patient dignity, alongside increased barriers to access- including financial barriers – especially for poorer patients as impacts of corruption in public health facilities. The analysis also shows that these corrupt practices sometimes result in poor health outcomes due to delays in or denial of care and challenging patient choices, often affecting their health-seeking behaviour.

In conclusion, the evidence presented in this chapter revealed the dynamics and intricacies backed by contextual insights on how and why several corrupt practices manifest in the manner they do in public health facilities, including their impacts on patients. In doing so, this chapter lays a foundation from the public sector component that is needed for the empirical analysis in chapter six, which focuses on the public-private mix interaction, and the extent to which corruption is enabled by the existence of and interactions between public and private facilities as it has provided insights of corruption from the public health sector facilities.

## Chapter Five

### Corruption in Private Health Facilities: Patients' and Providers' Experiences

#### 5.0. Introduction

This chapter builds on the preceding chapter by presenting empirical evidence of how and why corrupt practices manifest differently in private health facilities compared to the predominant forms revealed in public health facilities in chapter four. Furthermore, the findings from this chapter and that of the preceding chapter provide the background and foundation from which chapter six of the thesis, which deals with the public-private mix in health systems and how private health facilities interact with public health facilities in Abuja, Nigeria, to enable corruption in the views of patients and providers, is grounded. Therefore, in order to contribute to this public-private mix regarding corruption, we need to understand how the causes, manifestations, and impacts of corruption in private facilities, which we know very little currently in the scholarship, differ from those in public health facilities. This forms the basis of this chapter and serves as a key contribution of this study to the scholarship.

The analysis in this chapter is structured under three sections. *Section 5.1* presents the causes of corruption in private health facilities in Abuja, Nigeria, from the perspectives of patients and healthcare providers interviewed in this study. *Section 5.2* presents the various manifestations of corruption in these private health facilities. *Section 5.3* presents the impacts of these various forms of corruption and related practices on patients in private health facilities in Abuja, Nigeria.

## **5.1 Causes of Corruption in Private Health Facilities**

The underlying factors that emerged as drivers of corruption in private health facilities following in-depth interviews with patients, healthcare providers and health officials/policymakers in this study included: incentives aimed at profit maximisation, and poor regulation and lack of oversight on private health facilities in Abuja, Nigeria. The evidence suggests that these factors acting singly or combined create an environment for covert practices, which were sometimes corrupt and often had the support of the management of these private health facilities, to compromise the interests and well-being of patients in these private facilities for financial gains.

### **(a). Incentives related to Profit Maximisation**

The findings in this study reveals that incentives aimed at profit maximisation for private health facilities including individual financial gains for healthcare workers working in private health facilities is a leading cause of corruption in private health facilities in Abuja, Nigeria. The evidence also suggests that this factor is largely responsible for why and how corrupt practices manifest in the manner they do in private health facilities, as presented in *section 5.2*, compared to the forms of corruption presented in public health facilities in chapter four of this thesis.

In this study, the evidence suggest that the for-profit nature of these facilities serve as one of the primary incentives driving corrupt practices, as several of the private healthcare providers mentioned that they were made to follow operational guidelines and procedures by the management of the private facilities where they worked and whose top priority was to generate revenue using all means necessary. Several interviewed private health workers suggest that the culture in these private health facilities was to cut down operation costs by any means necessary while engaging in sometimes corrupt practices that boost profit at the expense of the patients interests and wellbeing.

For example, in an interview with a medical officer in one of the private hospitals where this study occurred, she described that the "fee-for-service" payment system, in her opinion, was an example of a system structure that breeds corruption in private health facilities in Abuja, Nigeria. She suggested that the amount of profit made was largely in part only feasible through such enabling practices.

*"From my experience here in the last three years, one clear example of an incentive used is the fee-for-service payment system. Because the hospital is paid for each service we provide and to make so much money from patients and their insurance providers, we are explicitly instructed to over-treat or offer unnecessary treatment to patients with sometimes cheap generics billed at higher costs. I can tell you the sole purpose for such incentive is to make more profit for the hospital and not really about the patient"* **[Medical officer- private hospital]**.

Other findings from the interviews conducted in this study also revealed instances such as the employment of unqualified personnel, for example, the employment of auxiliary nurses in some private health facilities where the incentive for such decisions is to pay lower wages while maximising profit.

*"The issue is that patients are deceived by hospital management into expecting a superior quality of care by paying higher prices and then only to be taken care of by auxiliary nurses who learned on the job but are without any formal nursing training in a bid to cut costs. In my opinion, this system breeds corruption in disguise, which might differ from what causes corruption in government hospitals. However, to me, this system cheats on patients, and what can one call such other than corruption?"* **[Medical officer- private hospital]**.

Other interviews with patients regarding incentives aimed at profit maximisation had them describe the following.

*"They knew they did not have the expertise to treat my chronic condition, but they kept using every tactic possible like non-stop referral to various doctors in this same hospital to milk me of all my resources just because they want to make money out of my unfortunate condition"* **[Patient- Private Health Facility]**.

*“Here, in order to drain me (money), they kept giving me follow up visits and several forms of laboratory investigations which in my opinion was not necessary. But with each visit I have to pay, therefore this was an incentive for them to keep me and my family using this hospital even when there is no need” [Patient-Private Health Facility].*

This evidence described above from interviews with patients and providers in private facilities revealed that these private health facilities use several disguises as incentive to make profits off patients through practices such as the use of underqualified health professionals, over treatment, over referral and follow-ups. These bad incentives often continue unabated due lack of proper oversight in these private health facilities which is presented next.

#### **(b). Poor Regulation and lack of Oversight on Private Health Facilities**

Another theme that emerged as a driving factor for corruption in private health facilities from the interviews with health officials/policymakers is the poor regulation of private facilities in Abuja, Nigeria, with a consequent lack of regulatory oversight and enforcement. The findings in this study suggest that private health facilities are poorly regulated, often with no enforcement of standards. These health officials mentioned that the number of private health facilities across the breadth of Abuja outweighed the number of public health facilities. These health officials further suggested that they were already lagging in oversight functions in public health facilities and talk more of private health facilities where oversight activities were rarely even budgeted for by the government. In their opinion, without adequate regulation of the private health sector in Abuja and the rest of Nigeria, private health sector facilities were left to operate without adhering to ethical guidelines and professional standards, creating a fertile ground for greedy practices that compromised the interests of patients.

Furthermore, the poor regulation and lack of oversight in these private health facilities created an enabling environment for private providers to engage in some forms of corruption that were

often covert and ingrained within regular service provision, sometimes making it difficult for patients to differentiate what is considered corrupt from regular private service provision. These health officials/policymakers also revealed that because most patients knew that private health facilities in Abuja and several parts of Nigeria are poorly regulated, they found it easier to ask private healthcare providers to engage in certain unethical and corrupt practices that benefit them but were often illegal, such as forging/falsification of medical reports which are presented in *section 5.2* under the manifestations of corruption in private health facilities.

For example, in an interview with one of the health officials in the ministry, the informant said the following:

*“You would not believe that due to lack of budget in my own division we have not gone for any oversight that include private health facilities in this city in over 2 years. Therefore, these private hospitals are just left on their own to do whatever they like, and would you blame them? That is why you get all sorts of complaints that the facilities there are not up to standard, and personnel are sometimes not even licensed, yet we are told they charge patients and arm and leg” [FCTHA official].*

Furthermore, the interviews revealed cases where due to lack of regulation of the private health system including lack of oversight visits, sometimes lasting several months to years, unqualified healthcare professionals across several cadres of staff were providing services in private facilities when they were not licensed to. Therefore, they lacked the requisite skills and ethics for providing such specialised services.

*“In one of our only visits to private hospitals here in Abuja in over 3 years, what my team and I uncovered was quite alarming. These means all these things have been going on unregulated. These private hospitals rely on the fact that we do not regularly review them compared to public hospitals. Several of their staff were unqualified, and they called them auxiliaries with no formal training. This practice has since been banned many years ago, but these private hospitals still keep auxiliary staff. For example, the auxiliary nurses have no formal nursing training. Some of them were cleaners, cashiers, and record clerks; they made them axillary because they had been assisting nurses over time. These people do not understand*

*some vital ethical and professional conducts, but because of poor oversight, they were hired, and these same people will treat patients at very huge costs" [Nursing official at the Ministry of Health].*

In another interview with an official of the Association of General and Private Medical Practitioners of Nigeria (AGMPN), he described the danger patients face from quacks who call themselves private medical practice owners. He described his recent experience as part of a task force with the health ministry officials and law enforcement agencies, where they cracked down on some private health facilities.

*"In one of the places [private health facility] we went, the owner of the private health facility was not even a qualified medical doctor; he was a laboratory technologist. In another place, she was a nurse and not a doctor. These people are not licensed by law to own a hospital. There were several such places busy proliferating around Abuja. It is worse when you leave Abuja city and head towards the rural settlements" [AGMPN Official].*

The evidence in this study shows that there is no oversight to reduce the incentive to maximise profits through quarterly visits by health officials, yearly accreditation visits by regulatory bodies, ensuring that laboratories and theatres are up to standard, and well-trained health workers are employed. Profit-maximisation in the context of information asymmetry between providers and patients, and a lack of effective regulation, and or regulatory enforcement, leads to significant quality-shading and patient exploitation. Therefore, the evidence suggests that either acting singly or in combination, incentives aimed at profit maximisation, poor regulation and lack of oversight drive corrupt practices as they occur in private health facilities in Abuja, Nigeria. These manifestations are presented next in *section 5.2*.

## **5.2 Manifestations of Corruption in Private Health Facilities**

Four major themes associated with subthemes emerged as forms of corruption that predominantly occur in private health facilities as revealed from the in-depth interviews with



patients, healthcare workers, and health officials in this study. Almost all the informants in this study who experienced these practices suggested that it was mainly in private health facilities. The manifestations of these corrupt practices included the following: (i) over-invoicing, insurance frauds, and other-related invoice frauds, (ii) Forging/falsification of medical reports (iii) Inappropriate prescriptions with the potential for kickbacks, (iv) Over-referrals/over-treatment and under-provision of health care.

#### **(a). Over-invoicing, insurance frauds, and other-related invoice frauds**

This group of practices emerged as a recurrent theme from this study and were revealed from interviews with patients and healthcare workers, including those working at payment points and insurance desks of these private health facilities where the study took place. The manifestation of these corrupt practices was more predominantly occurring in private health facilities in Abuja for several reasons.

The findings suggest that this group of practices often involve the knowledge and backing of the owners and management of these private facilities. Compared to other corrupt practices where individual healthcare workers engage in them discreetly, often away from the eyes of the management for their individual kickbacks, the evidence here suggests otherwise. Here, this group of practices seem well established into the fabric of these private facilities where the staff are being trained to accept these insurance fraud practices as a usual way of increasing revenue for the private health facilities.

*“Some key people here have asked me time to time to add more people whether real or fake names to the health insurance lists from government parastatals so that the monthly returns to the hospital for National health insurance is markedly increased”* [**Insurance desk officer at a Private Health Facility**].

The health insurance-related fraud found in this study included various practices perpetrated by healthcare providers but often patients as well to rip off the health insurance system through corrupt practices, aiming to increase financial gains for either the private health facilities themselves or for patients trying to avoid paying for relatives not covered by the scheme. These practices ranged from double billing and inflating of bills, over-invoicing, billing for services not provided, medical identity fraud, ghost patients, self-referral, collusion with providers and kickback schemes, and patient data manipulation. The evidence from the interviews suggest that this is a significant problem with private health facilities in Abuja compared to public facilities because there was less incentive for the management of public health facilities to create the avenue for this group of practices to thrive as the insurance companies pay the claims straight into the central government coffers.

In contrast to the views presented by patients and some medical staff of these private facilities, the management staff and senior providers suggest otherwise. They believed instead that private health facilities were the hardest hit by some of the deceitful and unlawful practices of patients relating to the use of health insurance schemes. Notably, their emphasis was on *medical identity theft or fraud*. Medical identity fraud refers to the practice of patients defrauding the health system by using the identity of others to receive services they were not entitled to. These management staff insist they often lost substantial revenues by the refusal of organisations and their insurance provider companies to reimburse them for services they have provided to patients who used identity theft to seek services for relatives and friends who were not entitled.

Regarding patients' experiences, the findings reveals that some of these practices such as over-invoicing often go on for a long-time without patients knowing. Some of the patients revealed that it was only brought to their attention by their Health Maintenance Organisations (HMOs) and their employers during quarterly or annual medical audits where they were queried about

exceeding their health insurance package limits. They suggested that it was only after such queries that, on further scrutiny, they detected such practices as overbilling and other fraud issues, which were often challenging to identify because these expenses had occurred several months before their attention was brought to the issue.

*"Even though I must admit that my family's bills are usually high due to my daughter's health problems, this year's bill was just way off the roof. How is this justified? Because they [the hospital] think I work for an oil company and I am not paying from my pocket, it was an opportunity to rip off my company. Moreover, we talk of corruption in government, but the private sector is sometimes part of the problem. Several times I noticed that they billed me twice for the same thing, and in other instances, they had charges on tests that neither myself, my wife, nor my daughter ever did. Hospital admissions that we stayed, for 10 nights, they billed us for 14 nights. The prices of some drugs and tests were out of this world, like 5 times their original costs. To me, such practices are fraudulent and plain corruption in my opinion"* **[Patient- Male oil worker at a Private Health Facility].**

In another interview with a patient working for one of the telecommunication companies, the informant said the following:

*"The cost of medicines in this place is outrageous. Often than not, they will sell you a very low-quality drug for the cost of a branded drug and even that they multiply it by 5 times. On several occasions, they even billed me for services not provided. For example, on one occasion, they billed me for a pap smear test [cervical screening], which was never offered to me and, even worse, was costing over 35,000 naira for a test usually done between 7,000 - 10,000 naira. I found the act of over-invoicing and false billing ridiculous"* **[Patient- Female Telecom worker at a Private Health Facility].**

Similarly, in an interview with one of the front desk staff who worked as a billing staff in one of the private hospitals, she suggested that health insurance-related malpractices do occur but that the hospital management often tells them it is not what patients claim and that it is complex and part of the business operations. In describing how the hospital management gets them to engage in such practices, the staff mentioned tactics such as manipulating the patient data to increase the number of patients under the federal government's National Health Insurance

Scheme (NHIS) in order to receive higher capitation each quarter. She also mentioned other practices like ghost patients.

*"I have been asked several times to increase the number of people using health insurance from government ministries so we can be paid higher capitation. By substituting names easily and leaving those who have retired still on our list"* [**Billing staff at a Private Health Facility**].

In another interview with a medical officer in one of the private hospitals, he described his experience where he and his colleagues had been asked to engage in several tactics that would increase the hospital's revenue through overbilling and invoice manipulative malpractices.

*"I have been told severally to increase the length of stay of patients on admission here even when clearly, they had no business remaining on admission so that we can bill them for those extra days. Sometimes, there was no basis for them to be admitted in the first place as they would have done well on outpatient treatment. Nevertheless, the directive is to admit them if they are health insurance clients from big corporations. To worsen the issue, I am asked to request a barrage of investigations even when not needed to justify the large bills"* [**Medical Officer at a Private Health Facility**].

In a similar interview with a pharmacist in one of the private hospitals, she also described her experience with health insurance malpractices as one in which the patients rarely even understood what was happening.

*"What can little me do? It is a directive, and you either carry out such instructions from the head of the pharmacy unit or risk losing your job. I am just eight months here, but this is how I met them operating. We often give patients cheaper generic drugs made in India, Pakistan or China and then charge their retainers the cost of brands from America or Europe which are very costly. The margins are not comparable. In some instances, where the patients are very enlightened and insist on branded drugs and when we do not have such drugs, we ask them to come back or wait while we quickly buy them at private pharmacies to allow us to inflate the prices. In such situations, we make sure we get a huge margin"* [**Pharmacist at a private health facility**].

As earlier highlighted, a major category of health insurance-related malpractices complained about by healthcare providers in these private health facilities described as often perpetrated by patients is medical identity theft or fraud by patients and their relatives while seeking care

in these private health facilities. These private healthcare providers highlighted this corruption problem as an issue of concern because they feel that private health insurance companies, the government and themselves are ultimately being short-changed as they are being defrauded through extra payments for people not catered for the scheme.

*"Every day, we see people coming for treatment when they are not members of that family covered by the National Health Insurance Scheme. The law says a man, his wife and not more than four children. Nevertheless, they bring extended relatives and sometimes nonrelatives claiming they are part of the cover. Digging deeper, we find that the scheme does not cover them. Some even call you names as being wicked if you deny those not covered by the scheme. In fact, on several occasions, some patients have told my staff or me that the government is the one paying, so what is our business? Some go as far as challenging us with abusive statements such as "na your papa money we dey use?" [is it your father's resources we are using?]"* **[Medical doctor at private health facility].**

*"As a private healthcare provider, we encounter patients daily trying to game and cheat the health insurance companies they use for services with their prescriptions. I have had experiences of patients with an adult prescription where in between, there is a buried prescription for a child or a different person unrelated to the person being seen. I have seen several prescriptions for an adult hypertensive that contained children deworming drugs or other syrups for children. I have also had situations where a child's prescription contained drugs for adult diabetics. When I investigated, the child's mother confessed that the diabetes drugs were for the child's grandmother, whom the insurance did not cover. This practice was done with the connivance of the medical doctor who prescribed those drugs"* **[Pharmacist at Private health facility].**

These findings above suggest that these fraudulent acts where patients use the identity of others to defraud the NHIS or private health insurance providers put an unnecessary strain on the health insurance system. On the other hand, some of the doctors interviewed in these private health facilities highlighted that they were often under pressure from patients or staff of their facilities who are connected to these patients to allow such fraudulent practices.

*"One of our nurses has refused to talk to me or even answer my greetings simply because I refused to see an elderly woman whom the NHIS did not cover. She suggested I was being difficult and not kind. Despite my explanation, she still took it very personally"* **[Medical officer at Private health facility].**

The various manifestations of this group of corruption problems again showed that institutional architecture and incentive regimes are cardinal to the occurrence of these practices in private health facilities in Abuja. In private health facilities, the evidence presented in this thematic section shows that this group of practices was predominant because it was easier for workers to engage in insurance fraud, such as over-invoicing and data manipulation, to receive higher capitation than the actual value for patients seen because they had the support of the hospital management. After all, the management of some of these private health facilities enabled these practices to thrive as part of regular operations with the sole incentive of gaining higher profit for their businesses. In the process, healthcare workers feel free to capitalise on this enabling environment to engage in other practices that might benefit them personally. Similarly, in the event of medical identity theft, the health system itself is at the receiving end of this corruption problem through unaccounted users, as in this case, patients are the ones who rip off the health system, be it the private health insurance or the government's National Health Insurance Scheme which private providers also participate in.

#### **(b). Forging/falsification of medical reports and certificates**

This corrupt practice emerged as a recurrent theme from the interviews with several interviewees in the study relating to health service delivery in private health facilities in Abuja, Nigeria. The evidence in this study suggest that this practice is a typical example of a corrupt practice where the evidence in most of the cases reveals that patients and their care-seekers initiated the corrupt practice. Most of the interviewed healthcare workers in this study suggested that patients and their relatives approached them to engage in authoring forged medical reports for numerous reasons that was beneficial to those patients. Similarly, some patients interviewed in this study did admit to having engaged in such practice or know

relatives or friends who had approached healthcare providers in private health facilities to author falsified or forged medical reports for them or their loved ones.

Forging/falsification of medical reports in this study, refers to unethical and illegal practices where healthcare providers, often medical doctors, provide patients or their relatives with medical reports and certificates for a fee or “in kind” incentive with the healthcare provider and the patient both knowing the report is falsified. The forged report is often issued to mislead relevant authorities to whom the reports or certificates are being issued to. Although the evidence in this study found that this corruption problem was a practice that often occurred between medical doctors and patients because of the virtue of medical doctors being allowed by law to author medical reports, the processes leading to such practice can, in some cases involve other healthcare workers who serve as an intermediary between the patients requesting the forged reports and the physicians authoring them. These health workers include record clerks, healthcare attendants, nurses, and hospital managers who play separate roles that aid and sustain this corrupt practice in these facilities.

Irrespective of the reasons provided by both healthcare workers and patients/care-seekers for engaging in this corrupt practice, the findings in this study reveals that monetary incentive for healthcare workers is the most common underlying factor which allowed this practice to thrive in private health facilities in Abuja. Another reason suggested by the evidence in this study why this practice occurred easier in private health facilities was the poor regulation and oversight of private health facilities with no checks from regulatory authorities on such authored fraudulent reports that are often untrue. Similarly, the evidence also suggests that the institutional structure of private health facilities in Abuja had fewer hurdles and obstacles to overcome by both patients who initiate the practice and healthcare providers who agree to engage in this practice in exchange for financial reward.

In interviews with some hospital managers in the private hospitals where this study took place, they described this corrupt practice as often exclusive to doctors who engage in it for personal financial gains. In one of the interviews, a hospital manager at one of the private health facilities described how they have had to sanction some of their medical doctors because of the falsification/forging of medical reports. He mentioned they have a reported case of a forged medical certificate, which the hospital forwarded to the Medical and Dental Council of Nigeria and the Nigerian Medical Association for medical investigation.

*“One of the doctors allegedly issued a forged medical report to a male youth Corp member to help him deploy back to Abuja from one of the northern states. He paid the doctor sixty thousand naira, but it did not work out for some reason. The Corp member reported the incident to the hospital authority” [Hospital manager- Private health facility].*

In another interview with one of the hospital managers, she described a case where they terminated one of the medical officers who issued a forged medical report for a female Corp member to help her redeploy to Abuja from one of the rural places where she was posted for the compulsory paramilitary National Youth Service Corp (NYSC) program in Nigeria.

*“What makes this more serious is that we had to fire this doctor as the lady who asked for the forged certificate labelled a complaint that she paid the favour done to her in-kind (sexual favour). However, the authorities would not accept the medical report as they said it came from a private hospital and will only accept medical reports from government-recognised hospitals. It was based on that she complained to us” [Hospital manager - Private health facility].*

However, the views of doctors' interviewed in these private health facilities regarding this corrupt practice vary. Some insist that the pressure often comes from patients, their relatives or colleagues at work who put so much pressure on them to assist patients rather than for their own financial gains as doctors. In an interview with a medical doctor at an outpatient clinic of one of the private hospitals in this study, he described his experience and those of his colleagues



regarding the forging of medical reports and why they had no choice but to give in to this corrupt practice.

*"Each time I had to issue such a report, patients approached me. They give many excuses, such as pressure at work and why they needed the medical report to get a few days of sick leave. Of course, they are not sick and want some days off work, while others want to change their working unit into a less stressful unit. Do you know I have had parents come to my clinic crying and pleading for me to issue their children with medical reports to say they have an illness so that they will avoid being posted to other distant parts of Nigeria for the National Youth Service Scheme? [compulsory paramilitary posting]. These parents are worried due to the insecurity problems in Nigeria. What do you do in such instances? It is a big challenge, so one yields to such pressure and not always because of monetary gain"* [Medical Officer at a Private Hospital].

In related interviews where patients' perspectives were sought, some agreed that the falsification/forging medical reports is a prevalent corrupt practice based on their individual experiences or those of their relatives and friends. Interestingly, most of the patients also corroborated the narrative of medical doctors that, in several instances, they, as patients, initiated the request for healthcare providers to provide them with forged medical reports. However, most of these patients also insist that the system left them with no alternative but to resort to such a practice to survive in a country with several challenges. They suggested that they had genuine reasons each time they or their relatives have had to make such requests.

*"Have you not seen the killings of Youth Corp members by Boko Haram terrorists, especially in the north-eastern part of the country? Let those who want to sacrifice their children's lives allow them to go to such places. Would you want me to fold my hands and lose my only daughter to a country that does not care? If anyone likes it, they should call this corruption, I do not care, and I will repeat it. I paid 70,000 naira to get the medical report from a doctor, and it was worth the price to have my only child close to me where there is some form of security here in Abuja"* [E.T- Patient's mother at a Private Hospital].

*"If you ask me, I will repeat this action again and again. Why wouldn't I? A job that does not care about your well-being and wants you to keep working like a slave from morning to night, sometimes including weekends. I have had miscarriages twice due to stress. I had enough, and this time I told the doctor to give me a medical report. Even though he said he could not give a justifiable medical reason, I told him to make one up so I could be on bed*

*rest at home for several weeks to avoid the stress from my work in the bank"* [Patient C.K. at a Private Hospital].

The evidence in this study reveals that these falsified medical reports and certificates are often prepared, signed, and issued by one person or, at best, two persons. In contrast, in public health facilities, you will need more persons other than the doctor. It sometimes requires signature from heads of units and official stamps from department secretaries. Therefore, the institutional set-up and barriers in private health facilities allow for more effortless engagement in such a practice than the multi-layered barriers in public health facilities, which do not allow discreetness seen with private health facilities. The evidence suggests that these practices were easier to engage in private health facilities because the checks and balances were fewer in private hospitals.

However, despite the evidence that multi-layered barriers are fewer in private health facilities, making it easier to engage in such practice, there were instances worthy of mention in these private health facilities where this practice occurred through a “cartel-like” network in some of these private health facilities. For example, a senior physician in one of the private health facilities sums it up below.

*"We are aware of cases where supposedly middlemen outside this hospital approach other health workers or doctors directly on behalf of patients to help them buy falsified medical reports. Some of these patients are not even registered with our hospital. For example, there was this case where the middleman as I like to call them for no better description, approached a nurse and a record clerk who in turn approached one of the doctors with a bribe to secure a medical report for someone not even registered with us to get a medical visa to travel to Canada"* [Senior Physician- Private health facility].

In another interview, one of the hospital managers also suggested that this practice is organised in a cartel like manner. He is quoted as saying:

*"We have had instances where non-medical doctors such as pharmacists, laboratory personnel, nurses and even security guards forged medical reports for a fee to help patients game the system"* [Hospital Manager - Private health facility].

Similarly, in another interview with a medical officer in one of the private hospitals, he described the pressure he and his colleagues sometimes receive from patients, his superiors and other hospital staff to issue forged medical reports and certificates to patients.

*"This is one aspect of this job in private hospitals in Nigeria that overwhelms my colleagues and me. The patients always approach us begging, sometimes even crying, that they need these reports for one reason or another. How long can you say no when bombarded left, right and centre? The intense pressure to issue these reports is enormous. Sometimes it is even your ogas [bosses] that put you under this pressure, and sometimes your other work colleagues. In the end, you must give in, and when you look at it, if you are giving in, then why not just collect the monetary gain that comes with it, so you know that you did not do this for nothing"* [Medical Officer- Private health facility].

This research also revealed the views of health officials from the supervisory health agencies for health facilities in Abuja. In one of the interviews with a director at the health ministry, he agreed that this corruption practice was becoming a menace and described how the government is working hard with other relevant regulatory bodies to ensure appropriate sanctions are meted on erring doctors or healthcare workers engaging in such a practice.

*"I can tell you that we are getting increasing cases of forging of medical reports, particularly from private hospitals in Abuja. Moreover, even though they are private hospitals, we still oversee their activities. We need to increase our supervision of these private hospitals because the issue is worse with them, and I think the lack of adequate workforce to supervise them since the small number of staff we have are already overwhelmed with the public hospitals, is part of the problem; I can tell you this. It is all about greed and quick money for these private hospitals people. If not, why would those in private practice who earn higher wages than those in public hospitals be engaged in such acts? What is the excuse for these doctors in private practice other than pure greed?"* [Health official & Director at Ministry of Health].

The evidence analysed under this theme – *forging/falsification of medical reports* provides empirical evidence that certain forms of corruption breed easily as a problem in private health facilities in Abuja. Here, several of the patients mentioned that they knowingly avoid public

health facilities in Abuja when it comes to such practice but prefer to go to private health facilities, which they find much easier to engage in such fraudulent and illegal activity. However, this is not to say that this practice cannot occur in public health facilities, but in this study, the evidence suggests that it is predominantly a problem in these private health facilities in Abuja due to several of the reasons highlighted. The evidence in this study also suggests that this form of corrupt practice is one where patients were often the initiators compared to other corrupt practices where healthcare providers often initiate. In this case, in addition to the financial incentives for healthcare workers in private health facilities to engage in such a corrupt act, this practice was more prevalent in the private health facilities due to the institutional architecture of the private health facilities in Abuja which has fewer barriers, making it easier for involved workers to perpetrate such an act.

### **(c). Inappropriate prescriptions with the potential for kickbacks**

Inappropriate prescription as adopted in this study refers to prescriptions made by healthcare providers to patients without proper justification as stated in medical guidelines, including prescriptions that do not consider patients' interests but are usually driven by interests such as the promotion of medicines for drug companies with accompanying financial benefits (Garuba, Kohler and Huisman, 2009; Kpokiri, Taylor and Smith, 2020). On the other hand, Kickback refers to an illicit payment made to an individual in return for facilitating a transaction. Inappropriate prescriptions in this study on corruption excludes wrongful prescriptions seen in cases of misdiagnosis or medical negligence, which are outside the scope of this research, and whose focus relates to wilful engagement by healthcare providers in such practices for financial rewards.

Several informants in this study, including patients and healthcare workers, identified inappropriate prescriptions with the potential of kickbacks as a recurrent corruption problem

in Nigeria. Although this corruption problem can be sector-wide, in this study, the interview findings from most patients using private health facilities and several providers identified this as a common problem in private health facilities. In the context of this study, as it will be shown, the evidence suggests that this practice occurs easily in private health facilities because it is allowed as an integral part of regular prescribing. Compared to the public sector, where such potential for kickbacks is to individuals, the evidence shows that private healthcare workers and private health facilities stand to benefit financially. The findings suggest that the private facilities benefit in terms of profit margin, hence, their support. Therefore, the scale of the problem in this study showed its common occurrence in the private health facilities where this study was carried out.

*“From my first week here (name redacted), it was very clear to me that we are being made to understand that we should prescribe the most expensive brands first even when cheaper generics could do the magic”. A common phrase used here is- ‘this is not a government hospital’. I understand that to mean more money comes from expensive prescriptions. But the issue for me is these ailments could have been sorted with cheaper generics. Unfortunately, the patients suffer the financial consequences”* **[Medical Officer- Private Health Facility]**.

*“Immediately after my orientation here, you would not believe it, but in my first 2 weeks, virtually every day, I was scheduled by the hospital to meet with pharma representatives from different companies to introduce me to their brand names. Where I was coming from where I did my internship in the federal government teaching hospital, we only prescribe by generic name and not brand/trade name. The pharma representatives ended each meeting with a promise that for every prescription, I will be rewarded at the end of the month. Our hospital will also make higher margin as well* **[Medical doctor- Private Health Facility]**.

The evidence in this study reveals that receiving financial/non-financial incentives from pharmaceutical companies and commission-based incentives from diagnostic facilities were highlighted by several informants as a reason for private healthcare providers engaging in this corrupt practice. This practice was more prominent among medical doctors, pharmacists, and laboratory technologists, and the evidence suggests that it is accepted as a typical business

approach in private health facilities because the management of most of these private health facilities allow such practice to occur in tandem with their regular prescription services. Some health provider informants felt that the practice often takes place as part of the hospital's agreed business plan to drive their commercial interest and boost their profit through prescribing of expensive drugs, and in the process, they often look the other way around as healthcare workers potentially receive kickbacks from pharmaceuticals for prescribing.

*"The margin is quite high with branded drugs, so the management has decided to ensure we stock our internal pharmacies with some of these brands. Doctors are encouraged to prescribe the high brands to mainly our premium clients, where money might not be a major issue. Their organisations or health insurance companies are paying some. So, it is not a big deal for such patients. It is not true that it is what we can get as individual doctors is the motive behind branded prescriptions. Some patients sometimes specifically ask for these branded medicines" [Consultant physician at a private health facility].*

In relation to the opinions of patients' regarding this corruption problem, the evidence suggests that they had limited knowledge regarding the direct evidence of the "kickbacks" that follow such inappropriate prescriptions. Instead, most were allegations or rumours that kickbacks were paid. This point is in keeping with Blundo and Olivier de Sardan's (2006) argument that sometimes most of the corrupt practices seen in the "corruption complex" have been reduced to rumours (Blundo and Olivier de Sardan, 2006b). Several of the patients interviewed, especially the less educated and poorer patients, did not even recognise if they had been given inappropriate prescriptions. Their limited knowledge made it difficult to know if a prescription was inappropriate. These patients suggest that the reason for such is because the doctor had the ultimate decision on what is prescribed to them, and therefore, they often assumed it was the best drug for their treatment, even if it were too expensive. For patients who recognised when inappropriate prescriptions were given to them, the evidence suggests that they were more educated and economically empowered, and others had some form of medical knowledge. The

evidence in this study also shows that even the more educated patients sometimes found it difficult to decipher when they have been prescribed a drug inappropriately due to the information asymmetry in health care. On the other hand, the interviews with healthcare workers and health officials did provide more empirical insights into the evidence of accompanying kickbacks and other benefits given to healthcare providers by pharmaceutical companies to engage in such practice.

In relation to analysis of patients' experiences regarding inappropriate prescriptions in private health facilities, the evidence reveals several occasions where patients were prescribed expensive medications, which in their opinions were not justified. The evidence further suggests that although the management of these private health facilities wanted these drugs sold inside their facilities, so they make a profit as well, however, in the instances where they did not have these drugs, patients were directed to private pharmacies outside the hospitals who had “connections” with the hospital. These patients claimed that, in most cases, they were told by the healthcare providers that these branded drugs were superior to generic drugs, even when this might not be the case. For example, in an interview, one patient narrated at one of the private health facilities where she had encountered pharmaceutical representatives marketing their drugs to doctors, and after that she felt, her prescriptions were changed to a more expensive brand without an explanation.

*"There was no test carried on me to show that my former medicines were not working, and I was feeling just ok, but one day my doctor changed me to this expensive drug and said it was branded. He said I would do better on the new expensive drug. He even directed me and gave me the contact of the sales representative that could get me the drug. When I showed my daughter, who lives in America, she said this was a new drug in the same class of drugs as the one I was on before. She also wondered why I was changed to this current drug. This new drug cost me 22,000 naira more every month, and even though my children pay for it, it was still too expensive"* **[Patient- Elderly Male Retiree- Private health facility].**



In another interview with a caregiver and a mother of three, she also described her experience with doctors who had prescribed expensive antibiotics for her children only to be reviewed during follow-up by another doctor and be told that there was no need for these antibiotics in the first place. She was told that her children would have still done well on far cheaper generic antibiotics compared to what she was prescribed.

*“One of my children was sick with a throat infection and was prescribed an expensive antibiotic. I remember the doctor saying this is a branded drug and will work faster. The next time I went to a government hospital to see a specialist this time around with my child, upon review of my child’s past medical history, the doctor in the government hospital wanted to know if I requested the drug myself or if my child had taken similar classes of drugs and it did not work before, I was given that expensive brand of drug. He told me there was no need to go straight to that 3<sup>rd</sup> generation of antibiotics when the older generations, which were cheaper, could have still been effective. That drug cost me over 18,000 naira and was quite expensive. I was upset when I found out”* **[Patient- Mother of three at a Public Health Facility].**

The findings also reveal that not only was this a recurrent experience with doctors who prescribed these medicines, but they also had experiences that showed the role of pharmacists and nurses in propagating this practice. Some patients revealed that their prescriptions were inappropriately changed by pharmacists and nurses, often to more expensive brands that differed from what their doctors initially prescribed. In an interview, a patient described an experience where a medical doctor had prescribed a particular antibiotic for him but was changed to a more expensive antibiotic by the pharmacist, which in retrospect, he felt was done to promote a drug that had been marketed to this pharmacist by pharmaceutical representatives.

*“My cousin works as a nurse here, and that is how I got to know why he [the pharmacist] changed my prescription. She told me that these drug companies advertise these drugs and often convince doctors, pharmacists and even nurses to make sure they prescribe these branded medicines. In return, they get a cut [kickbacks] from the pharma representatives for each prescription. I was shocked that they changed the drug written by the doctor who saw me. My cousin mentioned that the doctor was new and did not fully understand how these things operate here and that I should not be surprised if next time he too prescribes expensive brands for me”* **[Patient- Private Health Facility].**



In another interview, the informant described her experience concerning kickbacks from pharmaceutical representatives to doctors and the pressure on these doctors to prescribe their medicines at all costs.

*"They do it blatantly in front of your eyes. You meet the pharma representatives or private laboratory people with their flyers in this private hospital, speaking with the doctors. Next, you are asked to buy those same drugs, sometimes unavailable in the hospital. When they are unavailable, they ask you to come back the next day, even when you are very sick, so they ensure you buy from this hospital and not outside. They would have bought these drugs outside and marked the price by then. I must tell you; this drug was costly and scared me from coming here. Only they [health providers] can tell you why they insist on a particular type. They assume we do not know anything, but I can see these sales representatives persuading them in their clinics, and we bear the cost" [Patient- Private Health Facility].*

In relation to healthcare workers' experiences, the evidence from the interviews with private health providers revealed mixed experiences. While some healthcare workers, such as nurses and other support staff, described this as a corrupt practice, only a few doctors agreed that this was a corrupt practice. Instead, several doctors suggested that patients often misinterpreted the situation and did not have complete insight into why specific prescriptions were made due to their limited knowledge of the subject matter. The interviewed doctors suggest that the issue of drug prescriptions is often complex and is the physician's prerogative to decide which specific drug or test best suits a patient and is rarely about the most expensive brand nor is it about the potential of kickbacks.

In contrast, a few other healthcare professionals interviewed in this study suggested that the influence of pharmaceutical representatives had indeed changed the prescribing dynamics and is, to a considerable extent, responsible for the issue of inappropriate prescriptions for financial inducement for some of their colleagues. They insisted that prescriptions should be based on generic names, not trade names. These healthcare professionals further suggested that with physicians now prescribing specific brands instead of generic names, there is a tendency for

such practices to be driven by financial inducements from pharmaceutical companies. For example, in an interview with one of the nurses, she described how pharmaceutical representatives flood the clinic with gifts and cash in envelopes to induce doctors to prescribe specific brands of drugs.

*"This is not hidden. We see this always, and it is shameful if you ask me. These pharmaceutical representatives always try to convince our doctors to prescribe their brands. They bring gifts from as little as pens, notepads, stethoscopes, laptops, and many other things to induce our doctors to prescribe their brands. It is like a competition in which the pharmaceutical representatives tip the doctors more to get them to prescribe their drugs even when unnecessary. This practice is now done without shame in broad daylight" [Nurse-Private Health Facility].*

*"To me, this is a clear issue of inducement as you will see the pharma reps hiding under the disguise of giving refreshments during weekly doctor meetings. Then they present their brand of drugs to doctors at these afternoon meetings. Please tell me, what do you expect if you are fed weekly by one pharmaceutical company or the other? Certainly, it is like being bribed with free lunch to prescribe a particular brand at the expense of the patients; this is just one aspect, besides things like laptops, bags, and other things they give our doctors" [Nurse-Private Health Facility].*

Also, in another interview with a junior medical doctor, he suggested that the kickbacks gotten from inappropriate prescriptions were not only in the form of financial payments from these pharmaceutical companies but that they sometimes embed those kickbacks in the form of training such as the disguise of sponsoring doctors to conferences in return for prescribing their drugs. The most important thing for these pharmaceutical companies is that these doctors should lean toward prescribing the brands from their companies.

*"For example, many of our consultants have gone to several national and international conferences sponsored by these pharmaceutical companies. One cannot be sure if it is a form of kickback or not. It is difficult to tie the two together, but we know it is a way of repaying doctors for prescribing specific brands. The issue is that patients are the ones who suffer because sometimes these drugs are expensive, and I can tell you, as a doctor myself, that some plain generic drugs can still do the magic. I feel for the patients who bear these excessive costs" [Junior doctor at a private health facility].*

However, a consultant physician in the same private hospital as the junior doctor described above had a different view concerning the issue of inappropriate prescriptions and whether pharmaceutical representatives were inducing doctors.

*"Before most of my colleagues and I agree to prescribe a particular drug, we are most concerned about the safety, efficacy and side effects. We do not just solely consider cost in isolation, and I do not think that because the pharmaceutical representatives market their brands, so that means we solely prescribe those brands to patients because of that"* [Consultant Physician at a General Hospital].

As revealed by the empirical findings under this thematic section, the evidence suggests that the problem of inappropriate prescriptions by healthcare providers without proper justification might not be illegal technically but is not usually done with the best interest of patients. The evidence suggests that in the opinion of several informants regarding these inappropriate prescriptions, private healthcare providers in this study did not consider the interests of patients, who generally see this as a significant financial challenge to access care but were usually driven by financial incentives related to the potential for kickbacks for the prescribers and boost in revenue for the private health facilities. Similar findings have been found in India, where its sizeable pharmaceutical sector has undue influence in its dominant private sector and most physicians prescribed drugs solely for the potential of the kickbacks they receive from the large pharmaceutical companies in India (Das *et al.*, 2016). These companies are in major competition with each other, and therefore, the ones who offer the highest incentives in the forms of kickbacks for certain drugs, see their drugs been prescribed the most in India. These findings are in keeping with the evidence found in this study.

#### **(d). Over-treatment/referral and under-treatment of patients**

These two groups of practices- *over-provision* (over-treatment/over-referrals) and *under-provision/treatment* of patients were recurrent themes that emerged from the interviews in this

study, particularly from the views of patients and some healthcare providers. In this study, over-referral refers to a practice where healthcare providers, usually medical doctors but not invariably physicians refer patients to other specialists or healthcare professionals for investigations or treatments that are considered unnecessary, often with the intent of receiving financial gain at the individual level or increase in profit for the health facility (Anyanwu, Abedi and Onohwakpor, 2015).

Closely linked to the over-referral of patients in private health facilities is the problem of over-treatment/over-provision of services to patients, as the evidence showed that there were instances where these patients were not necessarily over-referred to other specialists but were over-treated by the same physician or private health facility with the primary motive of increasing revenue without any additional benefit for these patients. Some of the patients suggest that this over-treatment worsened their health conditions due to the effects of the multiple drugs they were given and the aggressive treatment and investigations. Other healthcare providers that were interviewed corroborated the experiences shared by these patients, while others disagreed. Those who disagreed suggest that nothing technically illegal did occur anytime they engaged in such practices. They suggested that, after all, these patients were never forced at any point during the treatment process, but it was their choice. If they felt they were being over-treated, they had the right and choice to refuse such treatment and seek health services elsewhere.

However, the evidence in this study shows that these groups of practices are a common occurrence in private health facilities in Abuja and are often not undertaken for the benefit of patients but as a disguise for financial gain by private healthcare professionals to increase their profit margins. The evidence in this study also suggests that in most cases, patients complained that these practices led to increased treatment costs, unwarranted laboratory investigations and

treatments or medical procedures, and often lower quality of care for patients. This view was also reiterated by a few private healthcare workers who agreed that some of the experiences of patients regarding these practices were valid. They suggested that these practices do often occur where they currently work or had worked before, and they also suggested that it was usually encouraged by the management/owners of these private health facilities in order to generate higher revenue.

On the other hand, at the end of the spectrum is also a practice related to the under-provision/treatment of patients, which was also a recurrent theme in this study. According to Nishtar (2010), in Pakistan, under-provision of health care refers to a state where the services provided for patients fall below acceptable standards for varied reasons (Nishtar, 2010a). Similarly, Syafinaz et al. (2016) in Malaysia also describe that in addition to lack of capacity and poor regulation, amongst other factors, the under-provision of health services is seen as a failure of private healthcare providers to provide adequate care for patients, including diagnosis, investigations, treatment, and procedures that meet the minimum standard of care required to the patients they serve (Syafinaz *et al.*, 2016).

Therefore, in this study, the under-provision of care for patients refers to practices where in a bid for private healthcare providers to cut costs while making a profit, and usually due to lack of capacity and poor oversight by the health authorities, these private health facilities provide less in terms of the quality of drugs, laboratory investigations and medical procedures while claiming to provide optimal treatment for these patients. In these instances, these patients are often unaware that they paid for more and received less in return. The evidence from the interviews suggests that when these patients eventually discover such practices, they feel cheated. In the opinion of several patients in this study, these deceitful practices led to their lack of trust in some private health facilities.

### **(i). Patients' experiences of over/under provision of care**

In relation to patients' experiences of over-referrals/over-treatment and under-treatment in the private health facilities where this research occurred, there were mixed experiences about these practices. While most patients were concerned that these practices were not done with their best interest at heart but for purely financial gains for the private facilities or kickbacks to individual healthcare providers. In contrast, other patients (usually affluent) were not bothered and did not feel the primary motive for private healthcare providers who over-treat them was financial. They saw nothing wrong with it and even felt that the more the cost of the treatment, the better the quality of such treatment. This perspective was also shared by a few poorer patients who believed that the more medications prescribed to them, the better the quality of the treatment. These nuanced views again highlight the issue of information asymmetry, where relative to the patients, the private healthcare providers in this study have more knowledge of the services better than the patient who is the consumer.

In an interview with a patient who uses private health facilities, he complained bitterly about the cost of treatment. He felt in his opinion that he and his family were often over-treated and had several over-referrals in the two private health facilities he and his family were using. He felt they had no choice because they were running from the long queues, poor quality of treatment and harsh treatment meted upon them in public health facilities in Abuja.

*“Sometimes I feel as if we ran from one problem to another. Here, no one is asking you for bribes or keeping you in endless queues like we experience in government hospitals, but treatment costs are discouraging. They do this deliberately to make a profit, knowing fully well that even though I am educated, due to my lack of knowledge in medicine I would not be able decipher what I need or do not need. The last time I was here, they gave me the same class of drugs, three of them as painkillers and three different antibiotics and these drugs were so expensive. My wife also complained that she feels over treated here each time she came and that these drugs cost so much compared to their costs in pharmacy outlets outside this hospital”*  
**[Patient- Private hospital].**

In another interview, a patient also described instances where he was asked to do countless blood tests for what he felt was malaria. He believed that the hospital felt he was rich because of his business and often over-treated and overcharged him for illnesses that were not complicated.

*“I felt slightly feverish and came in for a check which turned out to be malaria, but I was subjected to over eight blood tests, including an abdominal scan and X-ray. By the time I left that hospital that day, I had paid over 85,000 naira for what turned out to be malaria. Although I am not a medical doctor, I think these tests were unnecessary. However, it is usually their practice here to make sure you pay much money without considering the cost on you or the multiple drawing of blood from someone”. The experience is not palatable, and I feel frustrated these days but left with no choice. The government hospitals are a no go area for me. So, I continue to endure, but I can tell the experience is not pleasant, and the cost is too much” [Patient- Private hospital].*

Regarding the under-provision of treatment, in interviews with patients who use private health facilities in Abuja, the informants narrated their experiences below.

*“My problem with this private hospital is when you come here because they want to cut cost and still charge you high, they give poor quality medicines, and they claim is good. You end up paying for something different and getting something else. There was a time they even gave me a nearly expired drug” [Patient-Private Hospital].*

*“We paid more money to see a paediatric specialist with my daughter, but we ended up seeing a junior doctor who did not give us the quality of treatment we wanted for our child. To be honest, this is quite deceitful and felt like arm twisting us into receiving substandard care while paying a higher price for what benefits them but not us and without our consent” [Patient– Private hospital].*

The parents above needed a specialist care for their daughter but instead, they felt they got less care at a higher cost, which was not commiserate with the expertise of care they wanted. Hence, in their opinion, this seems to be a tactic by the private hospital to provide less care at the expense of higher profit.

## **(ii). Healthcare providers' experiences of over/under provision of care**

In relation to the experiences of private healthcare providers on these groups of practices, the providers interviewed had different opinions and mixed experiences when it came to these practices concerning corruption in private health facilities. Some agreed that these practices often occur and could be predatory without considerable benefit to patients and are practices that take root from incentives set in place by the management of these facilities where profit was the underlying motivation. On the contrary, others had a differing opinion, insisting that patients are generally not well informed enough to know if these treatments are warranted in the ratio provided to them, sometimes misrepresenting the facts.

In an interview with a junior medical doctor, she suggested that the management of the private health facility where she works covertly but sometimes pointedly drives them to over-treat and over-refer patients. She suggested that such experiences are more common when the hospital classifies the patients as “rich” clients. She suggests that by their records, these patients usually include those working for big multinationals, corporates, banks, or patients generally on premium private health insurance. She further suggested that the management of her health facility believed that money was not an issue for these patients or their organisations; hence, it was an opportunity to request a barrage of tests, investigations, and unnecessary medical procedures and treatments to make more revenue for the hospital. Therefore, in her opinion, the incentive for these practices is financial gain for the hospital and not necessarily the interest of the patients.

*“When I first joined this hospital, I was cautious of the need of over-treating or unnecessary referral of patients without justification. Although I must be sincere, in some instances, the patients insist we carry out unnecessary tests on them and prescribe drugs for every symptom. However, most of the time, the hospital management gave clear instructions. We do every test possible when patients come in and in my humble opinion, I think it is just to boost the hospital's revenue. Here you are constantly reminded that your salary is a product of*



*the hospital's profit. I can tell you the incentive was not about the patient but what the hospital can make" [Junior medical doctor- Private health facility].*

Other private healthcare physicians interviewed in this study also disagree with their colleagues who suggest that these practices are not an issue as long as the patients are wealthy and can afford the costs, painting the narrative that the problem with such predatory practices was only limited to financial barriers to access. Some physicians interviewed argued that this went beyond financial costs and sometimes had more prolonged and dangerous implications for the patient's health.

*"I have had several causes to be worried regarding the over-zealous treatment of patients particularly when it came to the use of antibiotics. The issue of anti-microbial resistance is a growing concern here in our hospital. Several of my patients have been given different classes of expensive antibiotics ranging from 20,000 to 50,000 naira for things as little as common cold or viral conditions that did not require antibiotics in the first place. The danger is that when severe conditions requiring such antibiotics occur later, they fail to work because of abuse, and this has been a serious challenge leading to complications. I recall one of my patients who ended up developing complicated bacterial pneumonia because of overtreatment with antibiotics that were given to her from this hospital and other private hospitals for no just cause" [Medical doctor- Private hospital].*

*"It is just about the profit in that hospital for its owners. The place needs more modern laboratory equipment, and they do not like stocking the pharmacy with quality drugs but prefer to buy cheap drugs and sometimes they even ration the medications. They ask the doctors, nurses, and pharmacist technicians to manage the limited medicines. It is tough, and we face challenges when knowledgeable patients begin to protest and demand something better" [Medical officer- Private health facility].*

However, a different view to those above was described by a senior physician, he believed that although such practices did occur, it was in the minority of cases, and that patients often misrepresent the reality of the process.

*"This is straightforward and should not be up for much debate. If a patient feels he or she is being exploited or thinks we have over-treated them, then it is his or her opinion and he or she has the right to go elsewhere. Patients are not medically trained, so they*

*often say we are over-treating them because we want to make money out of them. It is not usually the case. Don't get me wrong as I am not saying that some private medical practitioners do not hide under such disguise to reap money from patients, but it is not usually in the majority"* [Senior Physician- Private Health Facility].

The evidence analysed from the findings in this thematic section suggests that although these practices might not seem illegal in the technical term, in the opinion of several patients who use these private health facilities, they compromise their interests. These practices might not be like the more “traditional” or usual corrupt practices patients encounter in public health facilities, such as bribery and informal payments. However, they have consequences for patients, ranging from financial and quality-related issues, presented in the next section on the impacts of corruption in private health facilities. Furthermore, the evidence from the analysis suggests that some healthcare workers felt that the revenue they and their colleagues gained for their hospitals which are for-profit in nature, helps them in gaining favour from the hospital management. There has been evidence of the above findings in several LMICs and a few HICs, which buttresses this point that medical doctors who are paid on a fee-for-service basis often common in private health facilities compared to public health facilities, are far more likely to over-treat or over-refer patients since that increases their commission and boost revenue for the private health facilities (Glynn, 2022).

The evidence from the analysis in this thematic section also suggests that in the opinion of most patients and some healthcare workers in private health facilities in Abuja, over/under-provision of care are disguised forms of corruption in these private health facilities, which are often undesirable practices to patients. These patients found them not beneficial for their well-being and interests but are allowed to occur due to the incentive structure of these private health facilities tied to the institutional norms in the private health sector where profit-making is the top priority. However, information asymmetry is at the centre of this theme, and therefore,

opinions of patients regarding over/under provision might sometimes be limited since the knowledge lies more with the provider.

### **5.3. Impacts of Corruption in Private Health Facilities**

Following an analysis of patients and healthcare providers' experiences of corruption in private health facilities in the preceding section, the empirical evidence reveals a range of impacts on patients concerning the impacts of corruption in these private health facilities. Two broad categories of impacts on core UHC goals emerged from this study and include: (i) *undermining the quality of care provided to patients*, and (ii) *exacerbating financial risks for patients*.

#### **(a). Undermining the Quality of Care to Patients**

The evidence of patients' experiences of corruption in private health facilities in Abuja, Nigeria, as presented in *section 5.2*, suggests that corruption in private health facilities impacts patients by undermining the quality of care they receive in these private facilities. The findings revealed that practices such as under/over-treatment of patients, use of low-quality medicines and substandard equipment, and using auxiliary or unqualified healthcare professionals by private healthcare providers with the sole aim of profit maximisation undermined the quality of care provided to patients in these private health facilities in Abuja. The evidence in this study shows that the effect of these corrupt practices contributes to prolonging the disease course in some cases of under-treatment and suggested cases of anti-microbial resistance due to over-treatment of patients, like the unnecessary prescription of antibiotics for financial gains in these private health facilities.

Regarding patients' perception of private healthcare providers undermining their quality of care, in several interviews, patients complained that they came searching for specialist treatment in private health facilities in Abuja and were billed for that. However, they were seen by general physicians who were sometimes very junior medical doctors with limited experience

doing their compulsory National Youth Service Corp (NYSC). In their opinion, the quality of care they received was far lower than what they would have gotten from seeing specialist physicians.

*"In another private health facility in Abuja, before I was referred here, you would not believe that I went in for an appendicitis operation but ended up with severe complications because their instruments were contaminated. The theatre was not standard, in my opinion. They were simply cutting corners"* [Patient C.I- Private Health Facility].

*"I am not a medical person, but I can tell you that the nurses were not properly trained. My son got an abscess from an injection site, and even accessing his veins for drugs was a battle due to the poor skills of these nurses". At some point, I refused that I wanted to see their head"* [C.I, Patient's mother – Private health facility].

The evidence of such impacts in private health facilities undermining the quality-of-care ranges from their use of unqualified personnel to low-quality medicines and the lack of standard facilities leading to several complications for patients, which sometimes require further treatment in other private or public health facilities. These findings in this study regarding the compromise in the quality of care in private health facilities due to corruption are in keeping with previous studies in India by Das et al. (2016), who found that private healthcare providers in rural India who engaged in corrupt practices were likely to provide substandard services which led to an increase in the time needed for patients to recover from illnesses because of the complications resulting from the substandard treatments (Das *et al.*, 2016).

Similarly, significant impacts of specific corrupt practices in private health facilities such as inappropriate prescriptions is the issue of antimicrobial resistance, which has been on the rise, especially in patients who have had prior use and exposure to new-generation antimicrobials for otherwise uncomplicated infections based on unnecessary or overtreatment of patients (Kpokiri, Taylor and Smith, 2020). Therefore, the impact of this practice has the potential of increased drug resistance when drugs meant to serve as the last line of defence have been

prematurely used by patients due to inappropriate prescriptions by healthcare providers for financial gains.

### **(b). Exacerbation of Financial Risks**

Another prominent form of impact on patients regarding the corrupt practices they face in private health facilities in Abuja, Nigeria, found in this study, showed that from the perspectives of most patients, corruption exacerbates financial risks for them and their households. As presented under the various manifestations of corruption, these patients faced numerous forms of corruption, which strained their household finances, particularly for lower socio-economic class patients who had to use private health facilities. For example, **E.N**, a low-income earner described his experience regarding the impact of corrupt practices on his household finances while using private health facilities in Abuja. In his opinion, the impact has been quite substantial.

*“In my opinion, this is pure financial extortion. These private hospitals feel that anyone here has money and should be exploited. However, this is not true; I bring my family here because I am trying to avoid the troubles with government hospitals, but it does not mean I am a rich man. I have spent so much here that sometimes I have no money for other basic things at home. They use every possible tactic to drain you. It feels regrettable”* [**Patient E.N-Private health facility**].

Some patients suggested that these impacts were significant in several cases, leaving them with difficult financial challenges. The evidence also suggests that even for patients of higher socioeconomic status, the exploitive practices by private healthcare providers in Abuja, such as overbilling, and over-referrals/treatments, leave even this category of patients at risk of increased financial vulnerabilities.

## **5.4. Summary of Chapter Analysis**

The empirical findings analysed in this chapter from the perspectives of patients and providers, including health officials/policymakers, suggest that corruption in private health facilities

where this study occurred in Abuja, Nigeria, is driven by incentives aimed at profit maximisation, poor regulation of the private healthcare sector, and lack of oversight on private health facilities. These corrupt practices manifest in several forms, including overcharging/over-invoicing, health insurance fraud and other related invoice frauds, forging/falsifying medical reports, over-referrals/treatment, and under-treatment of patients. Most of these forms of corruption are believed to provide private financial gains, sometimes for the owners of these private health facilities and sometimes for the individual healthcare workers who directly engage in these corrupt practices. *Table 5.1* below summarises patients' experiences regarding the causes, manifestations, and impacts of corruption in private health facilities.

**Table 5.1: showing causes, manifestations, and impacts of corruption in private health facilities**

Manifestations of Corruption	Key Actors	Causes	Impacts
Over-charging/over-invoicing	Hospital management/Health workers to patients	Incentives related to profit maximisation	Exacerbation of financial risks (financial burdens, accumulation of medical debts)
		Poor regulation	Reduced access to private healthcare
			Poor health outcomes
Health insurance frauds, and other related types of fraud	Hospital management/Health workers to patients	Incentives related to profit maximisation	Lack of trust in private health systems
			Reduced patient coverage from employers
			Enforcement of insurance caps for patients due to ballooning bills

Manifestations of Corruption	Key Actors	Causes	Impacts
Inappropriate/ unnecessary prescriptions (driven by the potential for kickbacks)	Health workers/Hospital management to patients	Kickbacks	Increased anti-microbial resistance
		Lack of oversight	Adverse drug reactions
		Poor regulation	Increased healthcare costs for patients
Forging/falsification of medical reports	Patients request from health workers	Lack of oversight	Lack of trust by authorities (employers, courts professional bodies) for records from private health facilities
	Health workers suggest to patients	Disregard for medical ethics	
Under/over-treatment of patients	Hospital management/health workers to patients	Profit motive	Poor quality of care
		Quackery	Increased anti-microbial resistance
			Reduced patient satisfaction

These corrupt practices in private health facilities as summarised in *Table 5.1* above are often subtle compared to the forms of corruption presented in public facilities in chapter 4. Furthermore, these corrupt practices come under different disguises, so these for-profit private health facilities do not lose patients. The practices are subtle in the sense that these private facilities use clever and indirect methods ingrained into regular service provision to perpetrate them. Therefore, these practices are usually covert, with many patients not even recognising them as corrupt practices. Another reason for these practices going unnoticed is that, unlike those in the public health facilities, in some of the private health facilities, the management/ownership of these for-profit-driven entities are often in the know of such practices. Several private healthcare workers in the study suggest that their management often

encouraged them to engage in such practices in order to boost revenue for the hospital which in turn forms part of their salaries. Therefore, the incentive structure and institutional setup of these private health facilities allow these practices to occur easily and seamlessly since most are ingrained in the day-to-day operations of these private health facilities.

Similarly, the evidence in this study shows that patients prefer to initiate certain forms of corrupt practices to private healthcare providers, such as forging/falsifying medical reports and medical identity theft for health insurance in private facilities, because they felt it was easier to engage in private facilities than public health facilities. These patients felt that public health facilities often have multi-layered barriers to acquiring medical reports. Thus, the effort to bribe multiple actors to engage in this practice is often more difficult as patients need to get the cooperation of several actors in public health facilities compared to private health facilities where far fewer people and barriers are needed to carry out such an act.

Regarding the impact of these corrupt practices, the evidence suggests that unlike in public health facilities, where the impact was primarily related to inequity of access and financial barriers to access, especially for poorer people, in private health facilities, the main impact of corruption is largely relating to undermining the quality of care provided for patients in private health facilities and exacerbation of financial risks. The findings of such impacts in this present study are in keeping with findings in South Asia, where certain forms of malpractices, including corrupt practices, were easier to orchestrate in private health facilities due to poor regulation and limited hierarchical barriers with few checks and balances (Coarasa, Das and Hammer, 2014; McPake and Hanson, 2016).

In conclusion, the findings in this chapter show that corruption also occurs in private health facilities. However, the causes and manifestations sometimes differ from those presented in chapter 4 and are mainly tied to the incentive structure of these private health sector facilities.



At the same time, some of these problems in private health sector facilities are systemic and ingrained within their operational structure to exploit patients; some of these findings are hearsay, often with contention between patients and private health providers since some of these practices are not clear cut. Notably is the issue of information asymmetry where on the one hand, patients might not know when they are being exploited, but also, they might believe they are being exploited when they are not.

## Chapter Six

### Public-Private Mix Interaction: Patients' and Providers' Experiences of Corruption

#### 6.0. Introduction

This chapter addresses the study's third objective, which sets out to investigate how, and the extent to which, corruption is enabled by the co-existence of and interactions between public and private health facilities in the context of the mixed health system of Nigeria – and of Abuja in particular. Therefore, this chapter explores the nature of the interactions between the two sectors (public and private), and the impacts of these interactions on patients' and providers' lived experiences with regard to corruption.

From careful analysis of the data collected through the in-depth interviews (IDIs) and participant observation, five key themes emerged, regarding the nature of the interactions between the two sectors (public and private), and the impacts of these on patients' and providers' lived experiences with regard to corruption. Here, the themes are organised into two broad categories:

- (i) supply-side interactions (i.e., those that relate to the behaviours of providers – organisational and individual), which include *dual practice, health worker absenteeism, theft/diversion of hospital supplies, and diversion of patients and inappropriate referrals*, and
- (ii) demand-side perspective of the interactions (i.e., those that relate to the experiences of patients), with a focus on how corruption is encountered and experienced as they navigate care pathways incorporating both the public and the private health sector facilities.

This introductory section lays a foundation for the analysis in *section 6.1*. The evidence in this study suggests that supply-side interactions originate and may give rise to corruption through the actions and inactions of organisational and individual healthcare providers in both sectoral contexts. In this sense, public-private interactions can be implicated as a cause of corruption. Practices such as theft/diversion of hospital supplies and consumables (drugs, laboratory reagents, needles and syringes, hand gloves, diagnostic kits, and equipment) are straightforwardly illegal practices. Other practices such as dual practice, health worker absenteeism, inappropriate referrals, and diversion of patients between public and private health facilities, may or may not be illegal (the assessment is highly context-specific, as is shown *section 6.1*), but constitute unjust and exploitative behaviour, to the detriment of patients' health and welfare. This section lays the foundation for exploring the various corrupt practices presented in *section 6.1* and patients experiences of them through their journeys presented in *section 6.2* and how these practices are enabled by the existence of, and interactions between, the two sectors.

## **6.1. Supply-side interactions in the context of corruption**

### **6.1.1. Dual practice**

Dual practice is a term used to describe “*healthcare professionals who combine work in public and private health-care sector*” (McPake *et al.*, 2016, p. 142). These healthcare providers usually physicians but not invariably, generally combine salaried clinical work in public health facilities with fee-for-service work in private practices (Ferrinho, Lerberghe, *et al.*, 2004). In Nigeria, and in the context of corruption, dual practice often refers to public healthcare providers working in private health facilities during *government/official* working hours, which is prohibited by law (as enshrined in the medical code of ethics in Nigeria), but which is known to be extensive (MDCN, 2004, p. 57). The Medical and Dental Council of Nigeria (MDCN) in its code of ethics states: “*a registered practitioner in full time employment in the public service*

*shall not engage himself in extra-mural private practice during official duty time under any circumstance”* (MDCN, 2004, p. 57).

#### **6.1.1.1. Manifestations of dual practice in the context of corruption**

In the context of corruption, this study classifies dual practice as corruption and illegal practice in Nigeria when public healthcare professionals in full time government employment engage in practice in private health facilities during working hours which also includes when healthcare professionals are on call duty at night or weekends because they are paid call duty allowances, and those periods are considered official hours (MDCN, 2004). In most cases, these healthcare workers work their second jobs during regular working hours that should have been spent at their primary government jobs (Hipgrave and Hort, 2014, p. 704; Russo *et al.*, 2014). Dual practice during official working hours is also prohibited because it is a leading cause of health worker absenteeism (Hipgrave and Hort, 2014, p. 705).

In this study, dual practice in the context of corruption emerged as a prominent theme practiced by healthcare providers to the detriment of patients in public health facilities. Although this practice was of major concern to patients who are at the receiving end, the evidence from the interviews also identified several healthcare workers and policymakers who saw dual practice as a corrupt practice, especially when carried out during government working hours. There are two dimensions to the issue of dual practice within the context of corruption in Nigeria. First, it is illegal when carried out within official working hours as prohibited by the MDCN code of ethics, considered as moonlighting during working hours. Second, the evidence suggests that this sometimes gives rise to other forms of corruption such as patient diversions/inappropriate referrals. Several patients in this study mentioned that their doctors who practiced in public health facilities and combined private practice had asked them to see them in their private

practice. The common phrase some of the patients in this study mentioned being told by the healthcare providers who engage in this practice was:

*“Come and see me later at my private practice”* [Patients- Public Health Facility].

For example, majority of the doctors and laboratory technologists interviewed, agreed that they had practised in a private health facility while combining their primary job in public facilities during working hours at one point or the other in their careers. Similarly, more than half of the interviewed nurses agreed to have done same. The evidence of dual practice in this study was skewed to the form of practice where healthcare workers holding employment in public health facilities combine clinical practice in another private health facility, often leading to some form of absenteeism and a shortage of such category of health workers in their primary place of work. This shortage leads to a delay in or denial of access to patients visiting the affected health facility (as shown in section under the impacts of dual practice). The evidence also suggests that the effect of dual practice on patients was more in public health facilities where this research took place compared to the private health facilities. However, the evidence also shows that the management of private health facilities in this study sometimes encourage and enable the practice in private facilities.

*“The owner of that private hospital (name redacted) who is a former classmate of my oga (boss at work) asked my oga to send my colleague and I to cover his hospital while he was away for his annual vacation. But the problem here is that we did this for 2 weeks during official hours and the pay he offered for these 2 weeks was more than my 1-month salary in government.”* [Medical officer- Public Health Facility].

*“This particular private hospital (name redacted) knows that we were being owed. Hospital managers come from there to scout for doctors from our hospital. The pay is good too*

*good to let go. You know for every caesarean section one does there it's a big deal of money"*  
**[Medical doctor- Public Health Facility].**

In addition, other variants of dual practice were also identified where healthcare workers from public health facilities held other non-clinical jobs in the private system during official hours instead of being at their full-time primary government employment. These other jobs compete with their time and attention to deliver effective services to patients at their primary place of employment. For example, the findings showed evidence of doctors and nurses engaging in private consultancies in other organisations during working hours; hence they were absent in their primary place of employment. There were also instances where the healthcare workers from public health facilities revealed that they were involved in other business opportunities unrelated to clinical practice or any health-related field.

*"Two of our senior consultants abandon clinic days here leaving us with so many patients, some beyond our expertise to engage in medical research contract jobs for these NGOs who often pay them in US dollars"* **[Junior Medical Officer- Public Health Facility].**

*"In my last place of work, our oga (boss) combines clinical practice with his personal business of a consultancy during working hours. We are left to do most of the work while each time he is at his other job"* **[Medical Officer- Public Health Officer].**

The sub-sections below present an analysis of the causes and impacts of this group of corrupt practices from two main perspectives (patients and providers).

#### **(A). Public healthcare providers in private practice: Provider's perspective**

As earlier highlighted, the primary variant of dual practice found in this study is moonlighting, where healthcare providers hold primary employment in public health facilities but also engage in some form of practice at private health facilities during official working hours.

### *(A1) Causes of dual practice in the context of corruption*

In relation to the causes of dual practice as a corruption problem, several public healthcare providers who admitted to engaging in private practice during official hours insisted that *low salary of public healthcare providers* was the main reason why they engaged in it, and even those who said they did not engage in the practice had sympathy for their colleagues who were involved in the practice. In addition to low salaries, several public health workers also mentioned that they are often owed salaries by the government for many months, necessitating them to engage in dual practice during working official hours.

In an interview with a senior resident in one of the public health facilities, he agreed that although private practice was not allowed during official hours by the Nigerian Medical and Dental Council, he insisted that because the Nigerian government also knew its failings concerning the poor working conditions of medical doctors, they would not be morally justified to enforce such regulation.

*"I agree that my engaging in private practice during government hours is wrong practice because that means I am absent from work during that period. But we need a second source of income; if not, it will be difficult for doctors to survive in Nigeria. Imagine me as a doctor surviving on 350,000 naira [800 dollars] per month. How do I pay my house rent, school fees, feeding, transportation, and other needs? Where has a medical doctor survived on such a salary? {Senior Registrar- Public Health Facility}.*

He went further to say:

*"The government is still unprepared to tackle the issue of poor salaries in the public health sector in Nigeria, so why would people not abandon their primary work to look for their private money during working hours? Moreover, this is even worse for junior medical doctors who earn just 220,000 naira [500 dollars]. Even our senior colleagues who are consultants or professors earn between 600,000 to 850,000 naira [1400-2000 dollars]. Therefore, this is the only way to meet ends in today's Nigeria [Senior Registrar- Public Health Facility].*

In another interview with a consultant physician at one of the general public hospitals, he suggested that surviving on a single job in Nigeria as doctor in a public hospital was impossible.

He suggested although working in private practice during working hours is wrong, it would not stop because of the poor remuneration in the public sector.

*"Yes, I would not deny that I have been away from work sometimes to see patients during working hours. I cannot deny that. As doctors, we have every justification to source for extra income as every other Nigerian who is facing immense hardship does. Ours is even worse. The same public will laugh at us, saying; see how wretched this doctor and his family are. See the kind of school his kids are going to. All the time this doctor's car is always breaking down on the highway. Don't they pay him a salary? This doctor's wife, why is she looking so wretched? They go on and on belittling us on our poor living condition" [Consultant Physician- Public Health Facility].*

#### ***(A2) Impacts of dual practice in the context of corruption***

Although some public healthcare providers sympathise with why their colleagues engage in dual practice, those that do not narrate the impact of dual practice on their professional experience. One informant revealed how he and his colleague were left on their own during hospital Calls to attend to severe obstetrics emergencies that led to bad outcomes because the senior medical officers/consultants supposed to be covering the call were at their private practice.

*"I have been left with the nurses countless times to sort patients clearly beyond my pay grade. We have lost babies that, ideally, we should not have because of the delay in deciding on the next step of managing some of these pregnant women. The consultants leave us alone, and we cannot make major decisions. When you finally get to them, it is too late for the patient" [Medical doctor- Public Health Facility].*

*"On this occasion, a pregnant woman came with a breech presentation [Baby presenting with the buttocks] around 10 pm. I had done all the manoeuvres my skills could allow, but there was no progress. The senior registrar and consultant on Call were unavailable as they were doing another surgery in the consultant's private hospital. They finally sent a message to me via the phone on what to do, but by then, the baby's heartbeat was so low. The baby survived, but not without complications. I was distressed that night and do not want to face such a difficult experience again" [Junior Medical Officer- Public Health Facility].*



The section above presented some manifestations of dual practice as a corruption problem including its causes and impacts from the views of public healthcare providers. Despite the reasons provided by the healthcare providers, several of them also felt that dual practice was disadvantageous to the public health sector. The findings suggest that certain forms of dual practice represent corruption (e.g., moonlighting leading to absenteeism); and that dual practice of all kinds - corruption and non-corrupt - give rise to other forms of corruption such as diversions/inappropriate referrals that go alongside dual practice.

### **(B). Public healthcare providers in private practice: Patient's perspective**

Unlike the providers' perspectives where they were more concerned to highlight the causes of dual practice within the context of corruption, patients insights from the interviews were more on the impacts of dual practice as a corruption problem. However, few patients did also suggest possible causes, but these suggestions relied on third party information.

#### ***(B1). Causes of dual practice in the context of corruption***

Some patients in the study also suggested the government was partly responsible for why the practice is rampant due to the low salaries of public healthcare workers. Others, though, still insisted that this was not still a good excuse for healthcare workers engaging in such practice to abandon their primary duties in public facilities during working hours simply because of the extra financial gain such practice offers them.

*“One of the nurses mentioned to me and a few others while we were waiting at the outpatient department how this doctor we were waiting to see always came late to work. His clinic was supposed to last about 5 hours, but he wanted to see us all within 2 hours. Sometimes, he strolls in when there is only 1 hour left to the end of his clinic because he was attending to patients at his private practice. Meanwhile, he expects the government to pay him for the hours he was not here and still make money at his private practice. They [doctors] claim their salaries are poor, but the hardship is affecting all of us, not just them, and they even earn better compared to most Nigerian workers” [Patient- Public Health Facility].*

### *(B2). Impacts of dual practice in the context of corruption*

Several patients suggest that it is a frequently encountered problem affecting the quality-of-service provision availed to them. The findings suggest as shown below that this practice accounted for a lot of health worker absenteeism; another practice linked to corruption which is presented subsequently in this chapter. Several patients suggest that dual practice is responsible for much dissatisfaction while seeking care in public health facilities. Some further suggest that dual practice is a major underlying factor responsible for patients moving between public and private health facilities to seek care since they had no option but to follow the providers to their private practice, further propagating the cycle of dual practice as aided and abetted by the private health facilities. They mentioned that dual practice negatively affects the quality of health care they receive and short-changes the government.

In a interview with a patient, she described her experience of how dual practice affected the quality of care she received and the financial risks to her household.

*“I am just a stay-at-home wife, and things are extremely hard for my husband, who lost his job two years ago. So, our only option is this government hospital. However, my experience here is something I am not particularly eager to discuss because of how sad it makes me feel. For example, the doctor I usually see during my antenatal clinic here also has a private hospital near my home. He often comes extremely late, and sometimes he does not even come at all. We are sometimes left to see the midwives who write iron tablets for us, and that is it. I cannot afford to go to his private hospital where he prefers to spend most of his time” [Patient-Public Health Facility].*

In another interview, a patient described the impact of dual practice which led to him being diverted on several occasions by healthcare providers.

*“Unfortunately, this unfair practice left me and my family with no choice but to follow the doctor to his private practice. We came several times, and he was not at work. One of his proxies told us is best we go to his private practice if not it might take us weeks to track him down here” [Patient- Private Health Facility].*

In summary, taking into account the perspectives of patients and providers, the evidence suggests that dual practice in the context of corruption sprouts as an offshoot of supply-side interactions between the public and private health sector facilities in Abuja's mixed health system. The evidence presented suggests that in some instances, the private sector owners take advantage of the low salaries healthcare providers in the public sector earn to lure them into working in private facilities during official hours at the detriment of patients in public health facilities. Furthermore, the impacts of such practices give rise to other forms of corruption. Notably, dual practice as a corruption problem is intricately interwoven with other supply-side interactions as its occurrence leads to healthcare providers (usually public providers) engaging in practices such as absenteeism, inappropriate referrals, and diversion of patients between public and private health facilities, which in the long run continues to fuel the occurrence of corrupt variants of dual practice prohibited by the health system in Nigeria.

### **6.1.2. Health Worker Absenteeism**

While corruption, in simplistic terms, is known as *"the abuse of public office or entrusted power for private gain"* (Transparency International, 2017), worker absenteeism, on the other is described as *"the failure to appear for scheduled work or the loss of scheduled time to unscheduled work"* (Kisakye *et al.*, 2016). In the context of corruption, health worker absenteeism is considered a corrupt practice when health workers deliberately choose to absent themselves from work to pursue their private interests when they are supposed to be working in critical public sectors like health services (Ackers, Ioannou and Ackers-Johnson, 2016; Kisakye *et al.*, 2016; Onwujekwe *et al.*, 2019; Kirya, 2020).

Furthermore, this form of absenteeism refers to where healthcare workers take frequent absences under several disguises from public sector facilities to work in private clinics during working hours (Hutchinson, Balabanova and McKee, 2019; Onwujekwe *et al.*, 2019; Glynn,

2022). In doing so, these health workers sometimes engage in dual practice during official hours, and in turn, short-change the public sector by receiving wages for hours not worked in addition to financial gains they make conducting their private businesses (Hipgrave and Hort, 2014; Kisakye *et al.*, 2016). Other healthcare workers' absences are used to pursue several private interests and businesses that are not necessarily related to clinical practice. However, it is considered corruption because it is for their private interests (Kisakye *et al.*, 2016).

Therefore, within the context above, health worker absenteeism as a corruption problem, excluding legitimate reasons, emerged as a recurrent theme in this study, mainly originating from public health facilities. Although both healthcare workers and patients cited this practice as a significant problem affecting the delivery of services to patients, the insights into causes of this problem and the underlying dynamics came best from healthcare workers who are in a better position to tell if a fellow worker was truly absent at work or might have been away with official approval. Therefore, they had intricate details on why (causes) they or their colleagues were absent from work. In contrast, patients' experiences were often based on *third-party* knowledge shared with them by colleagues of the absent health workers.

In either case above, the evidence as will be shown in this theme suggests that most public healthcare workers, and patients felt to a large extent that worker absenteeism within the context of corruption is often aided by private health facilities that create the demand for such healthcare workers whom these private providers see as a temporary supply of labour. The findings further suggest that the ulterior motive for these health workers who engage in this practice, excluding legitimate reasons for being absent at work, is engaging in private interests, often for financial gains. Even though the evidence in this study shows that health worker absenteeism is a widespread problem in public health facilities in Abuja- an urban city in Nigeria, several of the interviewed patients mentioned that it was an even more common

problem in remotely located public facilities neighbouring the city where they were unable to access healthcare providers necessitating part of their reasons for seeking care in the city.

*“On countless occasions these healthcare workers go for days without showing up at health centres. This makes us develop complications or often present late at referral centres such as this government hospital” [Patient- Public Health Facility].*

#### **6.1.2.1. Manifestations of Health Worker Absenteeism**

The findings in this study shows that absenteeism within the context of corruption manifest in several forms. It ranges from where healthcare workers completely fail to show up for work at their primary place of employment, usually public health facilities- *“total absenteeism”*, to *“partial absenteeism”* including the concept of *“hour shaving”*. In the latter, these workers are accused by patients or their colleagues of using a significant period at work to engage in other personal interests often financial including dashing to their private practices in between hours. “Hour shaving” refers to situations where workers turn up late or are at work but not working. Instead, these workers engage in other private interests (Hahonou, 2015; Kisakye *et al.*, 2016; Kirya, 2020).

*“Numerous times these record clerks and even nurses left us for almost an hour to sell clothes and jewelleries to people during their working while we are desperately waiting” [Patient- Public Health Facility].*

*“Sadly, it is true, but on several occasions my colleagues are more interested in selling their stuff here than getting patients sorted. This builds up the crowd in my opinion” [Nurse- Public Health Facility].*

The evidence above suggests that those periods are used by health workers to trade and sell clothes and jewellery for personal financial gains. There were also reports of these healthcare workers taking long breaks beyond official break times or leaving these public health facilities before official closing hours to engage in other personal interests for financial reward at the

expense of paid hours from the government (Hahonou, 2015; Kisakye *et al.*, 2016; Kirya, 2020).

The sub-sections below present an analysis of the causes and impacts of this group of corrupt practices from two main perspectives (patients and providers).

### **(A). Health worker absenteeism: Provider's perspective**

Here, most healthcare workers interviewed offered insights into the causes of worker absenteeism within the context of corruption by virtue of the working relationships they have with colleagues who have been absent at some point including themselves. Some went further to share their experiences regarding the impacts of absenteeism to both the patients and them. These causes and impacts are analysed below.

#### ***(A1) Causes of absenteeism in the context of corruption***

In relation to the causes of health worker absenteeism as a corruption problem, several public healthcare providers admitted that this was a common occurrence. Several reasons were provided by these public healthcare providers for the occurrence of such behaviours within the context of corruption, including total and partial forms of health worker absenteeism. Several informants suggested that dual practice during official hours by their colleagues was a leading cause of absenteeism in the context of corruption.

*“Most of the doctors who are absent at work, usually our ogas (bosses), it is because they are their private practice making extra money for themselves. In fact, some of their private practice is not even far from this hospital, but nobody does anything. They are the supervisors and so we cannot say anything. It is normal way of life here”* **[Medical doctor- Public Health Facility]**.

*“Do I have an option but to be absent sometimes? No, I don't. These our ogas ask you to go and cover their private practice during official hours that is why we are sometimes absent at work. Although they usually give something for our services (money), but it is difficult to say*

*no when they ask you to do so because we are training under them* [Junior Registrar- Public Health Facility].

Several interviewed health workers also suggest that low salaries in the public health sector is a key factor that has led their colleagues and them into being totally or partially absent at work to engage in other private interests during official hours in order to augment their meagre salaries which ranged from dual practice, consulting services and personal businesses. This is also part of the reasons some “hour shave” (a partial form of absenteeism) during official hours.

*“One has no choice but to combine the selling of things here in the hospital to augment this meagre salary. That is why some of my colleagues including myself sometimes sell things at work. There is no time after work to engage in business. So, the only way is to combine it with one’s work”* [Nurse- Public Health Facility].

*“Truth be told I have been absent sometimes because I went to work on my farm especially during rainy seasons. The pay here is just too horrible to feed your family”* [Healthcare attendant- Public Health Facility].

#### ***(A2) Impacts of absenteeism in the context of corruption***

In relation to the impacts of absenteeism, as suggested by several healthcare workers in this study, they felt that absenteeism leads to burnout and disgruntlement for those left to carry the extra workload of absent colleagues. The evidence suggests that it leads to more complex problems where those available at work sometimes are left to perform tasks way outside the scope of their expertise, such as nurses performing procedures meant to be done by doctors or junior doctors performing functions of senior doctors/consultants.

In an interview with a junior resident doctor, he described several instances where he and his colleagues had to carry out procedures that were clearly above their expertise because their superiors were absent for no legitimate reason.

*“There was this time when a 39-year-old with her eighth pregnancy presented to us with profuse vaginal bleeding and a suspected uterine rupture. None of our senior registrars*

*or consultants on Call was around as they were at their private hospitals. It was a difficult case that was clearly beyond my pay grade. The intern, the midwife and I were concerned about how to save this woman's life. We had lots of complications that could have been avoided if we had the senior doctors around. We did a radical removal and less conservative approach because that's the skills we had"* **[Medical doctor- Public Health Facility]**.

In another interview, an anaesthetic nurse at one of the public general hospitals described a particular occasion where her two superiors were absent and were attending to the baptism of a colleague's daughter during official working hours which in her opinion was their private interest during working hours.

*"I was frightened as this would be my most advanced anaesthetic procedure since I joined. Because of my expertise, the intubation took a long time, making the surgical procedure longer. I would have preferred that my superiors were both around to guide me. Why would they both need to go for baptism, a private and personal event during working hours, yet still be paid by the government?"* **[Nurse anaesthetist- Public Health Facility]**.

Similarly, a laboratory technologist at one of the public hospitals described absenteeism as a major problem being faced in the hospital's laboratory with impacts on the quality and timing of services they provide to patients.

*"You will come to the laboratory on a Monday where hundreds of patients will be waiting for their tests, and half of your colleagues are absent. The oga [boss] himself is nowhere to be found. So, tell me, who will query those absent? If half of your colleagues are not at work without permission by the start of the week, your guess is as good as mine by the end of the week how many will show up for work. It is very frustrating and demoralising. For example, two of my colleagues told us they were at the private laboratory of our oga [boss] on such a busy Monday. These absent colleagues still received their salaries and got paid from the private laboratory"* **[Laboratory technologist- Public Health Facility]**.

The analysis in relation to the provider's perspective above suggests that several healthcare workers admit that absenteeism, excluding legitimate reasons, is a form of corruption which leads to other forms of corruption, such as dual practice. Several of those interviewed mentioned they or their absent colleagues used some of those periods to engage in private



practice for their financial interests. The healthcare workers had better insights into which colleagues were absent and what they might be engaged in during those periods of absence compared to patients who rely on hearsay/third party information. Other studies in LMICs have suggested that health worker absenteeism especially in public health facilities is a problem and that a substantial number of these workers use those periods for dual practice and other private interests (Lewis, 2011; Bouchard *et al.*, 2012; Naher *et al.*, 2020; Odii *et al.*, 2022; Angell *et al.*, 2023; Onwujekwe *et al.*, 2023).

### **(B). Health worker absenteeism: Patient's perspective**

This sub-section reveals patients' experiences related to the causes and impact of this practice on them while seeking care in public health facilities. Although better insights into the causes came more from the provider's perspective.

#### ***(B1) Causes of absenteeism in the context of corruption***

Most patients in this study recognised they might not have the most accurate information regarding the causes or reasons why hospital workers, particularly public healthcare providers, are absent since they do not work together or know the details of their schedules and often rely on what they were told (third-party knowledge).

*“The last time I was here with my old mother to see the orthopaedic surgeon, they said the doctor was not around. My cousin a nurse here mentioned that it is a normal thing for the orthopaedic surgeon to go for days without showing up at work because he is at his private clinic. He just leaves the medical officers here who are not specialists [Patient-Public Health Facility].*

*“Because anaesthesiologists are very few in this city, everyone is scrambling for them. My friend is one of them and he told me that his services are in high demand, particularly from private hospitals who pay very high for procedures he participates in and these procedures are often elective surgeries which occur during working hours making him absent from work [Patient- Public Health Facility].*

## ***(B2) Impacts of absenteeism in the context of corruption***

Despite the fact that most of these patients did not have direct insight into the causes of absenteeism (especially total absenteeism), however, several of the patients interviewed suggest that even those physically on duty in these public health facilities sometimes use the bulk of their time selling private things during working hours rather than attending to patients which has several impacts on them. They also revealed that some healthcare workers come to work extremely late, and some leave early before the official closing time. In the opinion of these patients, these cases of *hour shaving- a form of partial absenteeism* impact on core UHC goals for patients, including delays or denial in care and the eventual quality of care they get from public healthcare providers within the limited time they become available.

*" I feel so dissatisfied with the delay in care due to the actions of workers in government hospitals. The doctors will come in around 9 am and drop their bags, but you will not see them again till around 10:30 am or even 11 am. The nurses also told us that clinics last till 4 pm, but by 2 pm, you see some doctors packing their bags and leaving. Others say they will pick up their kids from school and never return to the clinic. What will one call this kind of practice when they come late and leave early mainly to sort their issues at our expense, and yet they collect their full salaries at the end of the month?"* **[Patient- E.N. at a general public hospital].**

In an interview with another patient at one of the general hospitals, he also described his experience where he termed healthcare workers as being *"present but absent at the same time"* **[Patient- Public Health Facility]**. He suggested these workers were physically around at the hospital but absent as they were not delivering the expected services. In his opinion, it was the same for him as healthcare workers who did not come to work. He went further to say:

*"These doctors and nurses are sometimes present physically but absent at the same time. There were countless times when we were here waiting to be seen, but they were busy on their phones with this WhatsApp and TikTok thing. It makes the whole thing so slow as they are often distracted. That is why I said they were physically present but absent simultaneously. What is the use if you are present but not doing your job? Some sit down and chat, and when you complain, they shout at you as if they were doing you a favour"* **[Patient-Public Health Facility].**

*“I have witnessed several times where record clerks and nurses abandon their work and are busy selling things instead of concentrating on us. It can be very frustrating. Sometimes they disappear for hours, and there is no superior to put them in order”* [Patient -Public Health Facility].

The evidence from these patients points to the concept of *"hour shaving"* – a form of partial absenteeism quite common in public health facilities where workers often use these periods during work to engage in their private interests with financial or non-financial gains (Bouchard *et al.*, 2012; Hipgrave and Hort, 2014; Ackers, Ioannou and Ackers-Johnson, 2016). From my participant/direct observation, this pattern of health worker absenteeism was more endemic than the *"total absenteeism"* variant. These health workers prefer engaging in *"hour shaving"* as a form of absenteeism because it was easier to prove they came to work than when they did not show up completely. In partial absenteeism, they often have an alibi in case it ever came up as an issue compared to those who did not show up to work completely.

*“Patients are waiting in queues sometimes frustrated but I have seen healthcare workers outside selling second hand clothing while patients are waiting sometimes for hours”* [Participant/Direct observation].

*“I have seen names of people I met during my fieldwork as signed in for those days, but they were not in the whole day or most of the day. They must have gotten people to sign the attendance registers on their behalf which is illegal or signed themselves and left for other private endeavours”* [Participant/Direct observation].

In summary, taking into account both the patient and provider’s perspectives, the findings show that health worker absenteeism in the context of corruption be it total or partial, is an avenue for workers to engage in other forms of corruption such as dual practice. In the context of mixed

health system, worker absenteeism is driven by low salaries and the need to augment them through engaging in other private financial source of activities chiefly dual practice.

### 6.1.3. Inappropriate Referrals and Diversion of Patients

#### 6.1.3.1. Manifestations of inappropriate referrals/diversions

This thematic section presents two interrelated corruption problems- *inappropriate referrals* and *diversion of patients* between public and private health facilities. Inappropriate referral of patients refers to unjustified and unsolicited referrals carried out by healthcare providers that were not guided by the need for further human or technological expertise in the course of the patient's treatment but rather for personal reward, usually financial (Litman, 2004, p. 1119). Intricately linked to inappropriate referrals is the diversion of patients, which usually follows these referrals. Diversion of patients refers to the deliberate and intentional directing of patients by healthcare providers, usually from public to private facilities, but sometimes vice-versa, with the intent of benefiting from such diversions, which often occurs from the exploitation of challenges in health service delivery (Jain, Nundy and Abbasi, 2014; Onwujekwe et al, 2019; Namadi, 2020). According to medical ethics, “*these practices are capable of corrupting clinical judgement of doctors by intentionally diverting from what should be their exclusive preoccupation: the well-being of their patients*” (Litman, 2004, p. 1119).

In interviews with healthcare workers in this study, some described the manifestation of such practices as follows:

*“For each patient these doctors refer to us here in this hospital (name redacted), they get something (money) at the end of the month. I know this for sure. If you ask me, would say this is an open secret” [Nurse- Private Health Facility].*

*“Even I as a healthcare attendant gets something each time, I direct patients here to their private laboratories instead of ours here (public facility). The owners of those labs*

*close to us here work here and asked me and my colleagues to send patients to them. I honestly think that's why they find so many excuses not to run tests here so we can send patients to their private labs" [Healthcare Attendant- Public Health Facility].*

The evidence above suggests that with this group of practices, there is often some form of personal financial gain for the referring healthcare worker. Hence, the links between these two corrupt practices. Although, in most cases, the evidence suggests that these inappropriate referrals/diversions are made for personal financial gains, there are instances where some healthcare workers, particularly the junior health workers who make these referrals on behalf of their superiors, claim not to benefit financially, but suggest that they make such referrals under their superiors' directives. In some instances, these junior healthcare professionals claimed they were coerced. However, others mentioned that despite such circumstances, they carried out such practices to gain favours from their superiors.

*"As a medical officer here, I don't want my ogas' trouble (boss). I just do as I am directed, so I don't fall into any person's bad book. On numerous occasions, they have pointedly asked my colleagues and I, to refer patients for no just cause to their private hospitals. If you refuse, you are on your own (consequences)" [Medical Officer- Public Health Facility].*

As seen above, the evidence also suggests that most of the inappropriate referrals and patient diversions are made from public to private health facilities. Although it was not exclusively so, as there were instances of reverse order where patients have been diverted from private to public facilities. However, irrespective of the direction of the referral or diversion, the evidence shows that these two practices often lead to patients moving between public and private health facilities as they travel along the patient journey seeking for care in Abuja's mixed health system. The findings above also show that medical doctors are the most implicated healthcare professionals involve in these forms of corruption perhaps because they have so much power in the decision-making process in patients treatment. By design, the power dynamics and information asymmetry favour physicians leaving patients at the prerogative of doctors.

Nevertheless, the evidence in this study also reveals that other healthcare workers, such as laboratory technologists/technicians, pharmacists, physiotherapists, nurses, and other allied healthcare workers are sometimes involved in these inappropriate referrals/diversions.

The evidence from the interviews suggests that several doctors divert patients from public to private health facilities on multiple occasions, even when these public facilities could provide such treatments for the diverted. These doctors then charged the diverted patients the cost of private healthcare, which was often far higher, while they benefit financially.

*“On three different occasions, the doctors from the government hospital sent me (private practice) for tests and treatment. The first time, it was to come and do echo meanwhile there was echo there. The other time was for a procedure on my leg but two of my neighbours did theirs there. I spent so much money for what would have been far less, but I had no choice”*  
**[Patient- Private Health Facility].**

However, some healthcare providers justified some of these referrals/diversions as appropriate due to a lack of basic facilities and equipment to care for such patients. The findings further reveal that these closely linked corruption problems had, on a few occasions, led health workers to be dragged before regulatory bodies, including legal authorities, on account of alleged misconduct. Interestingly, the evidence also suggests that some patients who sought care in both public and private facilities at various times for varied reasons sometimes found it difficult to delineate the boundaries for the inappropriate referral/diversion between public and private facilities, due to the ease by which healthcare workers especially medical doctors, nurses, and laboratory technologists shuttle between public and private health facilities to provide services.

The sub-sections below present an analysis of the causes and impacts of this group of corrupt practices from two main perspectives (patients and providers). The first category is more predominant, involving diversions/referrals from public to private facilities followed by the less common category from private to public facilities.

## *(A). Public to private diversions/inappropriate referrals: Patient's perspective*

### *(A1) Causes of public to private diversions/inappropriate referrals*

Inappropriate referrals/diversions made by healthcare providers from public to private health facilities was the dominant variant in this study. Regarding the causes of such forms of inappropriate referrals/diversions, several patients mentioned that they did not even recognise these were forms of corruption at the onset until late in the process, by which they have been impacted in diverse ways, including financial and non-financial impacts. Some of these patients were uneducated and could not comprehend the process. Others out of fear could not ask why they were being referred/diverted outside the public facilities they sought care. Most of the patients mentioned that with the tradition of the doctor being considered the "master" who knows it all, they were afraid to ask questions before being misconstrued as challenging the doctor's authority.

*“On this visit, the doctor just gave me a written slip and printed the name of a private centre behind the paper for me to go there so they can collect a biopsy from my swollen neck. He told me that even though it can be done in this hospital, he recommends I go to this private centre as there was no time for it to be done here” [Patient- Male Famer].*

However, several educated patients suggest that the cause for such diversions and inappropriate referrals was financial incentive for the healthcare provider diverting the patients. An informant described her experience and felt public healthcare providers hide under the guise of shortage of resources to engage in such practices.

*"I think they do this mainly for money without considering the patient. I was certain that this referral did not make any sense. I saw people having their scans here. When I asked why I was told to go to a private facility, the staff said the scans I saw them performing here were only for hospital staff and that they had too many scanning requests. Right before me, while we were speaking, he called someone at that private centre and said I would be coming to do a pelvic scan. The private hospital scan cost me more than what I would have*

*paid at this government hospital, and as far as I am concerned, he sent me there to make extra money at my expense" [Patient- Public Health Facility].*

*"All I did was protest why he would refer me just after two sessions to a private facility which I later found was owned by one of his colleagues from this government hospital. I had just started my sessions with him, which were to last for the next three months, and suddenly he asked to move me to a private facility due to a clash on his calendar. I asked if there was no other physiotherapist to attend to me since he had a conflict, and he got upset. Ultimately, I refused the referral, but this affected my treatment process as the atmosphere was cold and unreceptive each time I came for my appointment" [Patient- Private Health Facility].*

#### ***(A2) Impacts of public to private diversions/inappropriate referrals***

In relation to the impact of these practices on patients, the evidence shows that they exacerbate financial risks to patients as patients were often left with no choice but to follow the instructions of healthcare providers when the diversion is suggested to them. Patients suggest that a failure to do so is at their peril. Several patients also mentioned that because they were at their most vulnerable point, even when the diversion seemed inappropriate, they followed through with the suggestions by the healthcare provider.

*"The doctor I met told my two sisters and me that the best way he could assist our mother to be seen earlier was for us to see his 'oga' [boss] at his private hospital. He said if we were ready, our mother could be seen as early as we wanted, but we should be ready with the money. We mentioned we did not have that kind of money, as none of us was working then, however, we had to go to our relatives in the city to get some financial assistance. After that, our mother was seen the following week at the private hospital he had recommended. But this left us crippled financially" [Caregiver].*

In another interview, the patient described his experience of how his doctor diverted him from a public hospital to a private hospital which left him financially drained, but it was under the guise of *"this is your best way out"*.

*"I had my first internal fixation surgery here [public hospital], and the hospital did not have most of the plates and screws needed to fix my leg then. So, my doctor sourced them for me privately, which I paid for, and the surgery was performed here. However, I*



*required two more surgeries, and when the screws and plates became available in this public hospital, my doctor did not provide that information. Instead, he suggested I come to his private hospital to have the remaining two stages under the disguise that it was best to do everything in one place, but the cost there was so high. He stood to benefit financially from that process. By the end I was financially drained" [Patient].*

Other patients mentioned that they were unsure where the line between public and private health facilities is drawn since the doctors and nurses, they meet in these public facilities were often the same persons they meet at some of these private hospitals in Abuja. Therefore, they felt it was a continuum. These patients did, however, mention that care usually cost them more at the referred private health facility, although they were seen more quickly there than in public facilities.

*"What do I know, my son? I want to be treated, although I realised my daughter abroad kept asking her younger brother here with me why I was seen at another private hospital for some things that had been done in this government hospital before. I just assumed there is no difference since it is the same doctor that sees me in both places. I understand her concern though since I was charged more in the private hospital and my children complained bitterly of the financial cost. They all felt there was no reason for the doctor taking me to his private hospital" [Elderly Patient].*

#### ***(B). Public to private diversions/referrals: Provider's perspective***

##### ***(B1) Causes of public to private diversions/inappropriate referrals***

Regarding the perspective of providers on the drivers of these practices, several healthcare workers, especially junior cadre staff mentioned that these were done by senior colleagues for financial gain. Some also suggest that they are usually coerced into engaging in this inappropriate referrals/diversion of patients because there are no sanctions for erring healthcare providers, and therefore, these practices go unpunished.

*"In my opinion, it is purely for monetary gain. I recall one of our consultants who, at the slightest excuse, refers a patient out with flimsy excuses claiming there is no this or no*

*that to treat the patients. He instructed us to send the patients to his private hospital. I had no choice, and I also wanted to stay in the good books of my superior” [Junior Medical officer].*

*“This is certainly more common with our medical doctors, but what angers me is our fellow nurse colleagues' roles in aiding such wrong practices. Because they benefit financially, they are now the ones who act as proxies for these doctors” [Senior Nursing officer].*

However, other healthcare providers, usually the senior healthcare professionals had different viewpoint regarding the drivers of such practices. They suggest that the reason for such occurrences is driven by the dysfunctional state of public health facilities with shortage of facilities, drugs, supplies, and equipment. Therefore, these diversions/referrals are inevitable.

*“I will not rule out that such practices do not occur entirely, but it is often blown out of proportion by patients. Our public hospitals are in total disarray, and it is impossible to get the basic things needed for the treatment and investigations of patients. Therefore, I often understand why colleagues need to make some referrals to aid the treatment process for their patients” [Medical Consultant].*

### ***(B2) Impacts of public to private diversions/inappropriate referrals***

Regarding the impacts of these practices from the provider’s perspective, some healthcare providers, particularly those who mentioned that they were against these practices, corroborated some of the impacts of inappropriate referrals/diversions mentioned by patients in this study, such as exacerbation of financial risks and worsening of inequities of access for patients who did not follow through with the referrals/diversions due to delay/denial in care, others suggested otherwise.

*“I have been approached by patients in this hospital (public facility), crying that the last time they were diverted to private health facilities, they could not even end up paying their bills. One patient told me she borrowed money from her fellow traders’, and it was embarrassing. She felt she could have been operated here but they gave her 6 months to have the surgery. I work here, it’s just a ploy to divert these patients. Why would it take 6 months for Christ sake. These patients have no choice if not their care might be delayed for weeks and*

*months, so most rather look for money and follow these doctors to their private practice?”*  
[**Junior Nurse- Public Health Facility**].

*“You know we are usually the first and the last people these patients meet as they come in and leave this hospital. So, they sometimes rely on us, especially when they need direction or are frustrated, and the doctors have private hospital and want us to send these patients who rely on us. Several of them have come back complaining of the financial costs. I know two who told me their experience and I felt so bad for them”* [**Security Guard**].

On the contrary, some healthcare providers who agreed to have engaged in some referrals/diversions that seemed inappropriate to patients suggested that they were left with no choice but to suggest such referrals/diversions if certain patients were to be treated urgently to avert further complications by virtue of the dysfunctional state of some public facilities.

*" Even though its financially more expensive for these patients, some feel it has had some positive effect on their health regarding how quickly their problems were sorted in the private facilities. Some patients sometimes even cry, asking for any private hospital where these doctors work outside here. They tell you that they are willing to be referred no matter the cost. Well, we pity and connect them to these doctors because the hospital is not resourced enough to see patients?"* [**Record clerk at a public hospital**].

### **(C). Private to public diversions/inappropriate referrals**

The evidence in this study shows that this category of inappropriate referrals/diversion of patients occurred at a lesser rate than those from public to private facilities. Here, either the healthcare providers work in both the private and public facility or have some form of “connection” to healthcare providers in public health facilities they refer these patients to.

#### **(C1) Causes of private to public diversions/inappropriate referrals**

In this less common form of inappropriate referrals/diversion, the evidence as presented below suggests that there are often private interests or financial benefits for both the referring

physician from the private health facility and sometimes to the referred physician in the public health facility.

*“On three separate occasions, while seeing my cardiologist in this private hospital, he asked me to meet him at one of the government hospitals where he worked. I did not pay anything at that government hospital, but all payments were made to him in the private hospital where he had first seen me. He did a specialised form of ECG; he called it 'stress ECG'. In another instance, he did a doppler. I often returned back to the private hospital, and he used the information from the various tests at the government hospital to review me here”* **[Patient- Private Health Facility]**

*“I was around 34 weeks pregnant, and the doctor needed to clarify some issues about how my unborn baby lay in my womb. He asked me to see him at this government hospital the next day. He made me come in as a normal patient and he used their machine to check what he wanted to clarify, and I returned to see him at this private hospital that same day. I did not pay anything there, but I noticed the finance people here charged me for the test which was done at the government hospital”* **[Antenatal Patient- Private Health Facility]**.

As revealed by the evidence above, increased financial gain is also a key incentive for these diversions to private healthcare providers as individual workers and private facilities. On the contrary, the evidence suggests that the public health facilities where these patients were diverted sometimes do not receive official payments for the services or equipment used for such services. Instead, the evidence shows that the private health facilities where the diversion originated were the ones who benefited financially.

### ***(C2) Impacts of private to public diversions/inappropriate referrals***

Patients who were diverted from private to public health facilities for part or all of their treatments felt there was no additional negative impact from a financial standpoint to the already high costs they were exposed to in these private facilities. However, some agreed that government hospitals are the ones shortchanged by such a practice since they often do not make revenue for these services.

*"I agree the fact I did not pay anything at the government hospital and that all payments went to the private hospital where my doctor saw me initially, shortchanges government but who was I to complain? It saved me extra payments, and I had express entry to the public hospital. You know how long I could have waited or the harassment I could have faced there? Everything worked in my favour and seeing that the doctor already charged me in here already, it was not my problem if he paid the public hospital for the care I received or not."* **[Patient- Private Health Facility].**

*"I think because the doctor knows he is not going through the proper channel, it was on a Saturday he sent me to see the pathologist there. I was seen without opening a card there and did what took me there before I returned back here. I did not pay anything there since I already paid them here"* **[Patient- Private Health Facility].**

Therefore, regarding the impact of patient diversion from private to public facilities, which occurred less frequently in this study, the evidence shows that such corrupt practices often shortchanged public health facilities while private providers were the beneficiaries. The patients still paid for services at the private health facilities.

In summarising the evidence revealed from the perspectives of both patients and providers regarding the manifestations, causes and impacts of inappropriate referrals/diversions as a corrupt practice presented in this thematic section, the findings suggest that healthcare providers usually orchestrate these closely linked corrupt practices because of the unhindered access and connections they have between the two health sectors (public and private). Therefore, taking advantage of the easy interaction between public and private health facilities to propagate such corrupt practices further. Healthcare providers benefit from these corrupt practices while the impact on patients exacerbates financial risks, especially for poorer patients diverted from public to private health facilities, and a delay or denial in care for patients who cannot afford financially to go through with the referrals/diversions.

#### **6.1.4. Theft/Diversion of Medical Supplies and Equipment**

#### 6.1.4.1. Manifestations of Theft/Diversion of Supplies and Equipment

Theft of medical supplies and equipment, including diversion of these stolen supplies between public and private health facilities emerged as a recurrent theme in this study. These medical supplies and equipment ranged from oral medications and injectables, laboratory reagents, gloves, detergents, disinfectants, and other consumables such as cotton wool, methylated spirit, needles, and syringes. Other equipment includes hospital microscopes, stethoscopes, sphygmomanometers, surgical accessories, beds, and bedding, amongst many others. The evidence as will be presented in this theme also shows outright theft for sale by healthcare workers, particularly those in public health facilities to open markets and to patients within these facilities where they had been stolen.

For example, in an interview, a patient described an instance where they had seen government equipment used in private health facilities.

*"I saw it written on the X-ray machine that this was a government machine, yet I paid for an X-ray done in that private laboratory using this X-ray machine. I was referred to the place by someone from the X-ray department of this same government hospital. You do not need rocket science to tell you how this machine got there. My cousin also told me that she saw microscopes with government hospital labels in a private laboratory where she was doing her internship. Her boss who owns the private laboratory also works in one of the government hospitals"* [Patient- Public Health facility].

Other patients interviewed in private health facilities also narrated similar accounts of being sold drugs meant for free use in public hospitals. They wondered how drugs meant for use in public health facilities found their way to private health facilities. In this instance, the evidence here suggest that these private health facilities sometimes serve as conduits for theft of the supplies that occur in public health facilities, thereby creating "black markets" for public health facilities in a mixed health system such as Nigeria's.

*“The antimalarial drug they gave my child in this private hospital had a clear inscription do not sell with a label of X General Hospital (public facility). I honestly don’t know how it got here but your guess is as good as mine”.* [Caregiver- Private Health Facility].

The theft and “black-market” sales of medical supplies and equipment as evidenced above are made easy due to the mixedness and interactions of public and private health facilities often in close proximity in Abuja. The evidence suggests that healthcare workers' theft and diversion of medical supplies are primarily for financial gain. However, some findings in this study also shows evidence of health workers keeping quality medical supplies for personal use, including stealing addiction drugs, and selling sub-standard medical supplies to patients.

*"Here in my maternity ward, we have dealt with several cases of staff stealing pentazocine [painkiller IV drug] meant to reduce pain for our patients. Some staff are now addicted to this drug, and they steal it to satisfy their addiction problem. The same thing happened with diazepam as other colleagues in other wards are also battling these controlled drugs being constantly stolen. We have had instances where our staff were seen with these IV drugs"* [Hospital Matron].

The sub-sections below present some causes/factors that enable the theft/diversion of medical supplies between public and private facilities and to the open market, and the impacts of these practices to patients and the public health facilities themselves.

#### ***(A). Causes/factors that enable theft/diversion of medical supplies and equipment***

Regarding the factors enabling theft/diversion of medical supplies in this study, some patients revealed experiences where they were sold drugs in health facilities, which they felt were stolen by virtue of tags that had “*not to be sold on these drugs*”. However, several patients also suggest that theft was worse in rural public health facilities in satellite towns adjoining Abuja city, where they were referred from. They felt this is so because these rural public health facilities are often far from the eyes of government scrutiny and lack oversight. Some patients

described instances where they had been sold medicines and injections within public hospitals with the inscription, “*not to be sold.*”

*"I have had experiences where drugs meant for use in government hospitals in my satellite town close to Abuja were sold to me in private hospitals close to where I live. For me, the reason is government inspectors rarely come to our place to check what is happening. I recall when this antimalarial drug, the ACTs, had on the packs, 'not to be sold', but the pharmacists in this same government hospital sold the ACTs to me on several occasions. As you know, cash payment is the thing here. One day I looked at the pack and realised they were donated to Nigeria by the government of China, yet they were sold to us publicly in the private hospital pharmacy. Relatives and friends have also told me they bought these 'not to be sold' ACT drugs in private pharmacies and hospitals even in the city. I am curious how these free drugs got to such private pharmacies if hospital staff did not steal these medications. [Patient- Private Health Facility]."*

Furthermore, in the opinion of several patients in this study, they felt that public healthcare workers hide under the guise of shortage of health supplies and scarcity, i.e., - “*out-of-stock*” syndrome in public hospitals, to steal supplies in the name of keeping these supplies for emergency purposes during the stock-out period, only to sell to patients.

*“The nurse brought some of the injections out of his drawer. He said that because the hospital pharmacy is always out-of-stock, we keep some of the main emergency supplies to help people like me during emergencies and asked that I pay him by cash. I did not care if the money was going to his pocket or even if the drugs were stolen from the pharmacy at that point. I just wanted the person I had hit to survive. So, I paid for what he asked me though he acted suspiciously; that was none of my business. I paid him in cash, and he did not give me any receipt” [Caregiver- Public Health Facility].*

In another interview with a patient at one of the general public hospitals, the scarcity of drugs due to covid-19 lockdown, the patient suggested that this was used as a disguise to steal and sell drugs meant for free use in public health facilities. The informant described an experience during the covid-19 lockdown, where antiretroviral clinics were closed due to the impact of the pandemic. However, on one of the occasions, the patient was approached by a healthcare



attendant and a security guard who offered to sell antiretrovirals to the patient without even knowing which class of drugs the patient was on.

*"Due to the covid lockdown, there was problems with supply of drugs meant for treating our kind of condition. These two men approached me - one in a security uniform and the other was a healthcare attendant in his uniform. They knew we were here to collect our medications as our clinic is specially located in one part of the hospital. I was quite surprised that they had some drugs and knew their names. These drugs are supposed to be free, but because they knew the lockdown had affected clinics, they were taking advantage of the situation to sell free drugs to us. Where did they get these drugs if they were not stolen".* [Patient- Public Health Facility].

### ***(B) Impacts of theft/diversion of medical supplies and equipment***

Regarding the impact of this group of corrupt practices, mainly in public health facilities, the findings suggest that these create further medical supply shortages and worsen the persistent out-of-stock issue in public facilities. Some patients also mentioned that with these shortages coupled with the theft/diversion of supplies, they were left with the option of buying outside the hospital, further increasing their financial hardship as it is costlier buying outside than it would have been in public facilities.

*"Why wouldn't out-of-stock be a continuous problem in this government hospital when you see these people selling medications while none is in the pharmacy. Although they claim is their personal supplies, but I have my doubts. I just feel that most of the medications were stolen from the main system that is why there is always the problem of out-of-stock and is we the patients that suffer. We buy from their personal supplies at high cost or in private pharmacies at expensive costs* [Patient- Public Health Facility].

*"My concern with this issue of theft of drugs is that it leaves patients exposed to buying substandard drugs once the ones we can vouch for have been stolen from our supplies here in the hospital"* [Nurse- Public Health Facility].

In addition to the exacerbation of financial risks to patients, the evidence from the nurse above also suggests that the impact of such corrupt practice leaves patients exposed to buying substandard or low-quality medicines in some private retail pharmacies. Furthermore, the impact

of such practices on the public healthcare system itself leads to loss of revenue for public health facilities, including costs of prosecution when staff are caught stealing/diverting hospital supplies.

*"Sometimes is because of pilfering and taking to private hospitals that is why patients cannot get all the important tests done here. There were countless times we have had to deal with this problem. On one occasion, we had to suspend and eventually dismiss a staff who was caught selling hospital drugs. Also, one of our security guards once caught another laboratory worker with laboratory reagents worth hundreds of thousands. The staff confessed to taking the reagents to a private laboratory for private business and this makes government hospitals lose money"* [Hospital Manager- Public Health Facility].

*"Our patients are the ones who suffer the brunt of these stealing of hospital supplies, because once these things are stolen, we do not have enough to take care of patients with it. I must tell you that this problem cuts across all cadre of staff. From store clerks stealing toilet papers meant for patients' use to hospital cleaners stealing cleaning materials such as detergent and nurses pilfering needles and syringes to pharmacists and laboratory personnel stealing drugs and laboratory reagents. We have had cases where our doctors take our stethoscopes and blood pressure machines to their private hospitals, and even our microscopes have been taken to private hospitals"* [Hospital Manager- Public Health Facility].

Other occurrences of theft/diversion of medical supplies in this study indicated that this practice sometimes does occur in private health facilities, although at lesser rates.

*"Just a few weeks back, there was an incident where one of our staff stole several packs of detergent, and that same staff stole some vials of painkillers. Also, three months back, another staff member, a security guard who is supposed to apprehend people for stealing, was caught with painkillers, and injecting himself"* [Hospital manager at a private health facility].

In summary, in addition to the theft for open sale in the market, the evidence presented in this thematic section suggests that private health systems, including private hospitals, pharmacies, and laboratories, play some role in this mixed health system corruption problem by serving as conduits for diverted or stolen hospital supplies. Due to the interaction of public and private health sector facilities and the lack of accountability and oversight, healthcare workers

connected to public and private health facilities make it easy to steal and divert hospital supplies between the two health sectors.

#### **6.1.5 Analysis of Incentives Enabling Corrupt Practices in both Public and Private Sector Facilities**

This section of the chapter further delves deeper into the analysis, emphasizing the particular incentives arising from structures, systems, and organizational culture that enable corrupt practices in both public and private health sector facilities from the findings built from chapters 4 and 5 in this study. The symbiotic relationship between these sectors can be attributed to several factors. These factors analysed next are viewed through the lens incentives (systems and structures) and the prevailing organisational culture.

##### **A). Public Health Facilities**

##### **i) Shortage of Resources and Poor Remuneration**

##### **Incentives: structure and systems**

The lack of alternative resources: The evidence in this analysis suggests that the chronic underfunding of these public health facilities leaves healthcare providers with limited resources, creating incentives for corrupt practices such as informal payments and bribery to supplement their income. Similarly, as a means of survival strategy, in such resource-scarce environment, healthcare workers and patients often view corruption as a survival strategy to ensure access to necessary healthcare services. Therefore, engaging in bribery and informal payments to jump queues by patients and diversion of patients to private health facilities where they are further exploited financially and sometimes under/over treated for financial gain becomes the norm in such settings.

##### **Organizational Culture**

The evidence also shows that there is a huge problem of normalization of Corruption. The scarcity of resources led to a normalization of corrupt practices as patients and care-seekers within the health system come to accept rule-breaking as a means of coping with these challenges.

## **ii). Commercialization of Health**

**Structure and Systems:** In terms of incentives and financial gains, the commercialization of health services introduces financial motives, encouraging healthcare providers to engage in corrupt practices such as informal payments and theft of user fees for personal financial gains. Similarly, weak oversight and accountability contribute to an environment where corrupt practices such as informal payments flourished without fear of consequences.

### **Organizational Culture**

**Acceptance of Commercialization:** The organizational culture in these facilities were shown to tolerate or even encourage the unintended consequences of the commercialization of health services, fostering an environment where corruption became ingrained in day-to-day operations.

## **iii). Impact on Patients and Inequity of Access**

The informal connections and influence activities contributed to power dynamics that favour those with connections, creating an incentive for patients and healthcare providers to engage in corrupt practices. Similarly, the erosion of trust resulting from corrupt practices such as informal payments and bribery further perpetuates the cycle as patients felt compelled to use corrupt means to secure better treatment in these facilities and those who were unable moved to private health facilities with its own attendant corrupt practices related to profit maximization. With respect to the organizational culture in this sector, cultural acceptance of

preferential treatment led to the acceptance or even encouraged preferential treatment, making it easier for corrupt practices such as informal payments, bribery, and theft of user fees to become a standard practice.

## **B). Private Health Facilities**

### **i) Profit Maximization and Lack of Oversight**

#### **Incentives: Systems and Structure**

The evidence arising from the analysis shows that due to financial motivation in private health facilities, driven by profit motives with associated lack of transparency and poor regulation of the sector, patients using private facilities including those who ran from informal payments and bribery from the public sector facilities were bedevilled by further corrupt practices such as incentivized overcharging, health insurance fraud and other related invoice frauds to maximize revenue. After all, the poor regulation and oversight by health authorities in this sector create opportunities for such corrupt practices without fear of repercussions.

Similarly, the incentives propagating these subtle corrupt practices in order to preserve patient base from the private sector of which several of these patients had been diverted from the public sector due to corrupt practices such as informal payments and bribery and only to be faced with subtle corrupt practices. These practices faced here include overbilling, under/over treatment to maintain their patient base without raising suspicions, ensuring a steady stream of income for these private facilities.

#### **Organizational Culture**

The evidence from the analysis in this study shows that the encouragement from management of the private sector as suggested by several private healthcare workers claim that their management encourage such corrupt practices to boost revenue, suggesting an institutionalized

acceptance of corruption. The management's encouragement of such practices indicates an organizational culture that prioritizes financial gains over ethical considerations. Similarly, the acceptance and normalization of covert practices within these private sector facilities contribute to the ease with which corruption occurs.

## **ii) Information Asymmetry**

### **Incentives: Systems and Structures**

Regarding the incentive system and structure, several patients were shown to choose private facilities for corrupt practices due to perceived ease compared to public facilities, where multi-layered barriers exist. These patients found corrupt practices more accessible in private facilities due to fewer actors and barriers.

### **Organizational Culture**

Here, the evidence from the analysis shows that the problem of information manipulation: The intentional manipulation of information by private facilities contributed to an environment where patients were often not able to recognize or question corrupt practices.

## **C). Cross-Sectoral Dynamics (Public-Private Mix)**

### **i) Interaction of Corruption Forms**

#### **Incentives: Systems and Structures**

There is evidence of mutual benefit regarding corruption between the two health sectors in this study. From the analysis in this study suggests that the symbiotic relationship between public and private sectors facilities often arose from the mutual benefits, where corrupt practices in one of the two sectors indirectly supported similar practices in the other sector. For example, the shortage of resources did trigger corrupt practices such as informal payments, bribery, diversions and theft of fees and medicines and these practices in turn had feedback loops that

trigger other corrupt practices both within the public sector facilities and in the private sector facilities such as patients being sold substandard and sometimes expired drugs that were stolen and diverted from the public to private sector facilities.

**(ii). Lack of Cross-Sectoral Oversight:** The analysis in this study also shows the absence of effective oversight that spans both sectors (public/private) creates opportunities for corrupt practices to persist across both sectors including theft and resale of drugs and equipment across both sectors, dual practice, absenteeism among other corrupt practices.

### **Organizational Culture**

Regarding organisational culture, the shared acceptance of corruption, whether explicit or implicit, contributes to the perpetuation of corrupt practices across both sectors, with the private sector sometimes serving as a conduit for corrupt practices emerging from public facilities such as theft. Similarly, the analysis showed a strong resistance to change: The resistance to governance strengthening reflects an organizational culture that resists change when it threatens individual benefits particularly for the healthcare workers which were often derived from corrupt practices that linked both sectors.

### **(iii). Institutional Setup and Governance**

The lack of incentives for Governance Strengthening was a common finding across both sectors. The absence of strong incentives to strengthen governance arises from a system where everyone, to some extent, benefits from the existing corrupt practices in both the public and private sector facilities. Furthermore, the fear of disruption with healthcare providers across both sectors resisting governance reforms, fearing disruption to the status quo that provides personal benefits was strive.

In conclusion, the analysis in this section of the chapter shows that the symbiotic relationship between corrupt practices in public and private health sectors is sustained by a combination of financial incentives, weak oversight, and organizational cultures that tolerate or even encourage corruption. For example, the analysis suggests structural enablers where the coexistence of public and private sectors provides a structural framework where corruption can thrive, as corrupt practices in one sector is complemented or exacerbated by practices in the other. Furthermore, the lack of a strong regulatory framework governing the interaction between public and private sectors creates structural vulnerabilities that are exploited. Similarly, the absence of strong incentives to strengthen governance across both sectors allows corruption to persist. In addition, dysfunctional systems in public facilities and the lack of effective regulation in private facilities contribute to a structural foundation that enables these corrupt practices and the symbiotic relationship between the two sectors.

## **6.2. Demand-side interactions: Patients' journeys through public and private facilities and corruption vulnerabilities**

Building on the foundation laid in the introductory section of this chapter, this second part of the chapter presents demand-side perspectives on the interactions - and the effects of those interactions on corruption between the two health sectors within the context of the mixed health system in Abuja, Nigeria. Therefore, this offers another lens/perspective into how patients navigate the corruption problems identified in *section 6.1*. This macro theme here in *section 6.2* focuses on patients and their journeys and their encounters through public and private health facilities, and the interactions between them, including the pathways these patients travel through as they navigate the intricacies and dynamics posed by the corruption problems earlier identified under supply-side interactions in *section 6.1*.



In this study, I refer to "*patient journey*" to include patients' experiences along their patient pathways as they sought medical care from healthcare providers in public and private health facilities. In the case of outpatients, this journey often starts from entry to exit of a hospital visit on an outpatient basis, including the experiences patients encounter while interacting with providers from for example the record units, payment points, nursing stations, consulting clinics, pharmacies, laboratories, and investigation points, among others. In the case of inpatients, the patient journey includes hospital admission experiences through discharge out of the hospital. In both cases, the evidence in this study reveals that patients' experiences along these journeys sometimes include experiences of corruption.

These journeys described by patients come with several distinct but interlinked mapping points as they move from one point to another across these public and private health facilities. This study akin this process of "shopping" for care which "*refers to the behaviours and actions of patients as consumers of care as they make active decisions about their health and health care — e.g., due to comparative costs, operational challenges, whether to seek additional care, change physicians, or where to seek the care from*" (Glaser, 2021, para. 2). The evidence reveals that this "care experience" is sought by patients as they move within and between public and private health facilities is sometimes in a bid to seek for better or desired patient experience.

Although the "patient journey" experience in this study is unique for each of the interviewed patients, there are some common elements regarding the patient experience for most patients across several domains throughout their journeys while seeking care in facilities in Abuja's mixed health system. These everyday experiences fall under three main categories. Journeys that start from (i) public to private facilities (ii) private to public facilities (iii) public-private mix.

*(i). Patients' journeys starting from public health facilities*

The evidence in this study reveals that most of the patients who commence their journey from public health facilities do so for several reasons. These reasons range from personal preferences, financial considerations, seeking specialised treatment, and referrals. Several patients who sought care in public health facilities in this study mentioned that their preferred choice would not have been public health facilities, but rather private health facilities, if not for financial constraints. They said the perceived high cost of treatment in private health facilities made them to opt for public facilities. Most of the patients highlighted that the principal reason for not wanting to seek care in public health facilities is the unpleasant experiences that often leaves them traumatised including various forms of corruption they had either personally encountered or learned from their friends and relatives who encountered same while attending public health facilities.

In addition, several patients in this category also felt that the government and public healthcare providers seem to have deliberately set up the organisational structure and functions of the public facilities in such a way that it creates chaos for patients. These patients felt that this chaotic environment coupled with shortage of resources leads to most of the corruption problems they and their families experience which has impacted negatively on them both financial and non-financial impacts.

*“If not because I am a poor man and the fact that the specialist care I need here in Abuja is in this government general hospital, nothing in this world would have brought me here. Everything here is a problem. I sometimes ask myself if the government was deliberately doing this to punish poor people in this country. Nothing works in this country, and you come to the hospital, your experience is even worse” [Patient- Public Health Facility].*

This patient above suggested that he and his family only used public health facilities when there was no improvement with self-medication through off-the-counter medicines from local

pharmacies or when he had no money to seek care in a private health facility. Again, he said the following:

*"Right from the hospital gate, the security guards will want to make something financially out of your already difficult situation. You get to the records and card section, and the queue is like a market square which to me is like they do it deliberately so the record clerks can get money from people who want to jump the queue. Sometimes my family and I get here before 7 am, and before we can see a doctor is until 2 pm or 3 pm. When I finally get to see a doctor, he has written my medicines before I even tell him what is wrong with me. One time, I was asked to do some tests; the test took weeks before it was ready, and they sent me to their private laboratory for several of the tests which I had to pay through my nose" [Patient- Public Health Facility].*

Similarly, in another interview, a patient described her patient journey in these public hospitals as quite frustrating.

*"I came here because I was sent from a Primary Health Centre. It took me close to three months to see the gynaecologist here. Someone working here had to "connect" me, if not it would have taken longer to see a doctor here. All the tests the doctor wanted me to do could not be done here, so he had to send me to his private hospital to do them. If I had known this from the beginning, I would have just gone straight to that private hospital. Because after all this suffering and waiting for over three months, I still ended up going to do most of the tests at his private hospital and then coming back here again. You keep going back and forth between government and private hospitals. It is very frustrating" [Patient- Public Health Facility].*

The evidence above suggests that these patients like several others that were interviewed usually start their journey through a pathway that originates from a public health facility. However, based on their patient experience, they yearn to move or are forced to move to another health system, usually private health facilities. These patients usually "shop" for care often due to the systemic failure in the public health system, as was the case with these patients who started from public health facilities and then had to go to private health facilities for other services (Nikoloski and Mossialos, 2013; Glaser, 2021). They had no choice but to do so to get services that were not available or escape from the operational challenges, including corrupt

practices such as bribing healthcare providers in the public facilities where their journey originated. In the process, some of these patients were diverted to private health facilities for several of the laboratory investigations they needed which increased their financial expenditures. This journey between public and private facilities for some patients is faced with numerous challenges, including exploitation and corruption. These demand-side problems, as experienced by patients in this study, propagate the avenue for corrupt practices as the evidence shows that some healthcare workers take advantage of the dysfunctional public health facilities to divert patients' often due to desperation to their private health facilities at far higher costs for these patients. These patients have no choice but to navigate back and forth these two health sectors in order to get better services.

Despite the unpleasant experiences for these patients, the evidence shows that many still use the public health system. These points were underscored by the patients above who needed to see specialists who were mainly in public health facilities. At the same time, some specific investigations were unavailable at these public health facilities, hence the need to "forum shop" by going to the private health laboratories that provide such services which comes with the added risk of experiencing more corrupt practices.

#### *(ii). Patients' journeys starting from private health facilities*

The findings here also reveal that most patients who start their journey through private health facilities described doing so for one or more of the following reasons. These reasons include personal preference, a partial or complete absence of some investigations in public health facilities, the harsh and sometimes dehumanising treatment meted to them.

Most of the interviewed patients in this category highlighted that it cost them more financially starting their journey in private health facilities for illnesses that would have been treated cheaper in public health facilities. However, due to limitations of even the private health

facilities they have had to sometimes go back to the public facilities they were running from for some aspect of their care. Nevertheless, they felt they had no option but to start their journey through the private health system due to the earlier enumerated challenges with public health facilities even though they sometimes end up facing corruption problems here as well.

*“Despite the better experience here regarding seeing doctors quickly, however, the problem here is they charge you an ‘arm and leg’ for the price of medicines that are not even branded. They are sometimes not honest about it. In a few instances I have had to run back to government hospitals here in Abuja because those drugs did not help despite the huge amount I paid” [Patient – Private Health Facility].*

*“I feel welcomed and respected compared to what I used to get back then in government hospitals. However, the main issue here is they are not transparent in their billing with the bills often high and shrouded in mystery at how they arrived at the bill. They sometimes use very ordinary materials to treat me, but they write that they used high-quality materials simply because they feel one would not know since I am not a medical person. I think this is an unfair way of making a profit from patients by lying to them that you gave them branded medications” [Patient- Private Health Facility].*

While some of these patients described that the environment in these private hospitals was quite comfortable, and they felt treated with dignity, they still suggested they sometimes had doubts regarding the services offered to them as in terms of quality. Others also felt exploited financially in astronomical terms. Other patients also raised concerns about poor regulation by health authorities as there were instances where they were poorly managed in these private health facilities due to cutting costs measures by these facilities by engaging unqualified personnel.

*“I started from private hospital but ended in public hospital. I was in labour and the midwife in the private hospital; I later learnt was an auxiliary staff who started as a health care attendant in the hospital but was later made a midwife without proper midwifery school. She mismanaged my delivery that night, and I was eventually rushed to the National hospital [public tertiary hospital] due to a big vaginal tear that left me bleeding so much. I almost died if not that I was transfused in that government hospital and taken to the theatre” [Patient- Private Health Facility].*

The primary motivation in these instances described above went beyond seeking profit from the private facilities' healthcare providers to circumvent and break the rules for financial gains. The intentional use of unqualified midwives in private facilities abuses the entrusted power vested by the state on these private healthcare providers to treat patients. Hence, patients see their activities as corrupt, and other studies have found similar findings (Coarasa, Das and Hammer, 2014).

*(iii). Patients' journeys through public- private mix of health facilities*

The findings here reveal that right from the onset most patients had had their journeys mixed across both the public and private health facilities. These patients described that the default mode is often to go back and forth between these public and private health facilities as they seek care, which is brought about by several reasons, chiefly amongst them is the fact that they could neither entirely depend on the public or private health facilities. Therefore, to circumvent the challenges associated with both health sectors, including corrupt practices they encounter, they have no option but to move back and forth between public and private facilities for their care needs.

Other patients in this category also revealed that another critical reason they "shop" for care between public and private health facilities was the comparable costs of care- i.e., the direct and indirect spending they experience over time across public and private health facilities. In their opinion, most patients interviewed felt that they spent more on average to seek care in private health facilities, however, some of these patients also felt that they spent a considerable amount of money to seek care in public health facilities due to formal payments and informal payments including bribes. Therefore, some of these patients felt that it amounts to a significant cost when they sum up such costs in public health facilities.

*"You cannot get all you need in one place here in Abuja, unlike my sister, who tells me that she gets everything in one hospital in Germany. Here you must move between the government and private hospitals. You can get specialists in a government hospital, but the service there is deplorable, with people demanding money left, right and centre. So, one must go to private hospitals, which are sometimes costly and use shady tactics to rip you off as well. Moreover, again, the same doctors one meets here in this private hospital, are those I had previously met at the government hospitals. So, I think both us and the doctors move between the public and private hospitals in Abuja"* **[Patient attends both public and private health facilities]**.

*"Due to how frustrated I was with this government hospital, a health care attendant suggested that since one of the doctors here also works at another private hospital, it might be better to go there in emergencies. So, my family only come here [public health facility] when the issue is not an emergency. Then we go to the private hospital in emergency cases. Despite this, we also had a severe problem in the private hospital the last time when their oxygen got finished, and my daughter was sick. We were sent back here [public health facility]. Meanwhile, we were charged costly in that private hospital "* **[Patient attends both public and private health facilities]**.

The evidence across this third category of patients suggests that the typical patient journey/pathway in health facilities in this study involves shuttling back and forth across the two health sectors of public and private facilities, all in a bid, to seek the desired patient experience. Furthermore, the evidence as presented above suggests that neither of these two systems (public or private) provide these patients with the desired "patient-centred" experience, including experiences devoid of corruption as they had hoped. Mackintosh and colleagues suggest that such "care experience" is a widespread practice engaged by patients in LMICs in their bid to seek care in health systems which operate poorly funded public health facilities operating side by side with private facilities which themselves are often unregulated (Mackintosh *et al.*, 2016).

### 6.3. Summary of Chapter Analysis

In summary, the analysis from the provider-patient perspectives into the supply-side interactions (i.e., those that relate to the behaviours of providers – organisational and individual) and demand-side perspectives (i.e., those that relate to the behaviours of patients) which focused on how, and the extent to which, corruption is enabled by the existence of, and interactions between, the public and private health sector facilities revealed some interesting findings.

From the demand-side perspectives on the interactions - and the effects of those interactions on corruption between the two health sectors, it reveals that when patients seek services in health facilities in Abuja, Nigeria, they travel along a pathway that this thesis frames as “*the patient journey experience*.” As these patients navigate their pathways to seek care in this mixed health system, they move between public and private health facilities. On the other hand, the analysis also suggests that from the supply-side, the nature of these public-private health sector interactions in the context of Nigeria’s mixed health system generates additional drivers for corruption. These interactions create scope for several other forms of corruption, which patients from the demand-side face while seeking care as they navigate the two health sectors. These corruption problems, including their manifestations, causes and impacts, are summarised in *Table 6.1* below.



**Table 6.1: showing causes, manifestations, and impacts of corruption in public-private mix in health systems**

Manifestations of Corruption	Key Actors	Causes	Impacts
Dual practice	Health workers	Poor salaries of public health workers	Increased absenteeism in public facilities
		Enticement by private health facilities	Increased temporary workforce
Absenteeism	Health workers	Dual practice	Prolonged patient waiting times
		Weak oversight	Low utilisation of public health facilities
		Poor salaries of public health workers	Increase in self-medications and complications
			Poor health seeking behaviours
			Choice of unorthodox medicine (traditional)
Inappropriate referrals/diversion of patients between public and private facilities	Health workers	Information asymmetry	Increased spendings for patients across both settings
	Hospital management	Poor salaries	Wastage of public resources

Manifestations of Corruption	Key Actors	Causes	Impacts
			Deprivation of access for other patients
Theft/diversion of medical supplies from public to private facilities	Health workers  Hospital management	Weak accountability structures	Shortfall of medical supplies in public facilities

Furthermore, the evidence also shows that as patients move between the two health sectors often across the different levels of healthcare without regimentation, healthcare workers also move reasonably easily between public and private health facilities, resembling a "revolving door" system. This mixed health system set-up where the health facilities often operate without regimentation across the different levels of care creates multiple drivers for corruption in such an unregimented environment. As these healthcare providers revolve between public and private health facilities, they interact with patients who "shop" for care. In the opinion of most patients in this study, this interaction between them and providers provides opportunities for additional corruption vulnerabilities that the interaction of the public and private health facilities has enabled.

This fluidity between the two health sectors broadens the area of exposure for patients regarding corrupt practices and their vulnerability to such practices often enabled by the interactions of the two health sectors, such as dual practice, health worker absenteeism, inappropriate referrals/diversions of patients, and theft/diversions of medical supplies between

public and private facilities. For example, the analysis in this chapter shows that public healthcare workers' absenteeism to engage in private practice during official hours (i.e., dual practice in the context of corruption) aggravates the already health workforce resource shortage faced by public health facilities. With this shortage, patient waiting times are further prolonged, making it more likely for health workers in public facilities to exploit further desperate patients, including diverting them to private health facilities inappropriately, which is another form of corruption.

Similarly, in their quest to escape the challenges of public health facilities, these patients are faced with new corruption vulnerabilities from private healthcare providers when diverted as they encounter other corruption problems inherent in private health facilities that are driven by incentives such as over-charging of patients, inappropriate prescriptions, over-treatment/under-provision of services with the aim of profit maximisation which was presented in chapter 5. Therefore, this becomes a cyclical pattern as this public-private interaction continues to create scopes and an enabling environment with further corruption vulnerabilities through patient-provider encounters across the two health sectors. In combination, the evidence suggests that these two health sectors often aid and abet each other in continually propagating corrupt practices that impact patients as they navigate the mix of public and private health facilities, shown by the supply-side interactions and demand-side perspective on those interactions, and the effects of those interactions on corruption within the context of the mixed health system in Abuja, Nigeria.

In conclusion, the evidence from the analysis in this chapter which takes into account the enabling effect of the public-private mix in the interaction of the two health sectors, including its manifestations, causes and impact of corruption in Abuja, Nigeria's mixed health system, is highly contextual and suggests potential complexities to provide a clear guide to policy action.

## **Chapter Seven**

### **Review of Main Findings and the Implications for Policy**

#### **7.0 Introduction**

The principal focus of this thesis has been to understand how corruption is experienced by, and impacts upon, patients and providers as they navigate the "corruption complex" in the mixed health system of Abuja, Nigeria. This discussion chapter is structured into four main sections. The first section reviews the main empirical findings of the thesis, how the findings in each of the empirical chapters address the study's three objectives, their interpretation and significance, and how these chapters connect to each other to address the overall aim of the study. Further, it also highlights the specific contributions these empirical findings make to the scholarship, referencing the gaps identified in the literature review chapter; and existing policy understanding about the nature of corruption across public and private health sector contexts including a nuanced analysis of anti-corruption strategies in Nigeria's mixed health system. The second section presents the policy implications regarding the study's findings and makes policy recommendations. The third section presents some limitations of the study, and the last section suggests some priority areas for future research.

This thesis has drawn on qualitative exploratory research, mainly through in-depth interviews of patients, providers, and policymakers, and through participant observation to arrive at key empirical findings discussed next.

#### **7.1 Review of Empirical Findings**

This section reviews and discusses the main findings of the thesis from the analysis of the three results chapters, including how these findings address gaps in the literature and how the

findings in the results chapters connect. It further situates these empirical findings within broader scholarly works and debates.

### **(a) Corruption in Public Health Facilities**

In chapter four, I addressed the first objective of this research, which investigated the experiences of patients and providers concerning the causes, manifestations, and impacts of corruption as they occur in public health facilities in Abuja, Nigeria. The empirical findings in chapter four explicitly focused on the combined and nuanced experiences of patients and providers, which has not been the focus of previous works on corruption in Abuja's public health sector facilities.

This first category of corrupt practices in public health facilities, presented in chapter four, include bribery, informal payments, theft of formal charges/user fees, and influence- activities associated with nepotism. These corrupt practices are similar to forms of corruption seen in public health sector facilities in other LMICs, particularly in the global south. Other studies have documented similar forms of these "traditional" or more "formal" forms of corruption synonymous with public health facilities in the literature (Akokuwebe and Damilare, 2015; Hahonou, 2015; Tormusa and Idom, 2016; Onwujekwe and Odii, 2018; Abba-Aji *et al.*, 2020; Onwujekwe *et al.*, 2020). However, most of these studies, especially those conducted in Nigeria, except limited studies in Enugu, southeast Nigeria, were not empirical and included mainly commentary series, opinion pieces, and newspaper reports compared to the empirical findings presented in this research in Abuja, Nigeria. In Abuja, empirical findings of corruption in health service delivery were non-existent from the combined perspectives of patients and healthcare providers. Here, I argue that the experiences revealed from the combined perspectives of patients and providers in public health facilities in this study add nuance to the debate on corruption in the public health sector, especially with corruption in healthcare being

a complex and multifaceted issue that needs multidimensional perspective and nuances in interpretation.

Furthermore, in chapter four regarding corruption in public health facilities, I also presented some distinct corrupt practices including pressure from informal rules and undermining of patient's rights and dignity which might not have been strictly illegal practices covered by the legal definition of corruption; however, they fall under the "corruption complex" as defined in chapter two of this thesis which is a broader term that includes other definitions of corruption beyond legal to include moral, economic, public-office, and public-interest definitions (see: Olivier de Sardan, 1999; Blundo and Olivier de Sardan, 2006b; Hahonou, 2015).

Therefore, both the latter and the former group of corrupt practices fall under the multifaceted definition of corruption made more pronounced by the scholarly works of Olivier de Sardan, Blundo and Olivier de Sardan, and Hahonou (Olivier de Sardan, 1999; Blundo and Olivier de Sardan, 2006b, 2006a; Hahonou, 2015). Olivier de Sardan (1999), in his work on *the moral economy of corruption in Africa*, suggests that the broader term – "corruption complex" is more encompassing, especially in the African state, to also include informal practices that might or might not fit into the technical definition of corruption but provide an avenue for the perpetrators to derive personal gain at the expense of individuals or the public interest (Olivier de Sardan, 1999). The analysis of the findings in chapter four which focused on corruption in public health facilities in Abuja, Nigeria, reveals that these forms of corruption under the "corruption complex" had a range of impacts on patients in public health facilities in Abuja. These impacts include the erosion of the right to health care and patient dignity, alongside increased barriers to access- including financial barriers – especially for poorer patients.

Regarding why and how these forms of corruption in public health facilities presented in chapter four, manifest in the ways they do compared to the manifestations in private health

facilities presented in chapter five, some key underlying causes which I situate within broader scholarly works are argued next as the driving forces responsible for these forms of corruption in public health facilities.

#### *(i) Chronic underfunding of public health facilities and corruption*

In chapter four, this study highlighted key underlying causes contributing to corruption in public health facilities. Chronic underfunding emerged as a central factor, as the shortage of resources, including low salaries and inadequate medical supplies, drove healthcare providers to engage in corrupt practices. The resultant operational challenges, such as prolonged waiting times and scarcity of beds, created opportunities for corruption, exacerbating inequities in access.

This argument is supported by the findings of Hafez (2018), who argued that although Nigeria is regarded as an LMIC by the International Monetary Fund and the World Bank, it fares better economically than other countries in sub-Saharan with its substantial oil revenues. It is the largest economy of 54 African countries; despite this, it spends little to nothing on public healthcare, including its public health facilities (Hafez, 2018a). The government of Nigeria spends abysmally low on healthcare. Nigeria spends the least on healthcare compared to its sub-Saharan African counterparts, classified as LMICs (Hafez, 2018a). Nigeria spends less on health than almost every other nation, excluding war-torn countries. For example, only 0.6 per cent of GDP, or \$11 per person, was spent, continuously hovering under 1% in the last decade (Hafez, 2018b; NBS, 2021). With such abysmal low spending on public healthcare in Nigeria, the shortage of resources relative to the need of patients is not unexpected in public health facilities in Abuja. These shortages of resources in public health facilities include shortage of health workforce, drugs and medical supplies and equipment, and poor remuneration of the

workforce leading to low morale amongst public health workers. These factors drive corruption in public health service delivery in Abuja, Nigeria.

In addition, the chapter's evidence shows that the resource shortage relative to need worsens the operational challenges of public health facilities in Abuja. For example, these challenges include prolonged patient waiting time at outpatient clinics, scarcity of hospital beds for admission, and delays in hospital appointments and medical/surgical procedures, which leads to rationing. Healthcare providers exploit chaotic situations of rationing in these public health facilities. Such rationing encourages patients to circumvent the rules, such as queue jumping at clinics, hospital appointments/medical procedures through bribes and using "connections" of influence. Related practices such as bullying and intimidation of patients and undermining their human rights further put additional stress on patients to succumb to corrupt practices in these public health facilities and even, in some instances, lead these patients to initiate corrupt practices such as offering bribes to public healthcare workers. The impact of such corrupt practices on patients who cannot circumvent the rules or navigate these chaotic environments brought about by the shortage of resources is dire. Chapter four reveals that these impacts include inequity of access from financial and non-financial barriers. Similar findings in public health facilities have been reported in the literature (Husmann, 2011a; Hahonou, 2015; Rispel, Jager and Fonn, 2016).

#### *(ii) Commercialisation of relationships in public health facilities and corruption*

Additionally, the commercialization of public health services in Nigeria, where patients pay directly, added complexity to corruption issues. The cash-based payment system created vulnerabilities, leading to informal payments and even theft of formal charges. While some argued that commercialization could generate revenue for facilities, the study demonstrated



unintended negative consequences, including financial barriers for patients and opportunities for corruption.

Furthermore, these informal payments mostly occur in the cash-based payment environment of these public health facilities in Abuja, where both formal charges and informal charges are made. The findings suggest that not only patients are impacted by corruption in such a setting but also the government is impacted. In addition to informal payments as a corruption problem, this cash payment environment provides an avenue for public healthcare workers such as cashiers, record clerks and other staff to steal even the approved user/formal charges made by patients in these public health facilities due to their accessibility to such cash. In addition, through participant observation, I also showed, in chapter four, several instances where healthcare workers in public health facilities allegedly sabotaged the use of electronic payment options that would have reduced the incidence of informal payments. Other studies in the literature have reported similar findings and showed the negative impact of corruption through informal payments in public health facilities (Lewis, 2000; Balabanova and McKee, 2002b; Vian *et al.*, 2006; Onwujekwe *et al.*, 2010; Maestad and Mwisongo, 2011; Hahonou, 2015; Naher *et al.*, 2020).

The findings in chapter four also reveals how patients in public health facilities in Abuja, perceive the relative costs and benefits of using public health facilities with respect to informal payments practices they encountered or expect to encounter and how this influences the choices they subsequently made regarding whether they end up seeking care or not due to the financial barriers to care from informal payments. Furthermore, on the impact, I show in chapter four how patients felt informal payments were retrogressive and costly and how they arise as an offshoot from exploitive practices of healthcare workers saddled with implementing the commercialisation drive for services in public health facilities. For example, in chapter four, I

presented the empirical evidence where informal payments requested by public healthcare workers to retrieve cards led some parents to make hard choices on which of their children to access treatment in public health facilities, ultimately leading to the delay in presentation and eventual loss of a child due to the financial barrier to access the fear of informal payments caused. Other patients resorted to using traditional/herbal medications to avoid making informal payments which led to increased morbidity and, in some instances, mortality. Impacts of informal payments such as those presented in chapter four of this study have also been reported in other studies which resulted in patients deferring care, selling assets to seek medical treatment, or losing trust in the healthcare system (Thompson and Witter, 2000; Vian, 2003; Falkingham, 2004; Vian *et al.*, 2006).

In contrast, some public healthcare providers in this study, particularly the management-level cadre staff, had a different perspective. They felt the commercialised environment in public health facilities in Abuja offered an opportunity to reduce the incidence of informal charges since user fees/formal charges generate revenue for public health facilities to address the funding challenges and shortage of resources. A few patients in this study also felt that informal payments in the long term created a stable positive relationship with health workers that, when attained, prevented other corrupt practices such as bribery in subsequent visits and other related practices such as bullying, intimidation, and harassment. Other studies in the literature documented similar views of positive long-term relationships as a benefit for informal payments (Balabanova and McKee, 2002a, 2002b; Hahonou, 2015; Gaitonde *et al.*, 2016). Balabanova and McKee (2002) and Chawla *et al.* (1998) found that informal payments built long-term connections between patients and healthcare workers in public health facilities. They also suggested that it was believed to boost public healthcare workers' morale, prevent them from leaving the public healthcare system entirely, and allow patients to express gratitude to healthcare workers who please them (Chawla, Berman and Kawiorska, 1998; Balabanova and

McKee, 2002b, 2002a). Similarly, Vian et al. (2006) and Vian and Burak (2006) showed similar findings regarding the sentiments of why patients engage in making such informal payments with the hope of establishing long-term relationships between healthcare providers and in the transition economies of the former Soviet countries (Vian and Burak, 2006; Vian *et al.*, 2006).

The debates for and against the commercialisation of health in public facilities are genuine and need to be had. However, I argue that even within the "supposed" merit of the commercialisation drive of public health facilities, this policy has had unintended adverse effects on the very patients the government is protecting for various reasons. These reasons include the failure of the management of public health facilities to invest and insist on the use of financial technology, such as electronic payments and to ensure punitive measures for workers found to be exploiting formal commercial activities in public health facilities.

### ***(iii) Weak accountability in public health facilities and corruption***

Weak accountability systems within public health facilities, rooted in weak governance structures, were identified as another crucial factor identified in this study. The institutional setup allowed corruption to thrive across various areas, including record-keeping, payment processing, and triaging. The study argued that inadequate governance structures and limited accountability mechanisms created opportunities for corrupt behaviours, including bribery, informal payments, and theft.

Furthermore, the analysis revealed how political influence impacted corruption in public health facilities. The opaque dealings between facility management and the political class, coupled with seeking favours from politicians, contributed to interference in governance structures. This study aligned with both vertical and horizontal approaches to analysing corruption,

highlighting both the need for top-down but most especially bottom-up approaches that guides horizontal/network-based anti-corruption strategies.

There is a growing literature on governance within institutions which advances the argument that the institutional set-up and operation networks of organisations can contribute to the permeability or resistance of corruption within such institutions (Brinkerhoff and Bossert, 2013; Mackey *et al.*, 2016; Kohler and Bowra, 2020; Naher *et al.*, 2020; Vian, 2020). The literature on governance within corruption studies is closely linked to transparency and accountability frameworks which have also been one of several critical arguments for the reasons why public sectors in developing countries, including public health systems, are believed to be more corrupt relative to private sector entities (Brinkerhoff, 2004; Reich, 2018; Kirya, 2020; Vian, 2020).

Thus, the argument above holds far where regulation of private sector entities occurs. However, as with most mixed health systems in LMICs in the global south, the private health sector is poorly regulated, furthering the argument that accountability structures hold steadfast in a system with adequate regulation (see: Nishtar, 2010a; Coarasa, Das and Hammer, 2014; Das *et al.*, 2016; Mackintosh *et al.*, 2016). Therefore, I argue that just as in the private sector, in public health sector facilities as well, transparency and accountability are linked to the governance of public health facilities as institutions must be anchored on good regulatory frameworks for these facilities to address the problems of corruption in Abuja, Nigeria.

From the empirical findings in this study, I, however, argue that although there were weak governance structures and issues related to transparency and accountability frameworks that made several corrupt practices manifest in public health facilities in Abuja as have been seen in other LMICs such as works by Naher and colleagues in south Asia, Kirya in East Africa, Pope and colleagues in Swaziland, Kenya and Nigeria (Pope and Vogl, 2000; Kirya, 2020;

Naher *et al.*, 2020). These inherent institutional setups come with lacuna that is exploited by providers and, in some instances, by patients, allowing these forms of corruption found in the public health facilities in this study to thrive.

Specific corrupt behaviours may prevail depending on the enabling environment. In the case of the public health facilities, I showed in chapter four that certain institutional features facilitated the occurrence of these corrupt practices presented in this study. In this study, the weak governance structures and limited accountability mechanisms were across critical areas ranging from record-keeping, payment, cashier points, and triaging of patients, pharmacies, and laboratories. The weak accountability systems in these areas of patient encounter with public healthcare providers created opportunities. They paved the way for healthcare workers to engage in corrupt practices such as bribery, informal payments, and theft. Similar widespread incidences were documented by Lewis (2006) on governance and corruption in public health systems in developing countries (Lewis, 2006).

Similarly, public health facilities in Abuja, Nigeria, by their nature of being funded by the government through appropriations by politicians, makes them often susceptible to undue influence as a practice that impacted health service delivery due to easy political intrusion by health officials outside these public facilities or political office holders who appropriate funds for these public health facilities. Here, I argue that seeking favours from the political class by the management of public health facilities, including its health workers, worsens the interference and governance structures due to the opaque dealings between the management of these public health facilities and the political class interfering. This perspective is in keeping with the vertical approach of analysing corruption in healthcare as has been espoused by Vian (2008) and Vian and Norberg (2008), where some forms of corruption occur in a top-down nature with power dynamics at play. Policy interventions in corruption studies using the

vertical approach targets individual actors within the health systems to increase penalties for corrupt behaviours and strengthen regulatory frameworks (Vian, 2008b; Vian and Norberg, 2008).

Furthermore, the use of influence as a form of corruption gains traction in public health facilities in Abuja due to the weak governance and accountability systems that allow such influence activities associated with nepotism and patronage. This form of corruption is akin to one of the categories of corruption semiology by Blundo and Olivier de Sardan – "the piston" or "being connected", where services are delivered faster to users who are connected to the administrative bureaucrats (Blundo and Olivier de Sardan, 2001). This perspective is in keeping with the horizontal/network approach of analysing corruption in healthcare, as has been espoused by Gaal and McKee (2004) and Olivier de Sardan (2013), where corruption is entrenched amongst networks of relationships and social norms by individual actors (Gaal and McKee, 2004; Olivier de Sardan, 2013c). Policy interventions in corruption studies using the horizontal/network approach takes into cognisance key factors, including citizen participation (patients/providers alike) and transparency and social accountability mechanisms amongst networks.

In summary, the nuanced interpretation from the analysis of the findings here provided a comprehensive understanding of corruption in Abuja, Nigeria, encompassing traditional practices such as bribery, informal payments, theft, and influence-related activities. Unlike previous works, this research combined perspectives from patients and healthcare providers, offering a unique empirical contribution. The identified corrupt practices in public health facilities were categorized into a "corruption complex," acknowledging a broader definition that includes not only strictly illegal activities but also informality. These practices had tangible

impacts on patients, eroding the right to healthcare and dignity, and increasing access barriers, especially for economically disadvantaged individuals.

### **(b) Corruption in Private Health Facilities**

In chapter five, I addressed the second objective of this research, which investigated the experiences of patients and providers concerning the causes, manifestations, and impacts of corruption as they occur in private health facilities in Abuja, Nigeria. The chapter sheds light on how corruption is understood in these facilities, emphasizing the importance of exploring private health systems alongside public systems within the mixed health framework.

The findings reveal distinctive corruption problems in private health facilities, including inappropriate prescriptions, potential kickbacks, forged medical reports, health insurance fraud, and various invoice-related frauds. These practices, different from the overt corruption in public health facilities discussed in Chapter four, have diverse impacts on patients. These effects range from compromised quality of care leading to prolonged illnesses and antimicrobial resistance to exacerbating financial risks to patients, particularly those paying out-of-pocket.

According to the world bank, in 2019, about 70.52 % of Nigerians paid for health care out-of-pocket (OOP), one of the highest figures in the world, with most of these OOPs recorded in private health facilities (WHO, 2022). The evidence presented in chapter five from patients' perspectives suggests that these OOPs were worsened by corrupt practices often disguised by private care providers in Abuja. I argue in chapter five that the key underlying factors responsible for most of these corrupt practices in Abuja's private health system include incentives aimed at profit maximisation and poor regulation of the private health sector in

Abuja, which in itself is a key symptom synonymous with *mixed health systems syndrome* seen in mixed health systems (Nishtar, 2010b; Mackintosh *et al.*, 2016).

*(i). Incentives related to profit maximisation in private health facilities and corruption*

In chapter five, I showed that a leading cause for private providers' engaging in corruption is often incentive systems aimed at profit maximisation tied to the institutional structure of private health facilities in Abuja, Nigeria. Here, I showed that due to the covert manifestations of corruption in private health facilities enshrined in the day-to-day operations of these private health facilities, some patients did not even recognise that such practices were forms of corruption under several disguises until much later, after the financial and non-financial impacts of such practices have been experienced by these patients. In several cases, their attention was brought to such practices by third parties or through accidental findings. However, this is not usually the case with most corrupt practices in public health facilities, revealed in chapter four which are often more overt manifestations to patients. Nonetheless, their being less overt in manifestation compared to those in public facilities does not make the impacts of these practices in private facilities lesser on patients, which includes impacts on core UHC goals, such as reductions to quality of care, lack of pricing transparency leading to exacerbation of financial risks to patients and their households.

In chapter five, for example, I showed evidence of instances from the views of patients where private healthcare workers, usually with the knowledge and encouragement of their hospital management, overcharge patients with generic or sometimes even substandard treatments. However, these patients are often deceived into believing they receive premium care at higher treatment costs. Due to a lack of pricing transparency, the aim is to increase profit margins through fraudulent billings and claims. This study's findings are in keeping with similar findings by Das *et al.* (2008) in the Indian private health sector, which found deceitful practices



shrouded in opaque pricing of health services leading to a reduction in quality of care by private health sector entities that were poorly regulated in India (Das, Hammer and Leonard, 2008).

Although Das and colleagues stopped short of calling some of these practices corrupt because corruption was not the focus of their study, rather the quality of services being provided in private health facilities, they however, acknowledged that these were wrongful, predatory, and compromising practices, and suggested this as an area of future research into the contextual causes for such observations. My study delves into this area and classifies some of these practices as corrupt. Here, I argue that patients are deceived into paying for health care lower than the quality of services they had paid for. This is also amplified by the problem of information asymmetry in health service delivery where the knowledge of healthcare as a credence good lies more with the healthcare provider relative to the patient (see: Mossialos *et al.*, 2002; Rădulescu *et al.*, 2008; Nikoloski and Mossialos, 2013). Hence, some private health providers in Abuja, capitalise on the challenge of information asymmetry to perpetrate such fraudulent practices.

The view of fraud and corruption in this study is backed by the definition of fraud offered by the American Anti-Fraud Association, where fraud is defined as *an "intentional deception or misrepresentation made by a person or an entity, with the knowledge that the deception could result in some kinds of unauthorised benefits to that person or entity"* (Rashidian, Joudaki and Vian, 2012, p. 1). The actions of some of these private providers can be akin to someone saving up and paying the price of a "flawless" diamond - top-grade diamond in the GIA Clarity Grading system but being offered "I3" diamonds with far lower gradings. The fact that the buyer in this analogy might or might not have the expertise to differentiate between both grades of diamonds does not excuse the seller's deceitful actions. Private health providers also as

suppliers of health services are entrusted to provide transparency to patients who are consumers or “buyers” of their services (MDCN, 2014).

In this study, several private healthcare facilities in Abuja are opaque in their operations and lack transparency and accountability, in addition to information asymmetry reviewed in chapter two, culminated in the reason why patients in private health facilities often found it difficult to recognise manifestations of certain forms of corruption. Savedoff and Hussmann (2006) highlighted these characteristics, discussed in chapter two of the thesis, as critical reasons why it is difficult to detect and prevent corruption in health facilities (Savedoff and Hussmann, 2006). Due to the opaqueness in their operations and institutional setup and the fact that most of the activities of these private health facilities are barely scrutinised due to poor regulation (common occurrence in LMICs), these forms of corruption are prevalent in private health facilities in Abuja, Nigeria.

In this study, several private healthcare facilities in Abuja are opaque in their operations and lack transparency and accountability. In addition, the information asymmetry reviewed in chapter two culminated in why patients in private health facilities often found it challenging to recognise manifestations of certain forms of corruption. Savedoff and Hussmann (2006) highlighted these characteristics, discussed in chapter two of the thesis, as critical reasons why it is difficult to detect and prevent corruption in health facilities (Savedoff and Hussmann, 2006). Due to the opaqueness of their operations and institutional setup and the fact that most of the activities of these private health facilities are barely scrutinised due to poor regulation (a common occurrence in LMICs), these forms of corruption are prevalent in private health facilities in Abuja, Nigeria.

In her seminal piece titled *choked pipe: reforming the mixed health system in Pakistan*, Nishtar (2010) revealed that private health facilities in Pakistan, an LMIC manifest these practices

presented above in far greater proportions than public health facilities. However, as Das et al. (2008) in India stopped short of delving into the contentious issues of which practices were corrupt and why, Nishtar (2010) also avoided the murky territory of individual corrupt practices and how they specifically manifest. However, she suggested that the opaqueness of private health facilities due to poor regulation is not farfetched why their institutional setup allows them to proliferate into practices that provide low-quality services to patients yet overcharge these patients.

For example, some of these practices were often disguised as premium care through the over-provision of services or unnecessary procedures and treatment, which have been "padded" by high prices have been regarded as corruption by some patients and healthcare providers in this study as they are in the private interests of providers at the expense of patients. Therefore, this study delves into this area and provides empirical insights of corruption in private health facilities in Abuja, that is poorly understood like in other private health sector entities in LMICs in the global south. Chapter five presented granular empirical evidence backed by findings from the views of both patients and private healthcare workers that showed the role corruption explicitly plays in helping private facilities in Abuja achieve higher profit margins while keeping through reductions in the quality of healthcare and pricing transparency.

The analysis of the findings in the private sector underscores that profit-maximization incentives are a primary driver of corruption in private health facilities in Nigeria. Practices such as overcharging for generic or substandard treatments, disguised as premium care, aim to increase profit margins through opaque billing practices. Patients, often deceived due to information asymmetry, bear the financial and non-financial brunt of these fraudulent actions.

As discussed, next, poor regulation exacerbates the situation, allowing private health providers to operate opaquely. The lack of transparency and accountability, coupled with information

asymmetry, makes it challenging for patients to recognize and address manifestations of corruption in private health facilities.

## **(ii) Poor regulation of the private health sector and corruption**

In chapter five, I also showed that poor regulation of the private health sector drives most of the corruption in private health facilities in Abuja, Nigeria. Because of poor regulation of private health facilities in Abuja, some patients find it easier to initiate certain corrupt and fraudulent practices that benefit them, just as private providers do. I argue that some of these practices are "high stake" because even in Nigeria, where corruption is generally believed to go unpunished, certain corrupt practices are riskier to the healthcare professional's career than others. These corrupt practices have a high stake in the healthcare provider's professional career and attract more grievous punitive actions for gross misconduct from professional bodies of healthcare professionals when they are caught engaging in such practices. Therefore, private health facilities with less stringent regulations and oversight offer an easier environment for patients who want to engage in such practices.

For example, chapter five presented empirical evidence where patients found it easier to request fraudulent practices such as falsifying and forging medical reports. Although some cases of such practices can take place in public facilities, they were less endemic in public health facilities in Abuja due to the multiplicity of persons needed to carry out such practices compared to private health facilities, where it is more discreet and made easier by their opaque institutional structures which are poorly regulated. Healthcare workers in public health facilities found such risks too weighty compared to the returns. Hence, their propensity to engage and accept the preposition from patients is often lower for practices such as forging/falsifying records, which, when traced back to them, can be grievous since it has a trail compared to their counterparts in the private health sector.

As found in this study, Das and colleagues in India also showed that quackery and substandard quality of care were prevalent in several private health facilities, particularly at the primary and secondary healthcare level (Das and Hammer, 2014; Das *et al.*, 2016). Other practices, such as the engagement of quacks and the use of substandard drugs and equipment, are also easier in private health facilities in Abuja due to poor regulation of the private health sector in Nigeria, as evidenced by the interviews provided by some private health workers in this study. These findings also align with that of India, a country classified under the same category as Nigeria as having a large predominant private health sector that is largely unregulated (Das and Hammer, 2014; Das *et al.*, 2016). These corrupt practices were primarily enabled by poor regulation of the private health sector in India, as is the case with the findings in this study in Abuja, Nigeria.

The review of the findings emphasises the role of inadequate regulation in fostering corruption within the private health sector in Nigeria. Poor oversight creates an environment where the corrupt practices thrive, impacting both healthcare providers and patients. Furthermore, patients find it easier to engage in certain corrupt practices, such as falsifying medical reports, in private health facilities with less stringent regulations. The high stakes involved in such practices make them riskier in public facilities, where the multiplicity of individuals required for such actions acts as a deterrent.

In terms of comparative insights, this study draws attention to parallels with findings in India, another country with a dominant private health sector like Nigeria as classified by McIntosh and colleagues, highlighting the prevalence of quackery, substandard care, and corrupt practices in the private health sector due to poor regulation. The overarching argument is that the inadequacies in regulating the private health sector contribute significantly to corruption in

Abuja's private health facilities, echoing similar challenges faced by other countries with predominantly unregulated private health sectors, such as India.

In essence, Chapter five underscores the need to comprehend corruption in private health facilities within the broader context of mixed health systems. The nuanced understanding provided here prompts reflection on the intricate interplay between profit motives, regulatory shortcomings, and the resulting corruption dynamics, offering valuable insights for addressing corruption challenges in the private health sector, not just in Abuja but in comparable settings in Nigeria and other LMICs.

### **(c) Public-Private Interaction of Health Facilities and Corruption**

In chapter six of this thesis, I addressed the third objective of this research, which investigated how, and the extent to which, in the views of patients and providers, corruption is enabled by the co-existence of and interactions between public and private health facilities in the context of the mixed health system of Nigeria – and of Abuja in particular. Here, the focus is on the interaction of the two health sectors, including the interactions of patients and providers. I argue that the nature of the public-private interaction is itself a cause of several forms of corruption in Abuja's mixed health system. Hence it is implicated in the problem.

Chapter six presented two categories of themes regarding the nature of the interactions between the public and private two health sectors, and the impacts of these on patients' and providers' lived experiences with regard to corruption. The first category includes supply-side interactions i.e., those that relate to the behaviours of providers – organisational and individual, which includes corrupt practices such as dual practice, health worker absenteeism, diversion of patients/inappropriate referrals, theft/diversion of medical supplies and equipment between public and private facilities and vice versa. The second category is anchored on demand-side perspective on the interactions- and the effects of those interactions on corruption between the

two health sectors, centring around the patient journey as they shop for health care between public and private facilities. Here, I show that the interaction of these two health sectors leads to further corruption vulnerabilities for patients as they navigate the "corruption complex" within the mixed health system in Nigeria. The impacts of corruption following such interactions include inequities of access, for example, due to delays in and denials of needed services and additional financial barriers encountered in public facilities, alongside reductions to quality of care, pricing transparency and financial protection in private facilities. Therefore, the impacts range from a wide spectrum of those seen in both and private health facilities due to the broader exposure of patients to the impacts of corruption from both health sectors.

*(i) Public-private interaction of health facilities: Enabling corruption*

Regarding corrupt practices enabled by the interaction of public and private facilities in Abuja, chapter six showed evidence of such practices, including patient diversion/ inappropriate referrals and theft/diversion of medical supplies between the two health sectors. These practices are observed in Abuja's mixed health system, where public providers usually refer patients to private entities such as private hospitals, laboratories, diagnostic centres and retail pharmacy outlets for monetary benefit or other corrupt intentions rather than the patient's best interest.

I also showed that these practices significantly impact patients, such as delays or denials in receiving treatment which sometimes jeopardises their health outcomes, especially for poorer patients who cannot afford private health care following such diversions. Hence, the impact of such practices leads to barriers to care by increasing inequity of access, including financial barriers for patients that move across both public and private health facilities in Abuja. Even for patients who can afford private care at that moment following such diversions, the evidence in chapter six shows that some eventually became more financially vulnerable due to the exacerbation of financial risks to their households. Therefore, policy responses should target a

cycle that allows this continuous aiding and abetting between the two health sectors where patients are inappropriately diverted, especially from public to private facilities, without cause.

Again, in chapter six, I also show that the interactions of public and private health facilities lead to corrupt practices such as theft and diversion of hospital supplies and consumables (usually from public to private facilities) by healthcare providers meant for use by patients. Although healthcare workers sell these supplies to the open market in certain instances, the evidence suggests that a significant portion of these medical supplies end up in private health practices. In such instances, the interaction of the public and private health facilities aided and abetted corruption by offering the avenue for demand (usually from private facilities) and supply (usually from public facilities) of stolen medical supplies initially provided by the government for use at either free or subsidised costs in public health facilities.

Similarly, these theft/diversions severely affect the quality of healthcare services offered to patients as they compromise the essential medicines required to provide quality patient care, especially in public health facilities. Here, I argue that the interaction of these two health sectors enabled corruption by opening up channels for further corruption vulnerabilities. Furthermore, the diversion of patients between these public and private health facilities in Abuja for financial gains also creates a “black market” through an illegal and unconventional pathway for demand and supply forces in mixed health service markets whose purpose is to accrue financial gains to healthcare providers involved in such corrupt practices and not the interest of the patients as they are made to move across the two health sectors in Abuja.

Furthermore, in chapter six, I also presented two related corruption problems: *health worker absenteeism and dual practice*, and how healthcare providers rely on the existence of, and interactions of the public and private health facilities in Abuja, to engage in such practices. Here, I showed how health worker absenteeism, particularly in public health facilities, is linked



to corruption and how workers absent from work in public facilities excluding legitimate reasons for absenteeism, engage in dual practice during government working hours. In doing so, they delay and, more often, deny patients access to care in public facilities where they are absent from duty while engaging in their private interests. The spiral effect is that these practices further worsen the shortage of human resources (workforce) already plaguing the public health sector in Abuja and the rest of Nigeria.

These practices have severe implications for patient care because they contribute to long waiting times in clinics and delays in receiving care, including complete denial of care in some instances in public health facilities in this study. I argue in this thesis that such practices do not occur in isolation, as the evidence presented in chapter six showed that most of these absent healthcare workers in public health facilities frequently work in private health facilities regularly during working hours during those periods of absence. Hence, it is linked to another corruption problem, *dual practice*, that arises from the interactions of the two health sectors. Therefore, the mixed health system in Abuja provides the avenue for such corrupt practices to thrive in a continuous cycle of aiding and abetting between the public and private health sector facilities.

In relation to healthcare providers, their perspectives on these corruption problems, which are further potentiated by the interactions of these two health sectors, varied according to the following: (i) their professional cadre, (ii) their level of seniority, and (iii) those who work in a public or private health facility or both.

Based on the evidence presented in chapter six, it is easy for healthcare providers belonging to one professional category to reveal the alleged corrupt practices of healthcare workers in other professions. However, they are often not forthcoming with practices perpetrated by their colleagues in the same profession. For example, as presented in chapter six concerning

absenteeism and dual practice, in several instances, nurses were more comfortable suggesting that doctors were the usual culprits and how these practices impact health delivery for patients by the absence of the doctors engaging in these two corrupt practices. On the other hand, the more junior the healthcare worker is within a professional cadre, the more evidence they provide regarding the corrupt practices embarked upon by their superiors. Again, for example, junior doctors side with patients' views that corruption problems such as absenteeism, dual practice, theft/diversion, and inappropriate referrals/diversion of patients between the two health sectors are generally orchestrated by senior doctors, such as consultants or senior registrars. In their opinion, with such an array of corrupt practices across the health system, patients feel exploited. They are further exposed to other corrupt practices as they navigate their journey through public and private health facilities in Abuja, Nigeria.

#### *(ii) Public-private interaction of health facilities: Personal reflections*

Relying on the foundation laid in chapter two of this thesis, where Nishtar (2010) and Mackintosh et al. (2016) suggest that most LMICs in the global south, including Nigeria, are mixed health systems consisting of largely poorly funded public healthcare systems occurring side-by-side poorly regulated private health systems. They argued that health service delivery and its challenges could not be well understood, except within the context of their mixedness and interactions with public facilities because the two systems rely on each other for service delivery to patients in LMICs (Nishtar, 2010a; Mackintosh *et al.*, 2016). Extending this logic, I draw inferences using the findings in chapter six to argue that the public and private health sector facilities in Abuja's mixed health system and their operational challenges, including corruption problems, are best understood within the context of their mixedness and interactions. Most corrupt practices originating from either system intricately affects service delivery in the other health system with far-reaching impacts and consequences for patients across both health systems.

In chapter six, I showed several instances backed by empirical insights where patients rely on the services of each system due to the deficiencies associated with both health sectors. Moreover, this is even more true in a country like Nigeria, where its chronically underfunded public health sector has given rise to a burgeoning private health sector that is poorly regulated with evidence of several malpractices, including corruption. Since the two health sectors, including their patients and providers, interact, so do the experiences regarding the challenges of each health system, including corruption. Therefore, the fundamental argument of this thesis, backed by the evidence therein, reveals that corruption in health service delivery is present in public and private health facilities in Abuja, Nigeria, with none of the two health sectors spared. Thus, the exposure concerning corruption for patients navigating public and private health facilities in Abuja, Nigeria, is sometimes broader. The interactions of these two health sectors are therefore implicated in the mixed health system problems as they create scope for further corruption opportunities increasing further impacts on patients in Abuja's mixed health system.

Furthermore, I showed that when patients travel along their "patient journey", many move between public and private health facilities in Abuja's mixed health system without recourse to an ideal regimented health system. Irrespective of which health system their patient journey originates from, i.e., be it the public or private system, the evidence in chapter six shows that several of these patients come in some form of contact with the other health sector, which chapters four and five had shown to be already plagued with their unique health system challenges including corruption. Therefore, by the end of their "patient journey", several patients encounter corruption problems following their interaction with healthcare workers who also move easily between public and private health facilities to provide services, and these healthcare providers sometimes act outside official norms and procedures, using their position of entrusted authority for their private/personal gain.

These pieces of empirical evidence analysed in chapter six generate a new understanding of how patients experience corruption in Abuja's mixed health system of public and private health facilities. This thesis advocates that for a compelling analysis of the problems of corruption in health service delivery, a "mixed market" lens of public and private health facilities with its full range of health providers is needed. The "mixed market" lens captures the patients' experiences of corruption and related practices as they navigate the "corruption complex" in Abuja's mixed health system. In such settings, the impact of corruption is often along a continuum of care and not usually restricted to only one of the health sectors, even if one of the two health sectors is more prone to corruption. Thus, the "lived" patient experience concerning the causes, manifestations, and impacts of corruption in health service delivery is best understood by tracing and documenting the totality of the experiences patients face in their encounters with healthcare providers as they navigate both public and private health systems in Abuja.

Similarly, on the policy front, in chapter one, I argue that the primary sectoral focus regarding corruption health reforms in Nigeria has been the public health sector, and by doing so, the dominant private health sector, which often aids corruption in public health sector facilities is neglected (see: FMOH, 1988, 2009; Emejulu, Muo and Chukwuemeka, 2014; Anaemene, 2016). Therefore, I argue that such one sectoral focus only offers a partial policy response; however, this new way of understanding corruption in Nigeria using the "mixed market" lens offers a new policy understanding that is more cross-sectoral, inclusive, and comprehensive.

### **7.2.1 Mixed Health Systems and its challenges in Addressing Corruption**

In contrast to the mainstream thinking that corruption is mainly in the public sector health facilities, this study deviates and shows that corruption occurs across both public and private sector facilities in Nigeria. The evidence from the review of the findings in this study suggests

that the mixed health system of Abuja, Nigeria, characterized by a combination of public and private sector involvement, pose particular challenges in addressing corruption due to several factors that deviate from mainstream thinking that associates corruption primarily with the public sector. Some reasons why mixed health systems present unique challenges in addressing corruption in this study are presented below.

#### **(i). Regulatory Variability in the Private Sector**

**Lack of Standardization:** The review of findings shows that the private sector within mixed health systems in Nigeria lacks standardized regulation, making it challenging to implement consistent anti-corruption measures. Therefore, varying degrees of oversight contribute to corruption vulnerabilities as healthcare providers are accustomed to the lack of standardization in the sector.

#### **(ii). Profit Incentives in the Private Sector**

**Focus on Profit:** As presented in chapter 5, in the private sector, profit motives sometimes take precedence over ethical considerations by private providers. This drive for financial gain is shown to lead to corrupt practices, such as overcharging, unnecessary medical procedures, or kickbacks, especially in the absence of stringent regulatory frameworks.

#### **(iii). Commercialisation of Public Health Facilities**

**Complex Interactions:** With respect to the public sector component of the mixed health system, the commercialization of public health facilities, a trend observed in mixed health systems such as Nigeria, introduces complexities. While intended to generate additional revenue to support the chronically underfunded public sector facilities, the evidence shows that it sometimes inadvertently creates avenues for corruption, such as informal payments and theft,

particularly in cash-based environments like Nigeria. This complexity makes it difficult to address corruption.

#### **(iv). Patient Pathways Across Sectors**

**Cross-Sector Movement:** As evidenced in chapter 6 of this thesis, several categories of patients, move across public and private sectors seeking healthcare. This cross-sector movement complicates oversight, as corrupt practices in one sector often have ripple effects, impacting the overall integrity of the healthcare system that is made up of public-private sector interaction reality.

#### **(v). Resource Shortages and Underfunding**

**Chronic Underfunding:** The evidence in this study also found that the mixed health system in Nigeria including both the public and private sector facilities generally suffer from underfunding similar to fully public systems. Because the public health facilities within the mixed health system face resource shortages, it leads to corruption, as seen in the study's findings where shortages contribute to operational challenges and patient-provider interactions. The burgeoning private sector facilities are not really better off in some sense. This underfunding perpetuates a cycle of corruption posing more difficulty in addressing corruption in the entire mixed health system.

#### **(vi). Weak Accountability Mechanisms**

**Institutional Weaknesses:** In this study, the evidence presented across the three empirical chapters suggests that both the public and private sector facilities exhibit weak governance and accountability structures. These institutional weaknesses create opportunities for corruption in critical areas such as record-keeping, payment processes, and interactions with patients in the

public sector and sometimes the private sector facilities which poses challenges to addressing corruption at that micro level of interaction between patients and providers across both sectors.

#### **(vii). Power dynamics and Political Intrusion in Public Health Facilities**

**Influence of Political Class:** In chapter 4, the evidence shows that public health facilities funded by the government are very susceptible to undue political influence. Seeking favours from the political class exacerbate governance challenges, as seen in the study were political intrusion impacts health service delivery. This level of interference poses difficulty in addressing corruption.

In concluding this section, the challenges in addressing corruption in Nigeria's mixed health system of public and private sector facilities arise from a combination of regulatory variability, profit incentives, commercialization complexities, patient pathways, resource shortages, weak accountability, political influence, and inadequate private sector regulation. A nuanced understanding of corruption in the context of mixed health systems as distilled in this study is essential for developing effective anti-corruption strategies which are discussed in the next section.

### **7.2.2 Anticorruption Strategies in the Mixed Health System: A Nuanced Analysis**

#### **A). Current Governance Failures: Unraveling the Complex Tapestry**

The review of findings in this chapter suggests that the examination of corruption within the mixed health system, encompassing both public and private health facilities, reveals a nuanced and intricate landscape. In order to comprehend the failures of current governance

arrangements within the system, it is imperative to delve into the complexities woven into the fabric of power dynamics, institutional feasibility, and actor incentives.

#### **(i). Power Dynamics: Unpacking Influences**

The power dynamics within the mixed health system of public and private health sectors in Nigeria play a pivotal role in shaping corrupt practices. Institutional power imbalances, often skewed towards profit-driven motives in private facilities, create an environment where corruption can thrive unnoticed. On the public sector, it makes the health officials and public providers act as “untouchables” in the public health sector. This study therefore posits, that understanding how power is wielded and distributed among stakeholders within the construct of the political economy and informality incentives as espoused by authors such as Khan et al (2019) and Hutchinson et al (2020) is crucial for unravelling the intricacies of corruption with the aim of developing effective anti-corruption strategies that are context specific to Abuja, the rest of Nigeria and LMICs in general (Khan, Roy and Andreoni, 2019; Hutchinson *et al.*, 2020).

#### **(ii). Institutional Feasibility: Bridging the Regulatory Gap**

The evidence from the review in this chapter shows that current governance arrangements often falter due to the feasibility of regulatory mechanisms that cuts across both the public and private sector health facilities. For example, I showed that inadequate regulation of private health facilities allows for opacity in operations, enabling corrupt practices to persist. Addressing institutional feasibility requires a comprehensive overhaul of regulatory frameworks, ensuring they are robust, adaptable, and capable of mitigating the ever-evolving strategies employed by corrupt actors.



### **(iii). Actor Incentives: Aligning Motivations with Public Interest**

Another critical recommendation arising from the analysis in this chapter suggests that examining the incentives that drive actors, both in the public and private sector facilities, is paramount. In private facilities, profit maximization incentives contribute to covert manifestations of corruption. Simultaneously, within the public sector, a sense of entitlement is fuelled by perceptions of under-resourcing and the justification of corrupt practices as a means of coping with resource limitations. This study suggests that unravelling these incentives requires a deep understanding of the beliefs, values, and assumptions that guide decision-making among healthcare providers, policymakers, and patients.

### **B). Anticorruption Strategies: Navigating the Complexity**

From the findings and careful analysis in this study, the evidence shows that due to the complex nature of corruption in Nigeria's mixed health system, it therefore, necessitates multifaceted and context-specific strategies to address corruption in health service delivery. This study recommends that anticorruption efforts should be tailored to address the unique challenges posed by the coexistence of public and private health facilities.

#### **(i). Strengthening Regulatory Frameworks: A Unified Approach**

Enhancing regulatory frameworks within Nigeria's mixed health system of public-private mix is paramount for curbing corruption. A unified approach that bridges the regulatory gap between public and private sectors is necessary. This involves creating regulations that are not only stringent but also adaptable to the diverse operational contexts of both types of health facilities.

## **(ii). Empowering Stakeholders: Fostering Accountability**

Empowering stakeholders, including patients, healthcare providers, and regulatory bodies, is crucial for any meaningful anti-corruption strategy to succeed in Nigeria's mixed health system. This involves promoting transparency and accountability through increased awareness, education, and participation. Patients, armed with knowledge, can demand transparency in pricing and services, acting as a formidable force against corrupt practices even in the opaque private sector facilities.

## **(iii). Addressing Under-Resourcing: A Nuanced Perspective**

From the evidence presented in the analysis in this chapter, the issue of under-resourcing must be nuanced in the anticorruption discourse. Rather than viewing it as mainly a justification for corruption by the healthcare providers, understanding the assumptions and beliefs surrounding under-resourcing is essential. Therefore, meaningful anti-corruption efforts should involve re-resourcing within the public sector, challenging the entrenched norms and fostering a sense of shared responsibility for public health facilities where chronic underfunding is a key culprit for corruption.

## **(iv). Integrating Faith and Values: Ethical Dimensions**

Another dimension to the discourse relates to morality. Exploring the role of faith and values in the context of corruption is crucial. Sense of entitlement and justifications rooted in faith need to be addressed through ethical dialogues and interventions. Engaging with communities and participants to reshape perceptions and align values with the broader goal of imbuing a sense of service in both public and private health sector facilities can be a powerful tool in the anticorruption struggle in Nigeria's mixed health system.

### **(v). Embracing Complexity: Opening Doors to Solutions**

One of the significant contributions of this study to knowledge is the contribution of this nuanced analysis lies in its ability to open avenues for addressing the challenges of working with corruption. Recognizing the multiple layers and levels involved allows for a more holistic understanding, paving the way for targeted interventions. By exploring the wider matrix of intersections, blame, acceptance, and decision-making, strategies can be developed that resonate with the complex realities of the mixed health system.

In navigating the complexity, the emphasis should be on creating solutions that are adaptive, context-specific, and cognizant of the diverse actors and motivations at play. Anticorruption initiatives must not only target visible manifestations but also delve into the underlying power structures and institutional dynamics that perpetuate corrupt practices. Only through such a comprehensive approach can the mixed health system evolve towards a more transparent, accountable, and ethically grounded healthcare environment.

### **7.2.3 Contribution of the Thesis to Knowledge: Unravelling the “Corruption Complex” in Mixed Health Systems**

This thesis makes a significant contribution to knowledge by delving into the intricate dynamics of corruption within the mixed health system, specifically in Abuja, Nigeria. A key focus is on unravelling the “corruption complex” and not merely highlighting corruption within mixed health systems, thereby avoiding a hard-line dichotomous border of public and private sector which the evidence presented in this study shows is easily crisscrossed by both patients and healthcare providers. This study encourages a shift from a black-and-white perspective to a more holistic exploration of corruption's multiple layers and intersections. It emphasizes the

need to explore the wider matrix of blame, acceptance, and decision-making to effectively address corruption challenges. Several key contributions emerge from this exploration.

**(i). Understanding the “Corruption Complex within Mixed Health Systems**

The thesis provides a nuanced understanding of corruption within the broader concept of the “corruption complex” including informality and corruption within the mixed health system, emphasizing the interplay between public and private health facilities. It goes beyond surface-level manifestations, dissecting power dynamics, institutional feasibility, and actor incentives that contribute to the corruption complex.

**(ii). Relevance/Generalizability to Other Nigerian States**

While this study is rooted in the context of Abuja, the findings and insights presented have broader relevance to other Nigerian states. The systemic issues uncovered, such as poor regulation, opaque operations, and the impact of corruption on patient care, are likely prevalent in varying degrees across the country. This thesis serves as a foundational exploration that can inform anticorruption efforts in different Nigerian states.

**(iii). Relevance to other LMICs**

The thesis extends its relevance beyond Nigeria, offering insights applicable to other Low- and Middle-Income Countries (LMICs) grappling with similar challenges in their mixed health systems plagued by performance challenges. The “corruption complex”, influenced by factors like poor regulation and power imbalances, often transcends national borders. Comparative studies with other LMICs can draw parallels and distinctions, enhancing the global understanding of corruption in healthcare.

#### **(iv). Contributions to Anticorruption Strategies**

This thesis contributes to the development of targeted anticorruption strategies. By emphasizing the need for context-specific interventions that address the unique challenges posed by mixed health systems, it provides a roadmap for policymakers, healthcare providers, and regulators in Abuja and beyond. The recommendations extend to considerations of power dynamics, institutional feasibility, and actor incentives in crafting effective anticorruption measures.

#### **(v). Ethical Dimensions and Cultural Considerations**

A distinctive contribution lies in the exploration of ethical dimensions and cultural considerations, such as the role of faith and values in shaping perceptions of corruption. This adds a layer of depth to the anticorruption discourse, recognizing the importance of cultural context in crafting interventions that resonate with the beliefs and values of diverse communities.

In summary, this thesis contributes to knowledge by advancing our understanding of the “corruption complex” within mixed health systems using Abuja, Nigeria as an exploratory base while offering insights applicable to other Nigerian states and LMICs. It not only identifies challenges but also provides a foundation for developing targeted and culturally sensitive strategies to combat corruption and enhance the integrity of healthcare delivery on a broader scale.

### **7.3 Policy Implications and Recommendations: Targeted Areas for Impact**

This section of the chapter discusses the policy implications and recommendations from the review of the main empirical findings to suggest interventions to policymakers in order to address the causes of corruption in Nigeria's mixed health system. From the findings discussed in the preceding section, this thesis identifies the need to target critical actors in the health system whose actions or inactions are implicated in the problems of corruption in Nigeria's health service delivery. These target audiences include (i) Professional associations (ii) healthcare providers, (iii) patients, and (iv) health officials/policymakers representing the government.

#### **(a). Professional Bodies/Associations: Strengthening Horizontal Approaches to Anti-Corruption in Health Facilities**

In the fight against corruption in health facilities, horizontal approaches are essential for fostering transparency, accountability, and integrity within communities. While community organizations like Ward Development Committees and facility health committees are critical in many Nigerian states and low- and middle-income countries (LMICs), the context of Abuja-FCT does not typically have such ward committees which necessitates exploring alternative avenues. Here, I discuss the role of professional associations and bodies in ensuring horizontal approaches to anti-corruption efforts within health facilities in Abuja.

Abuja as the capital city of Nigeria, hosts a diverse array of professional associations and bodies that can act as effective vehicles for horizontal strategies against corruption in health facilities. These organizations, comprised of professionals and experts within various fields, possess the expertise and credibility necessary to drive anti-corruption initiatives. Some of these professional bodies and their roles in horizontal anti-corruption approaches include:

**(i). Nigerian Medical Association (NMA)**

The NMA, with its branches in Abuja, plays a pivotal role in promoting ethical standards and combating corruption within the healthcare sector. By engaging healthcare professionals, the NMA can facilitate awareness campaigns, training sessions, and advocacy efforts against corrupt practices.

**(ii). Nigeria Association of Pharmacists (NAP)**

NAP, representing pharmacists in academic institutions, can collaborate with health facilities in Abuja-FCT to ensure the responsible use of pharmaceutical resources. Their expertise can aid in implementing transparent procurement processes and monitoring the distribution of medications, mitigating opportunities for corruption.

**(iii). Association of Medical Laboratory Scientists of Nigeria (AMLSN)**

AMLSN members, specializing in laboratory services, can contribute to anti-corruption efforts by ensuring the accuracy and integrity of diagnostic procedures. They can advocate for proper equipment maintenance, accurate reporting, and adherence to ethical guidelines, thereby reducing avenues for corruption.

**(iv). Nigerian Nurses and Midwifery Association (NNMA)**

The Nigerian nurses association, representing nurses across Abuja-FCT, can emphasize ethical conduct and integrity within nursing practices. By promoting accountability and transparency, nurses can act as watchdogs against corrupt activities in healthcare settings, thereby upholding patient safety and trust.

## **(b) The Healthcare Worker: Functional Health Systems and Improved Remuneration**

Targeted policies focusing on the challenges healthcare providers face in Nigeria's health system must be at the centre of the policy discussion if corruption problems must be addressed. After all, patients interact with healthcare providers, and corruption does not exist in a vacuum. From the evidence presented in this study, the shortage of resources and the dysfunctional state of public health facilities, including poor remuneration of public healthcare workers, are leading factors that create an enabling environment for corruption, such as bribery, informal payments, absenteeism, dual practice, theft and, diversion of patients and medical supplies between the two health sectors, amongst others. Therefore, a reform agenda to tackle corruption in Abuja and the rest of Nigeria should include concerted efforts to increase sustained funding to the Nigerian health sector, including healthcare workers' salaries are more likely to be supported by both healthcare providers and patients.

Evidence of such policies has been recommended by scholars on corruption in healthcare systems in the literature. For example, this recommendation is in keeping with those of Vian *et al.* (2006), who advocated that practices such as dual practice, bribery and informal payments may very well be impacted by a better understanding of how healthcare workers are rewarded, the wage differences between different kinds of healthcare workers, and other specifics about the fair treatment and sufficiency of government remuneration policy (Vian *et al.*, 2006). This recommendation is essential within the context of mixed health systems as it breaks the cycle of connivance between public and private health facilities. Private health facilities know fully well how poor public healthcare workers' salaries are. Therefore, they often lure these public healthcare providers into corrupt practices such as diverting patients and medical supplies to private health facilities and dual practice by offering them extra income. In addition to a solid accountability environment, higher wages for public healthcare providers would go a long way in raising the desirability threshold for public health providers to engage in corrupt practices



that can bring them to disrepute or take the risk of being sanctioned when caught engaging in corruption.

Furthermore, this thesis showed several occasions where the dysfunctional state of public health facilities set up a cascade of events which encouraged healthcare providers to engage in corruption and related informal practices. These practices are at odds with formal rules in what is often regarded as *practical norms*, which are sometimes at crossroads with official regulations within such a dysfunctional health system. The recommendation, therefore, is that the government should make these health facilities much more functional by providing the needed machinery, equipment, and human resources to make these public facilities more work and user-friendly for providers and patients, respectively. Doing so reduces the enabling factors for corruption in public health systems, including the cyclical link of diverting patients to private health facilities except absolutely required.

### **(c) The Patient: Citizens' Voices in Addressing Corruption**

The need to account for the voices and experiences of patients who are the consumers of health services is fundamental in instituting an effective policy response to address corruption in public and private health facilities in Abuja and the rest of Nigeria. This study recommends that patients' voices be at the heart of corruption reforms and policy intervention to address the causes of corruption.

There is a continuous need for strengthening and supporting existing mechanisms like the "whistle-blower" policy on corruption in the Nigerian health sector by domesticating and contextualising the various nuances, including patients' experiences of corruption. For example, in this study, patients' views provided insights into how public providers exploit the commercialisation of health in public facilities through informal payments and the theft of approved user charges, mainly from cash payments. The voice of patients and their experiences

is critical to shaping the future of policies that will plug such loopholes from being exploited by healthcare providers, which might only be visible to the government through citizens' (patients') voices. Similarly, to reinforce citizens' voices, in this case, the patients, this thesis advocates for continuous public education and awareness campaigns in Abuja and the rest of Nigeria regarding patients' experiences of corruption and the need for reporting to appropriate quarters. In conjunction with the Ministry of Health, the Federal Capital Territory Health Administration (FCTHA) should launch public awareness and education initiatives to educate patients on amplifying their "*citizens' voices*" on their rights and responsibilities as patients and how to resist and report corrupt practices.

In an article by Gray-Molina - *Does voice matter? Participation and controlling corruption in Bolivia*, Bolivia's citizens' health board engagement comprised patient groups that considered their experiences and crafted policies that served as a significant deterrent for informal payments. This, in turn, improved internal revenue for public healthcare spending in Bolivia (Gray-Molina, de Rada and Yáñez, 1999, p. 12). I believe the Bolivian government enhanced the feasibility of such successes, making room for patients' perspectives as the government planned and developed its commercialisation reforms in health service delivery. The patients were critical stakeholders, and their input was considered to ensure that intended government reforms and policies were not exploited. In Abuja and the rest of Nigeria, the patients' perspectives and voices have been largely missing (Adeloye *et al.*, 2017). Therefore, with the empirical insights drawn from the voices and perspectives of patients in this study, policy intervention to plug loopholes exploited by healthcare providers can be easily addressed. For example, the increasing penetration of electronic payment modalities in Nigeria can be encouraged by the management of health facilities in Nigeria in order to reduce the incidence of corrupt practices such as theft of user fees by health workers and informal payments. Although theft can still occur via electronic payment, it leaves audit trails where perpetrators

can be traced and punished. Scholars such as Vian and Norberg have advocated a similar vertical approach to addressing corruption (Vian and Norberg, 2008).

#### **(d) Policymakers/Health Officials: Regulatory Oversight and Accountability Structures**

As revealed in the three empirical chapters of this thesis, a significant underlying factor that allows corruption to flourish in public and private health facilities in this study is the problem of lack of oversight and poor regulation, with almost a total absence of regulation and oversight on private health facilities in Abuja and rest of Nigeria. The evidence shows that due to poor regulation of private health facilities, patients have been subjected to unethical, deceitful, and sometimes corrupt practices such as overcharging and unnecessary treatments as well as under/overprovision of care that compromise patients' interests at the expense of profit maximisation for private healthcare providers.

Therefore, improving regulatory oversight that covers not just the public health sector, but also private health facilities should be at the top of the policy response of policymakers and health authorities in Abuja and Nigeria the rest of Nigeria. For example, The Service Compact (SERVICOM) units which the government established to monitor and escalate reported failure in effective service delivery, including corrupt practices, should be extended to have a footprint in the private health sector since the two health sectors have been shown to interact on several fronts. The Ministry of Health and Federal Capital Territory Health Administration (FCTHA), Abuja, should step up their efforts to adequately regulate and monitor health facilities in Abuja, including private healthcare facilities that have been left largely unregulated. Doing this will ensure compliance with professional and ethical guidelines in health service delivery, including checkmating corrupt and fraudulent practices detrimental to patients. These checks should include frequent audits to enforce compliance with practices that adhere to established quality

standards. In addition, the regulatory bodies should be given the necessary resources to carry out their oversight functions with due diligence.

In addition, this thesis advocates for creating a grievance redressal mechanism by the FCTHA for patients to report corrupt practices by both public and private healthcare providers. The FCTHA and the Ministry of Health should investigate all reported incidents and take all the necessary actions against transgressing health workers if found to be involved in such practices. Similarly, regulatory bodies of the different healthcare professionals who are saddled with enforcing discipline across the various health professions, such as the Nigerian Medical and Dental Council, the Nursing and midwifery council of Nigeria, pharmacists and laboratory technologists Council, amongst others, working together with the supervising Ministry of health and the FCTHA should step up disciplinary proceedings against healthcare providers, public and private medical professionals who are found to partake in corrupt and fraudulent practices. Appropriate sanctions ranging from fare penalties, and suspension of licences, can serve as a deterrent to other healthcare providers. Furthermore, this thesis advocates for strong collaboration and partnerships with relevant professional bodies to improve oversight and regulation that considers both the public and private facilities in Abuja and the rest of Nigeria.

#### **7.4 Methodological lessons as part of the contribution of the thesis**

The use of the respondent-driven sampling (RDS) technique, which factors in heterogeneous participants, offers valuable methodological lessons for ensuring diversity and avoiding bias in research like this. Some key lessons derived from employing this technique include:

### **(i). Leveraging Social Networks**

This heterogeneous driven method leverages existing social networks, allowing researchers to access diverse populations that might be otherwise challenging to reach. By tapping into these networks, researchers can expand their participant pool beyond initial contacts, ensuring a broader and more heterogeneous sample.

### **(ii). Enhancing Participant Diversity**

The process also encourages participants to refer others from their social circles, resulting in a chain referral process. This approach naturally leads to a more diverse sample as individuals are likely to refer people with different backgrounds and characteristics, enhancing the overall diversity of the study population.

### **(iii). Minimizing Selection Bias**

Unlike traditional convenience sampling methods, RDS minimizes selection bias by incorporating a broader range of participants. Since individuals within social networks are more likely to trust and share information with each other, this method helps in reaching individuals who might be hesitant to participate in a study conducted by unfamiliar researchers.

### **(iv). Accounting for Heterogeneity**

RDS accounts for the heterogeneity of participants by capturing individuals from various social, economic, and demographic backgrounds. This diversity enriches the dataset and ensures that findings are representative of a wider population, allowing for more generalizable and robust conclusions.

## 7.5 Limitations of the Study

While this qualitative empirical research has provided invaluable insights into how the problems of corruption are now understood within the context of mixed health systems in Abuja, Nigeria, this project had several limitations in addition to those earlier presented in the methods chapter.

The findings of this study are mainly from selected health facilities in Abuja, and there might be the issue of generalizability of findings with other regions of Nigeria. Although this study focused mainly on the experiences of patients and healthcare providers, and some policymakers in Abuja, some participants had lived in other parts of Nigeria and did share such experiences; however, there is still a place for research across several cities in Nigeria if resources, time, and scale were to permit. Doing so provides a more extensive representation of the experiences and perceptions of patients and providers in other parts of Nigeria.

This study also relied mainly on qualitative data gathered through in-depth interviews. Even as qualitative studies remain the best approach for understanding patients' and providers' experiences of corruption in public and private health facilities, more is needed in some regards. For example, while looking at the differences in the impact of corruption concerning financial barriers to care in public and private health facilities, an objective means of ascertaining the costs was limited and would have been best with quantitative research. The study relied on what patients claimed they spent. For example, the costs of paying bribes, informal payments, and additional costs of approved user charges by patients in public facilities were not objectively measured. It would have been insightful to compare patients' financial expenditures in private health facilities through practices such as over-charging/overbilling and over-provision of care.

Similarly, this study may have influenced social desirability bias, relying heavily on patients' and healthcare providers' self-reported experiences and perceptions of corruption. To avoid stereotyping or judgemental notions, patients and healthcare providers may have under-reported their complicity in corrupt practices or over-blown their experiences with corruption when it came to other people's engagement.

## **7.6 Future Research Priorities**

Given the specific emphasis of this study's objectives and findings, there are considerable areas for future research that spring out of this study and remain as gaps following this research. In this last section of the discussion chapter, opportunities for additional research are highlighted; many of these relate to the study's limitations highlighted above. While this study reveals that "everyday" corruption in health service delivery in Abuja, Nigeria, has negative impacts on patients regarding the equity of access, quality of care and financial vulnerabilities, more rigorous studies are needed to quantify these impacts in measurable terms in health service delivery in Nigeria's mixed health system, including how corruption interacts with other factors that influence patient outcomes in mixed health systems.

Furthermore, a contentious area of debate between the views of patients, healthcare providers and policymakers that arose from the findings in this study is the commercialisation of health in public facilities resulting in practices such as informal payments that negatively impact patients by creating barriers to care and financial protection issues. Future research to design specific solutions and strategies to address the loopholes that public health providers exploit in commercialising relationships between providers and patients can be a priority for research.

Finally, from a methodological perspective, this study used some form of participation observation (moderate type) as a support method for data collection alongside the primary data collection method- *in-depth interviews*. It would be insightful for future researchers to conduct

longer-term empirical research using participant observation as a lead ethnographic method within health facilities, especially for a sensitive topic such as corruption. From my fieldwork experience, I realised that it takes much time to gain the trust of healthcare providers and patients on the issue of corruption in health service delivery. Sensitive phenomena such as corruption would benefit from long-term observations of the interaction between healthcare providers and patients in their natural environment using prolonged participant approaches in health facilities. In this study, where a moderate form of participant observation was used in addition to the IDIs, I mentioned how cashiers and record clerks deliberately sabotage the use of point of sale (POS) machines in public health facilities in preference for cash payments, which makes it easier to steal user fees. Such insights and much more can be offered through long-term observation of patients and providers where time and resources permit. Longer-term participant observations will offer the extra layer of insights into practices that interviews sometimes cannot provide due to the sensitivity of corruption. What healthcare providers and patients say in interviews regarding specific forms of corrupt practices might differ from what happens when observed in a natural setting over a more extended period due to the complex and multifaceted dimensions of corruption in mixed health systems.



## Chapter Eight

### Conclusions

#### 8.0. Summary

This concluding chapter is in three sections. This first section briefly re-states the rationale for the project, in terms of the importance of the topic and the lack of related evidence. The second section summarises the responses to the study's three objectives, and the final section provides the thesis's response to the overall aim of the study.

As discussed in chapters one and two, most previous studies of corruption in the health sector – both in Nigeria, and in LMICs more generally - have focused on public facilities. As a result, the evidence base is incomplete; and there is a need to understand the causes, manifestations and impacts of corruption across public and private health facilities. This is especially true in Nigeria, in which the private health sector plays a dominant role in service delivery. Therefore, using Abuja as a case example, this thesis sought to explore the "corruption complex" as it occurs within the public-private mix in Nigeria. It is known that mixed health systems in LMICs are vulnerable to performance problems across multiple dimensions, including: equity of access to care; the safety, quality, and appropriateness of care; and financial protection. However, evidence of how corruption aggravates such problems - as patients and providers operate within the public-private mix in the health system - had not previously been studied.

In addition (and perhaps related to the above lacunae in scholarship), policy responses to corruption have also tended to target mainly public facilities. Related interventions have been 'top down' in nature and have failed to take into account patients' and providers' experiences of corruption (Berger, 2014; Glynn, 2022).

To address these gaps, this present study sought to examine corruption from a mixed health system perspective. It has presented evidence of corrupt practices in public and private health facilities, and the experiences of patients and providers regarding the causes, manifestations, and impact of corruption across these settings, and how the interaction of the two sectors (public and private) create further scope for corruption.

Its specific aim was to examine how corruption is experienced by, and impacts upon, patients and providers as they navigate the "corruption complex" in the mixed health system of Abuja, Nigeria. This was addressed through three objectives, as outlined below.

### **8.1. Response to the Study Objectives**

#### **(1). What are the experiences of patients and providers concerning the causes, manifestations, and impacts of corruption in public health facilities in Abuja, Nigeria?**

Corruption in public health facilities is driven by a number of variables, including: the shortage of resources; low salaries; weak accountability structures; and the commercialisation of relationships between patients and providers. Corruption manifests in public health facilities in varied ways, including: bribery; informal payments; theft of (user fees, drugs, and medical supplies); pressure from informal rules; and use of influence activities associated with nepotism.

Related practices in public health facilities have a negative impact on core universal health coverage (UHC) goals, including: erosion of the right to health care; and increased barriers to access, including financial barriers, especially for poorer patients. Furthermore, for some patients, the resulting financial impacts of health care encounters led to impoverishing health expenditures as revealed by experiences of some patients in chapter four of the thesis.

**(2). What are the experiences of patients and providers concerning the causes, manifestations, and impacts of corruption in private health facilities in Abuja, Nigeria?**

Corruption in private health facilities is driven by incentives related to profit maximisation in a context defined by inadequate regulation and the absence of transparency as revealed by the evidence presented in chapter five. Patients' and healthcare providers' experiences of corruption in private health facilities differ from the experiences of patients and providers in public health facilities. In private health facilities, corruption manifests in different forms, including inappropriate prescriptions with the potential of kickbacks from pharmaceutical companies and other private entities; forging of medical reports; over-referrals/over-treatment, and under-provision of services. Other manifestations of corruption in private health facilities include over-invoicing, health insurance fraud, and other-related invoice fraud.

These varied manifestations of corruption in private health facilities are more 'covert' than the forms seen in public facilities in this study. They are often disguised as part of the regular operational practices in private health facilities, making them difficult to be recognised by patients - compared to the more 'overt' forms of corruption experienced in public health facilities. These differences in manifestation between the two health sectors are partly tied to the differences in their institutional structures and incentives. In the views of patients, these corrupt practices in private health facilities impacts on core UHC goals, including reductions to the quality of care, pricing transparency and financial protection with exacerbation of financial risks to patients and households.

**(3). How, and to what extent, is corruption enabled by the co-existence of and interactions between public and private health facilities?**

Various types of public-private health sector interactions create scope for corruption, implying that the "mixedness" of the health system is itself implicated in the problem of corruption in Abuja. Most patients in this study feel that the interaction of the two health sectors enables

corruption by opening further opportunities. Patients feel that the interactions of the two health sectors serve as a conduit for engaging in several forms of corruption in Abuja's mixed health system. The evidence in this study shows that patients' experiences of corruption span a "broader" area considering the diverse manifestations of corruption across public and private health facilities in Nigeria.

Related manifestations of corruption in the public-private mix in health system include: dual practice, health worker absenteeism (enabled by dual practice), inappropriate referrals from public to private settings, and theft/diversion of medical resources. The impacts of corruption due to the interactions of the two health sectors include inequities of access, for example, due to delays in and denials of needed services and additional financial barriers encountered in public facilities, alongside reductions to quality of care, pricing transparency and financial protection in private facilities. Overall, in Abuja, Nigeria's mixed health system setting, the evidence suggests that patients feel that neither of the two health sectors is entirely devoid of corruption and its impacts, considering that the public-private mix itself is a driver of corruption to the detriment of their health and welfare.

## **8.2. Overall Response to the Aim of the Study**

This study concludes that patients experience corruption in both public and private health facilities in Abuja, Nigeria. However, the causes, manifestations and impacts of corruption differ across these two health sectors. In the public health sector, corruption creates financial and non-financial barriers to health care – aggravating inequities of access. In the private health sector, corruption undermines the quality of care for patients and exacerbates financial risks. Further, the public-private mix is itself implicated in the problem – giving rise to new opportunities for corruption to the detriment of the health and welfare of patients. These

interactions contribute to the causes of corruption in the public sector - especially the problem of scarcity (e.g., due to dual practice, absenteeism, theft, and diversions). For policymakers in Nigeria to address the problem of corruption in health service delivery, a cross-sectoral approach - inclusive of the full range of providers within the mixed health system – will be required. This thesis recommends that the "mixed market" lens inclusive of public and private facilities offers an optimal lens for scholars and policymakers to investigate, understand and address the problems of corruption in Abuja and the rest of Nigeria.

## Appendix A: University of Edinburgh Ethics Approval

**Your Research Ethics form submission has been reviewed**

**Mark Hellowell <drmarkhellowell@gmail.com>**

Wed 11/08/2021 10:36

**To: Sabastine Wakdok <Sabastine.Wakdok@ed.ac.uk>**

This email was sent to you by someone outside the University.

You should only click on links or attachments if you are certain that the email is genuine and the content is safe.

Dear Sabastine,

Your Research Ethics form submission ("Navigating the 'corruption complex' in mixed health service markets: a case study of Nigeria" [ID: 280102]) has been reviewed.

Category: Approved

Level: 2

Additional comments:

None

## Appendix B: FCT Abuja, Nigeria Ethics Approval



### Notice of Expedited Review and Approval of Research

**Approval Number: FHREC/2021/01/108/08-09-21**

**Full Study Title: Navigating the Adverse and Corrupt Practices in Mixed Health Service Markets: a Case Study of Nigeria.**

**Principal Investigator: Dr. Sabastine Wakdok**

**Address of Principal Investigator:** No 105 Fabian Nwora Avenue, Efab Metropolis Estate, Karsana, Abuja, Nigeria.

**Date of receipt of valid application:** 20/08/2021

The Federal Capital Territory (FCT, Nigeria) Health Research Ethics Committee (FCT HREC) has given expedited approval to the study described in the above stated protocol. The FCT HREC has determined that this research qualifies for expedited review pursuant to the National Code of Health Research Ethics.

This approval is valid from **08/09/2021** to **07/09/2022**.

Note that no activity related to this study may be conducted outside of these dates. Only the FCT HREC approved informed consent forms may be used when written informed consent is required. They must carry FCT HREC assigned protocol approval number and duration of approval of the study. The FCT HREC reserves the right to conduct compliance visit to your research site without prior notification.

The National Code of Health Research Ethics requires the investigator to comply with all guidelines, rules and regulations regarding the conduct of health research, and with the tenets of the code.

**Modifications:** Subsequent changes are not permitted in this research without prior approval by the FCT HREC.

**Problems:** All adverse events or unexpected side effects arising from this project must be reported promptly to FCT HREC.

**Renewal:** This approval is valid until the expiration date. If this project is to proceed beyond the expiration date, an annual report should be submitted to FCT HREC early in order to request for a renewal of this approval.

**Closure of Study:** At the end of the project, a copy of the final report of the research should be forwarded to FCT HREC for record purposes, and to enable us close the project.

For queries and further information contact FCT HREC office. I wish you best of luck with your research.

Desmond Emereonyeokwe  
Secretary, FCT HREC  
September 08, 2021.



## Appendix C: Research Information Sheet



Dr Sabastine Wakdok  
Global Health Policy Unit  
School of Social and Political Science  
University of Edinburgh  
Tel: +44 7478 606019  
E-mail:

### Information Sheet on the Study titled - Navigating the “corruption complex” in mixed health service markets: a **case of Nigeria’s mixed health system of public and private health facilities.**

This study is part of my PhD research in Global Health Policy at the University of Edinburgh, United Kingdom. The purpose of this research is to contribute to a better understanding of the operationalisation and provision of health services to patients as they ‘shop around’ i.e., move between public and private health facilities in Nigeria to seek care. This study, therefore, intends to understand the experiences of patients in terms of service provision as they seek care from health care providers and also the experiences of health care providers as they render services to patients in public and private health facilities.

There has been growing concern that corruption and adverse practices undermine the quality of health service provision to patients in Nigeria. And therefore, several attempts at policy reforms have been instituted to improve the service experience, however, these reforms have not achieved the desired outcomes. A major, reason being put forth has been corruption and informal practices in health service provision. But the views of patients as consumers of health care have not been taken into account to address these problems. Also, the views of health care providers and the challenges they face while providing health care has been underexplored.



Therefore, it is on this backdrop, that this study aims to understand the perceptions, experiences and 'lived' realities of both patients and health care providers with regards to corruption and related adverse practices in Nigerian health facilities. Most especially, as Nigeria is a mixed health system consisting of public and private health facilities with patients actively 'shopping around' for health care between these two settings. This study would like to understand your experiences with regards to problems of corruption and other adverse practices including the incentives, norms, and social relationships as you seek care between public and private health facilities.

This study will only involve adult patients and health care providers that can give informed consent. It is voluntary and you can withdraw at any time in the study. The study will be carried out within the Federal Capital Territory, and this will involve you to be interviewed. All interviews and focus groups will be anonymous and kept strictly confidential. At the beginning of each interview and as also stated on the consent form, I am not interested in your current or past medical histories as this is not needed. In the event such information is offered during the interview, it will be made of your own free will. Even at that, the specifics of such information will be completely anonymised so as not to link your interview with any particular patient.

All your data will be processed and stored in accordance with the General Data Protection Regulation (GDPR) along with the Data Protection Act 2018 (DPA). The project will also be guided by and adhere to the University of Edinburgh's data protection guidance and regulations, see <http://www.recordsmanagement.ed.ac.uk/InfoStaff/DPstaff/DataProtectionGuidance.htm>

All personal details, including contact details, addresses, phone numbers etc, will be kept strictly confidential within the research team, stored on password-protected and encrypted devices and/or University secure servers, in accordance with the General Data Protection Regulation, and the latest University of Edinburgh data security protocols. Electronic project data will be uploaded as soon as possible to a secure University of Edinburgh server and stored there for the duration of the project, only accessible to the project team. All paper records will be transferred to locked storage at the University of Edinburgh [or other location in the field] as soon as practicable. Your Consent Form will be stored separately from your responses. The audio recordings will be deleted after two years following completion of the researcher's PhD although the anonymised transcriptions will be retained. All data will be deleted using the latest University of Edinburgh protocol for secure data deletion.

Your participation in this study is completely voluntary and will be at no cost or risk to you. The information generated from this study will be used to recommend policies that will improve both the patient and health care provider experiences in Nigerian health facilities.

Thank you.

Sincerely,  
Sabastine Wakdok

## Appendix D: Research Consent Form



Global Health Policy Unit  
School of Social and Political Science  
University of Edinburgh  
Tel: +44 7478 606019  
E-mail:

### **Consent form for interviews relating to the study: *Navigating the “corruption complex” in mixed health service markets: a case of Nigeria’s mixed health systems of public and private health facilities.***

I am currently undertaking a PhD project at the University of Edinburgh, in the United Kingdom, relating to the topic of corruption and adverse practices in health care facilities in Abuja, Nigeria. I am particularly interested in how patients experience and perceive corruption and adverse practices as they seek out and utilise health care in different settings – including in public and private sector health care facilities. Please see the Information Sheet for a more detailed outline of the project’s aims, objectives, and methods.

In line with the University of Edinburgh’s ethical guidance, we need to ensure that only people who wish to do so participate in this study. Your participation in the interview or focus group is entirely voluntary and you can stop the process at any time. You will not be compensated for your participation.

The interview or focus group content will be digitally recorded and subsequently transcribed by myself. Neither your name nor that of anyone you mention nor any other personal details that would identify you will ever be referred to in these transcripts. The transcript will be labelled with a pseudonym and only basic details of your status will be recorded (e.g., outpatient, inpatient, health worker etc.). Any personal details will be anonymised, and we will not intentionally reveal your identity to anyone. All transcripts and datasets will remain anonymous, and any identifying detail will be removed or given pseudonyms in the transcript. At the beginning of each interview and as also stated

on the information sheet, I am not interested in your current or past medical histories as this is not needed. In the event such information is offered during the interview, it will be made of your own free will. Even at that, the specifics of such information will be completely anonymised or given pseudonyms so as not to link your interview with any particular patient.

I expect that the interview will take about 1 hour. The information or focus group content will be written up in the course of this research. It may therefore have an influence on the findings and analysis of this research and, in addition, the recommendations for health system and policy reforms that emerge from it. I would be grateful if, on this basis, you could confirm, by signing the form below, that you have understood the above, have had the opportunity to ask any questions relating to this form or the accompanying information sheet, and are happy for me to use the recorded interview or extracts from it in this way.

Please feel free to reach me at any time on these numbers; +2348038528008; +447478606019

**Please initial each box**

If you are happy to participate in the research, please initial each box as appropriate (leave blank any box for which you prefer not to give consent) and then sign this form at the end:

1. The researcher has given me my own copy of the Participant Information Sheet, and I have had the opportunity to read and consider the information.

☐

- 
2. I have been given the opportunity to ask any further questions and have had these questions answered to my satisfaction.

☐

- 
3. I understand that participating in the research involves interviews which include audio recorded interviews or written notes. The interviews would last about 1 hour per participant and expected to occur in the hospital setting or via audio conferencing if Covid-19 protocols do not permit face-to-face interviews at time of the interviews in Abuja.

☐

- 
4. I have been given information about how my data will be stored and used during and after the end of the research, and I have read and understood this.

☐

5. I understand that my words may be quoted in the final version of the PhD thesis as well as possible future *academic publications, articles, books, reports, web sites, related to the research project.* ☐

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6. I agree that in order to preserve anonymity, either a pseudonym; or a number; or descriptors e.g., age; gender; role – is what will be used. ☐

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7. I agree for the data I provide to be retained by the researcher in secure storage which will be deleted after 2 years following completion of the researcher's PhD, although the anonymised transcription will be retained securely. All data will be deleted using the latest University of Edinburgh protocol for secure data deletion. ☐

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8. I agree that members of the project team can re-contact me at a future date should they wish to follow up on this research. ☐

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9. I understand that my taking part is voluntary; I can withdraw from the project later, and I do not have to give any reasons for why I no longer want to take part (*and this will be without any impact on any related services I am using*). I have read and understood the Participation Information Sheet about the implications of withdrawing at different points during the life of the project. ☐

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10. I understand I can ask for specific quotes or statements not to be used (or to be redacted from the data) if I wish. ☐

---

11. I understand that if I want to withdraw from the project, I can contact Dr Sabastine Stephen Wakdok, who will discuss with me how existing data will be managed, as outlined in the Participant Information Sheet. ☐

I agree to take part in this research project.

Name /Initials of research  
participant

Date

Signature

Name of researcher recording  
consent

Date

Signature

Dr Sabastine Wakdok

## Appendix E: Research Interview Guide



### **Interview guide for the research on Navigating the “corruption complex” in mixed health service markets: a case study of Nigeria’s mixed health system of public and private health facilities.**

This study is designed to understand how patients experience and perceive adverse and corrupt practices as they seek and utilise health care in different settings – including public and private sector health care facilities in Nigeria using Abuja, the Federal Capital of Nigeria as a case study. The study is with respect to primary care services at General outpatient clinics and the view of health care providers will also be sought to in order to help provide a holistic answer to the research problem.

Your participation in this study is completely voluntary and the interviews will take about an hour per research participant. It will be a semi-structured interview where you can express your understanding on the subject matter freely. The interviews will be recorded and thereafter transcribed except where the research participant forbids any recording, then notes will be taken as much as possible to capture the information shared.

Also, any information obtained from this interview will be kept strictly confidential and your responses will be entirely anonymous.

#### **Biodata of research participants**

1. Initials of research participant
2. Age of research participant in years .....
3. Gender of participant a) Male b) Female
4. Marital status a) Single b) Married c) Divorced d) Widow/Widower e) Prefer not to say f) Others.....
5. Highest level of education a) None b) Primary c) Secondary d) Tertiary e) Postgraduate f) Others.....

6. Occupation a) Health professional b) Public servant c) Private employee d) Trader e) Artisan f) unemployed g) Housewives f) Others.....

### Interview question guides (semi-structured interviews)

#### Patients/Care-seekers

As a patient who has received or is still receiving care at the outpatient clinics in Abuja in which over time you might have had the need to visit this hospital or other (public or private health) facilities, I would like if you can describe your experience while visiting this hospital.

Following exchange of pleasantries and making the interviewer comfortable by asking how he or she is doing. Then a broad question introducing the topic.

- I. If it is ok by you let's start by tracing your pathway as a patient/care-seeker while you were visiting ..... hospital for treatment. How was your experience generally with regards to receiving health care in this health facility (be it public or private)?

What was your experience like in receiving health care in this hospital?

How was it when you arrived?

Who did you see first?

What happened?

How were you received?

Get the patients/care-seeker to chronologically describe and breakdown their experience and the practices they might have observed at each of these points during their visit in the hospital.

If it may help, could you describe your experience at each of these points.

(Points of orientation for the interviewer)

- Arrival at the hospital entrance/gate
- Reception hall
- Records/Card section
- Cashier/payment points
- Insurance desk,
- Nursing station
- Emergency unit
- Consulting room
- Pharmacy,
- Laboratory (bloods, urine, stool etc)

- Radiology unit (Xray, USS, MRI, CT)
- Wards
- Any other point in the hospital raised by the patient/care-seeker.

Interviewer (then drill down further asking for details on any aspects which analytically you think had potentially raised practices which might be undesirable to the patient/care-seeker or possible interpretation of what seems to be corrupt or related practices).

Two levels of Interviews should guide the discussion:

a) Description

b) in between those moments ask about the general view of the patient with regards to the practices he or she described at each point that you think relates to undesirable or corrupt practices from the patient's perspective. E.g., if interviewee mentions Informal payments, Interviewer can ask how you feel about it? What is your view about what you experienced?

**Health Care Providers/Health Care Worker: Trace the health care provider pathway through the questions.**

- II. Can you kindly describe your day-to-day work as a health care provider in this health facility (e.g., Doctor, Nurse, Pharmacist, Laboratory technician, Facility manager, Record clerks, Hospital cashiers etc)- Questions will depend on the type of service the health worker provides to the patients.
  - Explore what practices they also observe amongst themselves and their colleagues and why they do think these practices occur. For example, Nurses and if they mention practices like absenteeism or doctors if they mention dual practice.
  - Following the descriptive part of the interview, the reflective part sets in. Use prompts during the reflective part of the interviews to guide the discussion based on the literature review which might have outlined common practices elsewhere by HCP. Other common practices in the literature include informal payments, bribery and gift taking, theft at Pharmacy etc. Probe and explore deeper if these are mentioned and why they think these practices occur.
  - If they suggest that there is a tension between institutional set-up and organisational structure or perhaps something different. Follow the direction of their travel and ask them to describe their experiences regarding this tension. (Note this will be the analysis on incentives, norms etc).



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